NDIS Quality and Safeguards Commission

Inquiry Report

Own Motion Inquiry into Aspects of Supported Accommodation

January 2023

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Commissioner's foreword

The experience of a house as a home is an important contributor to the quality of our lives. Our homes are often the heart of our life, where we spend time with our family and friends, the base for our community engagement and where we feel comfortable and safest.

I believe that an essential element of a good life is safe and secure housing. People with disability should have access to accommodation and services that support living independently that not only makes them feel safe and secure but also feels like, and is, their home.

The National Disability Insurance Scheme (NDIS) was designed to enhance the lives of people with disability and amplify their rights in accordance with the UN convention of the rights of people with disability. While the NDIS has been in operation for almost a decade and has enacted a shift to consumer independence and consumer driven markets to elevate quality, there are some areas and service types where this shift has not been fully realised. One of those areas is supported disability accommodation.

As young adults, share homes are where many Australians take their first step to independence and learn to navigate living with different people. For many people with disability, sharing with other people is also a feature of home life in supported accommodation, but their experience is too often characterised by limited choice and a sub-optimal home environment.

During 2021 and 2022, the NDIS Quality and Safeguards Commission undertook an Own Motion Inquiry (the Inquiry) focused on the experiences of NDIS participants living in supported accommodation to better understand the challenges faced by participants in living in these settings and providers in creating environments that support participants' disability needs, while providing a sense of home.

I would like to thank Arthur Rogers for undertaking the Inquiry in its early stages and Rose Webb and Samantha Taylor for working on the Inquiry for much of 2022. I also want to acknowledge the work of Professor Christine Bigby in completing the accompanying literature review.

This Inquiry has found:

- There is a need for specific regulation of group home settings to enhance the quality and safety of these settings for people with disability.
- Greater engagement with people living in group homes is required to support their exercise of choice and control.
- The attitude and aptitude of the workforce drives a high number of the issues evident in group home settings.
- The interaction of supported independent living (SIL) and specialist disability accommodation (SDA) arrangements affects the ability of people with disability in supported accommodation to make changes to their living arrangements.
- We need to better understand the supported accommodation market and how people interact with it including by improving the collection, monitoring and analysis of relevant data.
- The interface with health and the supported accommodation system is not effective for many people living in these settings.

One of the key aims of this Inquiry was to identify models of best practice for the delivery of supported accommodation that can inform the NDIS Commission's capacity building work with providers, and the development of relevant practice standards and quality indicators. This component of the Inquiry has been delivered through a literature review conducted by a body with expertise in researching models of best practice and supported accommodation for people with disability (see Appendix D).

We also identified a range of issues relating to the 7 providers covered in depth by the Inquiry. A detailed analysis and review of each of these providers has been provided to the NDIS Commission executive for separate follow up action, which will include consideration of potential compliance and monitoring action where appropriate.

I would like to acknowledge these providers and their willingness to commit to continuous improvement to ensure their service offerings align with the intent of the NDIS and contribute to creating a good life and homes for their participants. Going forward, I will also be taking a personal interest in the active responses of each of the providers.

The Commission's response to the findings of this Inquiry includes commitments to new initiatives together with other activities targeting group home settings which will be integrated into our ongoing work program. A priority for us will be ensuring people with disability and their families/supporters are consulted on how best to implement changes arising from this Inquiry.

Some of the key new initiatives we will undertake to address the issues raised by this Inquiry include:

- changes to regulation and monitoring of supported accommodation, including the development and introduction of new standards for supported accommodation
- developing targeted programs of communication, engagement and education to amplify the voice of people with disability living in supported accommodation
- increasing oversight of all supported independent living (SIL) services, including unregistered providers, to ensure they are meeting the NDIS Code of Conduct.

Lastly, I would like to thank the many NDIS participants who took time to speak to our inquirers and myself, sharing their experience, challenges and aspirations. At the Commission we look forward to hearing more from all of you and many other people with disabilities as seek to improve choices and quality across the disability sector.

Tracy Mackey
NDIS Quality and Safeguards Commissioner

16 January 2023

Executive Summary

Background

The NDIS Quality and Safeguards Commissioner (the NDIS Commissioner) has powers under section 27 of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* and section 29 of the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* to initiate an inquiry about supports or services delivered by NDIS providers that were the subject of a complaint or a reportable incidents, or a series of complaints or reportable incidents. These are known as 'own motion' inquiries.

This first Inquiry using these powers focuses on the experiences of NDIS participants living in supported accommodation. The Inquiry examines reportable incidents and complaints that have been made to the NDIS Commission in connection with the supported accommodation services (specifically group homes) provided by 7 of the largest providers of these services over the period 1 July 2018 to 30 September 2022.

The purpose of this Inquiry is to enable the NDIS Commissioner to identify trends in issues that are occurring in supported accommodation, what is causing those issues, models of best practice to eliminate or address these issues, and how the NDIS Commission can use its powers to support the delivery of higher standards of support in these settings.

This Report

The Inquiry Report describes:

- the context for the Inquiry and the approach to undertaking it
- the regulation of these supports and the obligations on NDIS providers and their workers
- the supported accommodation market in Australia: what it is, how it is funded; who lives in group homes, and some broad information about the 7 providers covered by the Inquiry and how they fit in the market
- a summary of the types of reportable incidents and complaints examined in the Inquiry
- the features of a best practice framework for group home living and how these features should be applied in the regulation of these settings going forward
- observations arising from the examination of available material including work that should be progressed to assist in addressing some of the issues that impact on the quality and safety of supports of people living in group homes.

Approach

This Inquiry has involved:

- Detailed examination of around 7,000 reportable incidents and complaints about supports in group homes notified or made to the NDIS Commission about 7 of the larger Supported Independent Living (SIL) providers in Australia over the period 1 July 2018 to 30 September 2022.
- Major research into models of best practice for the delivery of supported accommodation that might be appropriate for consideration by the NDIS Commission in its capacity building work with providers, and in the context of any future amendments to NDIS Practice Standards and Quality Indicators.
- Detailed analysis of policies, procedures and systems of the 7 providers in managing incidents and complaints, their governance, risk management and assurance, and mechanisms to enable them to identify, analyse and treat the underlying causes of these issues to prevent recurrence.
- Direct engagement with people living in group homes across Australia, and targeted consultation with people with intellectual disability about their experiences and aspirations for their supported accommodation arrangements. There has also been engagement with stakeholders representing the interests of people with disability and the industry.

Providers included in the Inquiry

The providers included in this Inquiry are:

- Aruma Services
- Endeavour Foundation
- Life Without Barriers
- Lifestyle Solutions (Aust) Ltd
- Minda Incorporated (including Minda Housing Ltd)
- Scope (Aust) Ltd (including Home@Scope)
- The Disability Trust.

These 7 providers were chosen because they represent a significant part of the supported accommodation market across Australia, and the NDIS Commission had received complaints and been notified of reportable incidents relating to their supports.

A detailed report has been prepared for each of the 7 providers explaining the reportable incidents and complaints and other things about them that have been examined during the Inquiry. These reports will not be published because they contain protected Commission information under the meaning of the NDIS Act 2013. These reports and the Inquiry examination of their arrangements informs the Inquiry Report.

Although the Inquiry has examined incidents and issues relating to only 7 providers, these providers have a significant market share in respect of supported accommodation, either nationally or in a specific jurisdiction. NDIS participants receiving SIL supports from these 7 providers represent 18% of all NDIS participants receiving SIL across Australia.

For this reason, the observations made in this Report about the underlying factors contributing to incidents and issues relating to these providers may be considered to be indicative of the experiences of people with disability who receive supported accommodation from other large to medium providers in the NDIS. Therefore the findings of the Inquiry are open to broader application by the NDIS Commission in its advice, information, education, training and future regulation of providers of group home settings.

Research into models of best practice for supported accommodation

One of the key aims of this Inquiry was to identify models of best practice for the delivery of supported accommodation that can inform the NDIS Commission's capacity building work with providers and the development of relevant practice standards and quality indicators. The component of the Inquiry has been delivered through a literature review conducted by a body with expertise in researching models of best practice and supported accommodation for people with disability.

The Living with Disability Research Centre at La Trobe University was commissioned to deliver this element of the Inquiry. The project was led by Professor Christine Bigby and involved the review of relevant literature published (in English) between January 2015 and February 2022. The resulting paper is included at the web links in **Appendix D** to this report.

Observations and actions

The Inquiry has been able to deduce broader issues in the NDIS around people's experience in supported accommodation other than those that are related to the NDIS Commission's functions from the breadth of matters that were able to be examined through the Inquiry. This is because issues such as how these supports are funded, how NDIS participants access support and guidance independent of their provider to plan for any changes to their living arrangements, and how they interact with mainstream services (particularly health) contribute to the incidents and issues that affect them in their homes.

The Inquiry was not able to identify solutions to all these issues, however it identified a range of areas of work for NDIS providers and the NDIS Commission to pursue to improve the quality and safety of supports to NDIS participants living in group homes.

Particularly, there is a compelling case for mandating elements of the Best Practice framework, particularly Active Support and Frontline Practice Leadership. This framework would go a significant way to addressing the quality of life of people with disability living in supported accommodation, and the benefit of applying these practice elements to reduce the incidents and issues experienced by people with disability is borne out through the detailed examination of matters undertaken by the Inquiry.

There are a number of aspects of regulatory and scheme design that warrant much further exploration than the broad observations made through this Inquiry.

It is also apparent through this Inquiry that additional oversight and regulation of these types of supports is warranted.

The main areas of observation and action arising from the Inquiry include the following.

- The need for **specific regulation of group home settings** to enhance the quality and safety of these settings for people with disability, most of whom have the most significant support needs in the NDIS, and as a result for whom poor quality outcomes would have a catastrophic impact on their quality of life. This can be achieved through a range of measures, starting with the development of new Practice Standards specific to these settings.
- The **attitude and aptitude of the workforce** drives a considerable number of the issues evident in group home settings. The majority of workers in this sector are committed, capable and well versed in and observant of the rights of people with disability. There are some workers however whose attitude and aptitude will not be addressed by training or routine supervision. Providers should work to develop organisational cultures that eliminate abusive and neglectful conduct of their workers, and take action to address such conduct, including through referral to the NDIS Commission when appropriate.

- **The way that Supported Independent Living (SIL) and Specialist Disability Accommodation (SDA), interact** appears to drive some issues for how people with disability are able to work with their providers to make changes to their living arrangements when they wish to make them. There are limited levers for providers to assist people to make changes where they wish, or to fill vacancies efficiently, or to easily adjust support arrangements as a person's needs change. There is a broader design issue about whether people living in group homes have the same extent of choice and control over their NDIS supports as other NDIS participants.
- There has been limited engagement with those people who have transitioned to the NDIS from state and territory funding arrangements about **options for more contemporary living arrangements within the NDIS, should people wish to explore these**. This is mainly left to their current providers to facilitate on an individual or house by house basis, and almost always limited to the options that the current providers might have available.
- This is particularly apparent in remaining **large institutional settings** where it is up to providers to plan for and facilitate redevelopment, where they own the existing property. A number of larger facilities are owned by state and territory governments with no plans for redevelopment however. In all cases close consultation with people with disability living in larger settings and their families should be undertaken to make sure that their views and preferences are taken into account as the home and living landscape in the NDIS evolves.
- The **interface with health and the supported accommodation services** is not effective for many people and is reflected in high levels of incidents and complaints. Incidents arise in relation to the transition of participants from the health system to the disability support system, from inadequate access to health care resulting in accelerated deterioration where a person has a chronic condition, and poor quality end of life support. Providers are trying new approaches to address these interface issues, however it is apparent that a system level approach would be beneficial.
- **Understanding the supported accommodation market and how people interact with it**. There are limitations in the data of both the NDIS Commission and the NDIA which constrain analysis of the market and how people who live in these settings engage with other supports, or have assistance with exercising their choice and control to the extent of others in the NDIS. It is critically important that these settings are more closely monitored and that both agencies are aware of where they are and who lives in them to enable more active engagement across each agency's respective functions. This is particularly important given the characteristics and circumstances of this population.

The body of the report provides deeper consideration of these and a range of associated issues, including matters relating to engagement with participants, provider behaviour, provider governance, markets and the regulatory environment.

Next steps

The NDIS Commission has commenced planning for the implementation of actions to address issues arising from this Inquiry.

Further detailed consultation with people with disability is planned to inform how best to implement changes arising from this Inquiry.

The NDIS Commission encourages people with experience living in or related to supported accommodation to share feedback about this report, or insights about supported accommodation, with the Commission. The views of people with disability and those who support them help the Commission to find ways of improving the experience of people living in supported accommodation.

If you would like to share your experiences or feedback on this report, please email **contactcentre@ndiscommission.gov.au**.

Chapter 1:

Background to the Own Motion Inquiry

The NDIS Quality and Safeguards Commission (NDIS Commission) is an independent Commonwealth agency established to improve the quality and safety of NDIS supports and services.

The NDIS Commission is established under the *National Disability Insurance Scheme (NDIS) Act 2013* (the NDIS Act). The functions and powers of the NDIS Commission and the NDIS Commissioner are set out in Chapter 6A and Part 3A of Chapter 4 of the NDIS Act. The NDIS Commission's functions and powers reflect the *NDIS Quality and Safeguarding Framework*, which was agreed to by all Australian governments in 2017.

The NDIS Commission works with NDIS participants, service providers, workers and the community to implement a new nationally consistent approach so participants can access services and supports that promote choice, control and dignity.

The NDIS Commission regulates the quality and safety of NDIS services and supports. The Commission's activities include:

- upholding the rights, health and safety of people with disability
- development of a nationally consistent approach to managing quality and safeguards
- registration of providers
- education activities and provision of information
- complaints management, including, assessment, investigation, conciliation and resolution of complaints
- oversight of a provider's responses to reportable incidents and taking action as appropriate
- behaviour support leadership and oversight
- compliance and enforcement, including investigations
- market oversight
- supporting providers to meet their NDIS worker screening obligations.

The NDIS Commission began operations in New South Wales and South Australia on 1 July 2018. Operations expanded to Victoria, Queensland, Tasmania, the Northern Territory, and the Australian Capital Territory on 1 July 2019. Operations began in Western Australia on 1 December 2020, and the residential aged care providers supporting NDIS participants also became registered NDIS providers on 1 December 2020.

Context for this Inquiry

This is the first Own Motion Inquiry (Inquiry) initiated by the NDIS Commission. It is looking into aspects of supported accommodation in the NDIS.

The Inquiry was established because the NDIS Commission was observing a range of issues through reportable incidents and complaints, and in feedback from people with disability, advocates, and other stakeholders about the experience of people with disability in those settings.

The NDIS Commissioner can initiate an inquiry into a complaint or a reportable incident,[1] or a series of complaints or reportable incidents, about supports or services delivered by NDIS providers. An Inquiry can be used to establish the facts about one matter or a group of matters, to identify the cause/s, and whether changes are needed to avoid recurrence.[2]

It is appropriate to initiate an inquiry about a series of complaints or reportable incidents where the NDIS Commission wishes to focus on systemic issues and identify areas for change to improve the quality and safety of supports for people with disability across the NDIS.

The NDIS Commission is particularly concerned about supported accommodation settings because they involve continuous, intimate and fundamental daily life support to people with disability. People living in supported accommodation generally have high support needs, depend on others for most aspects of their daily living needs, and may have few protective mechanisms available to them, both to identify risks to them and act on those risks to avoid harm.

In this Inquiry, 'supported accommodation' means support that is often referred to in the NDIS as 'supported independent living' (SIL), as well as 'specialist disability accommodation' (SDA). The Inquiry focus is on supported accommodation that involves congregate living, which is a form of accommodation sometimes referred to as 'group homes'.

1 Registered NDIS Providers are required to notify the NDIS Commission of reportable incidents as defined under s73Z of the NDIS Act.

2 **About own motion inquiries | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)**

These services typically involve residences where a group of 3 or more people with disability live together. The accommodation is often provided for by an organisation, and the people living in the accommodation receive significant support with most aspects of daily living, and if they didn't need that support they would not need to live in the accommodation. It does not include individual independent living options or shared living in family situations.

This Inquiry does not seek to make any assessment as to whether supported accommodation is an appropriate model of support for people with disability. This has been raised by a number of stakeholders during the Inquiry.

Supported accommodation services form part of the NDIS market now, and are likely to be chosen as a support option by people with disability for some time. The future role of these services in the NDIS is a matter for the people with disability who participate in the NDIS and should be determined by the choices they make.

The experiences of people with disability living in group home settings has had attention through a range of reviews and inquiries over many years. Most recently, focus on this issue has arisen through a series of hearings held by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission), and an Inquiry by the Joint Standing Committee into the NDIS on Supported Independent Living (SIL) in the NDIS completed in 2020.[3]

A number of the conclusions arising from this Inquiry bear out observations made by the Joint Standing Committee Inquiry into Supported Independent Living. The Disability Royal Commission is scheduled to report to the Australian Government in September 2023.

A person we consulted with who wants to move into a group home said: "The person I am living with now makes the decision and choices for me and I do not like that. I want to be heard. I want the focus on me and be able to make my own choices."

Another person who lives in a group home said they would prefer to live by themselves. They would like more control about who comes in and out of their home, and the supports they get.

Terms of reference

This Inquiry is to examine:

- the complaints and reportable incidents received by the NDIS Commission about issues and incidents that are occurring in supported accommodation provided by a selection of NDIS providers
- the trends in those issues and incidents
- identify, if possible to do so, the underlying factors causing or contributing to these issues and incidents
- models of best practice in supported accommodation that could address or eliminate those issues and incidents
- ways to promote continuous improvement and higher standards of support in supported accommodation.

The full Terms of Reference for the Inquiry are at **Appendix A**.

The approach taken to initiate and undertake the Inquiry is described in **Appendix B**.

The Terms of Reference set out the considerations taken by the then NDIS Commissioner to determine the providers who would be included in it. This involved consideration of data across the NDIS providers with a high market share in SIL (as at end of the 2020–21 period), and where the NDIS Commission had a volume of notifications of reportable incidents, as well as complaints.

3 **Supported Independent Living – Parliament of Australia (aph.gov.au)**

The providers included in this Inquiry are:

- Aruma Services
- Endeavour Foundation
- Life Without Barriers
- Lifestyle Solutions (Aust) Ltd
- Minda Incorporated (including Minda Housing Ltd)
- Scope (Aust) Ltd (including Home@Scope)
- The Disability Trust.

All the providers covered by the Inquiry are registered NDIS providers and have completed their registration renewal process, and therefore are no longer subject to the transition provisions set out in section 26 of *NDIS (Provider Registration and Practice Standards) Rules 2018*. This means all of the providers covered by this Inquiry are required to comply with all the Practice Standards.

The Inquiry has examined more than 6,260 reportable incidents (excluding unauthorised restrictive practices) and 850 complaints that have been notified by or made about supported accommodation services delivered by these providers over the period 1 July 2018 until 30 September 2022.

While there are a significant number of reportable incidents that concern the use of an unauthorised restrictive practice (URPs), the Inquiry did not examine these matters in detail because a separate program of work is underway in the NDIS Commission on this important issue. Nonetheless, some observations are made about the use of restrictive practices in this report.

The perspective of people with disability

The experience of people with disability is the central consideration for the Inquiry and has been taken into account at every stage. This has been included through examination of the material held by the NDIS Commission related to the complaints covered by the Inquiry, which in every case describe the experience of a person or people with disability. For reportable incidents, these also relate to the experience of a person with disability, although these are the providers' account of that experience. These reportable incidents and complaints relate to the experiences of more than 3,500 people with disability.

The Inquiry has involved many meetings people with disability living in their homes in Queensland, Victoria, New South Wales (NSW) and South Australia. The Inquiry has met more than 50 people with disability on these visits.

These visits took place in people's homes, on their own terms. They were informal and unscripted. Some involved hours of engagement, others, shorter periods of time. In every case, the residents guided the visit. There was also engagement with support workers. The Lead Inquirer is grateful for the time that all these people took to engage with her. This report includes de-identified descriptions of some of the people that were visited by the Lead Inquirer and the NDIS Commissioner, who attended some of these visits.

Small groups of people with disability were also directly consulted about their experience in supported accommodation. This was an important consideration for the Lead Inquirer – what is important to people with disability and their supporters in supported accommodation – and shapes the findings and activities arising from the Inquiry. The consultation included people with disability and family members of people with disability. This consultation was undertaken by 3 advocacy organisations: VALID, the South Australian Council on Intellectual Disability and the Council for Intellectual Disability (NSW). The outcomes of this consultation are published in full alongside this report with the links at **Appendix C**.

These reports will be used by the NDIS Commission to develop material for people living in group homes. The way in which this consultation was undertaken will also assist the NDIS Commission in determining approaches to engagement with people with disability to progress a number of the actions arising from this Inquiry.

The Lead Inquirer is confident that the breadth of people that the Inquiry has engaged with are representative of the diversity of people with disability living in group homes. The Lead Inquirer acknowledges however that this in no way assumed to represent the perspectives of all people with disability living in group homes. Nonetheless, there are common themes from that engagement that would reflect the views of many others.

One person with disability who was consulted said: "One thing that's good about my life is that I'm here today to actually discuss some of my experiences and suggestions as well".

The rights and perspectives of people with disability are central to how the NDIS Commissioner performs her functions. The NDIS Commissioner's Strategic Plan 2022–2027 has a focus on amplifying and promoting the rights of people with disability, and enabling informed choice using regulatory frameworks to promote and remove barriers to quality and safety. Many of the actions that the NDIS Commission will take arising from this Inquiry will require much more discussion and engagement with people with disability and their supporters to shape. The NDIS Commissioner will actively engage with people with disability to take forward changes to the regulation of supported accommodation in the NDIS so those changes fulfil this commitment, as well as engage on other activities arising from this Inquiry.

Stakeholder engagement

During the Inquiry there was engagement with a number of stakeholders representing the interests of people with disability, the disability sector and industry (**Appendix E**).

Through these stakeholders the Inquiry built a better understanding of the way in which the NDIS works for people with disability, the factors that are thought to drive issues with quality and safety in supported accommodation, and the challenges that people with disability face in exercising choice and control over their supports when they live in supported accommodation.

Industry stakeholders also assisted the Inquiry in understanding some of the issues that may place constraints on providers to improve the standard of support in supported accommodation, and the broader challenges that they face in operating within the NDIS market.

The NDIS Commission engaged with the National Disability Insurance Agency (NDIA) through the Inquiry, particularly in obtaining data to assist with understanding the profile of NDIS participants who live in supported accommodation and the supported accommodation market. The Inquiry also engaged with the NDIA on work being undertaken to consider the way that 'home and living' supports are provided for in the NDIS.

Treatment of Protected Commission Information

The material examined during the Inquiry included considerable amounts of 'protected NDIS Commission information'.[4] The NDIS Commissioner has detailed information about the reportable incidents and complaints relating to each provider, which include protected NDIS Commission information such as personal information of NDIS participants and their families, advocates and other supporters, as well as details of the providers' staff such as support workers, house managers and key personnel.

Given that protected Commission information is subject to restrictions on disclosure set out in the NDIS Act,[5] this report does not contain specific commentary about each of the providers or any other identifiable information about a person beyond what is necessary to support an understanding of how the findings and recommendations have been formulated.

A report has been prepared for each of the 7 providers detailing the data and other information examined during the course of the Inquiry. These reports also include information for the provider about actions the NDIS Commission may require them to take to address any issues that have been identified through the Inquiry. This may include the NDIS Commission monitoring the work that some of these providers have underway in relation to any issues identified through the Inquiry.

4 'Protected Commission information' is defined in section 9 of the NDIS Act to mean information about a person (including a deceased person) that is or was held in the records of the NDIS Commission, not including any information that has been published on the NDIS Provider Register.

5 These include sections 67B, 67C and 67D of the NDIS Act, which establish offence provisions in relation to persons who use or disclose protected Commission information for an unauthorised purpose, or persons who solicit or offer to supply protected Commission information unlawfully.

Each of the 7 providers was afforded the opportunity to review the reports about them. It was not a requirement to provide feedback to the NDIS Commission, however all of the 7 providers did provide feedback, which in some cases resulted in minor amendments to their Report, and in one case the addition of further information.

As these reports contain significant amounts of protected Commission information, the reports about each of the 7 providers will not be released.

Principles for undertaking the Inquiry

The Lead Inquirer applied the following principles in undertaking this Inquiry:

Rights of people with disability

NDIS participants living in supported accommodation have a right to be safe and to be supported in their home. They have the right to choice and control over how their accommodation and other supports are delivered, and to have their personal preferences accommodated in their home.

Quality providers and workers

NDIS participants living in supported accommodation are supported by workers who have the skills and capabilities to deliver their supports, and conduct themselves in the delivery of those supports in a manner that reflects the rights and preferences of the people in whose homes they work. The providers that are responsible for the delivery of these supports work to continuously improve these supports through practice review, workforce development, feedback and learning.

Thriving, diverse markets

NDIS participants living in supported accommodation are able to participate equally in the NDIS by: choosing the providers that deliver their supports, and how they will be delivered; maximizing their own independence, including by access to community and mainstream services; making complaints, and having those complaints addressed; and where incidents occur, having those incidents responded to and learnt from so they are avoided in future.

Ben[6] loves music and dancing. He has just started back at his Tuesday evening dance class. It has been closed due to COVID-19. Ben is enjoying reconnecting with the friends he hasn't seen since 2020. He doesn't see his family very much since his parents died, so his friends at dance are the main people in his life apart from the people he lives with, and his support workers. Ben, Stan and Theo have lived together for 10 years. They enjoy each other's company and like watching TV together. Ben generally picks what they watch and it's usually a musical or a DVD of a concert. Ben finds it difficult to communicate with people he doesn't know. He will often simply agree with or repeat what they say. His support workers have worked with him for many years and know his likes and dislikes. They help him to communicate his likes and dislikes to other people so he has an independent voice.

This report

This Inquiry Report has been compiled for the NDIS Commissioner by the Lead Inquirer, Ms Samantha Taylor, Strategic Advisor to the NDIS Commissioner. Ms Taylor was assisted in the preparation of this Report by Ms Rose Webb (Inquiry Advisor), and other officers of the NDIS Commission.

6 The case studies included in the report are about people the Lead Inquirer met during the Inquiry. Their real names have not been used.

Chapter 2:

Regulation of supported accommodation

The NDIS Commission regulates all NDIS providers and their workers in relation to their obligations under the NDIS Act and NDIS rules. The NDIS Commission uses a risk-based approach to regulation that is proportionate to the scale of organisations and any breaches, and responsive to an expanding market that has not previously been subject to regulation or oversight in any systemic way.

Registration, together with the NDIS Code of Conduct, are the central mechanisms that enable the NDIS Commissioner's regulation of NDIS providers.

Generally, NDIS participants can choose who provides their NDIS supports from providers that are available and willing to provide those supports. There is some limitation on that choice, which is determined under the regulatory framework for the NDIS delivered by the NDIS Commission.

NDIS participants are only able to choose providers that are registered NDIS providers to provide:

- any supports where they have their NDIS plan managed by the NDIA
- SDA in any circumstance[7]
- Plan management services, if they are partly or fully plan managing their NDIS funds
- any support that involves the use of a restrictive practice
- specialist behaviour supports where they need a behaviour support plan to be developed.

Other than in these cases, participants are able to choose any provider to deliver their NDIS supports.

All providers of SDA are required to be registered NDIS providers. However, not all providers delivering supported accommodation are required to be registered NDIS providers.

All NDIS providers, whether registered or not, are bound by the NDIS Code of Conduct.[8]

On registration – providers are subject to a number of conditions of registration, set out in section 73F of the NDIS Act, including the conditions to comply with the NDIS Code of Conduct[9] and to comply with NDIS Practice Standards (Practice Standards)[10] which are provided for in the *NDIS (Provider Registration and Practice Standards) Rules 2018* (Registration Rules).

Other conditions of registration include that registered providers must implement and maintain an incident management system and complaints management and resolution system that comply with the respective requirements outlined in the *NDIS (Incident Management and Reportable Incidents) Rules 2018* (Incident Management Rules) and the *NDIS (Complaints Management and Resolution) Rules 2018* (Complaints Rules)[11].

Registration requirements for providers of supported accommodation

Supported accommodation is a term used in this Inquiry to describe NDIS supports and services that are delivered in a group setting. NDIS providers delivering certain supports must be registered under these 'classes of support' (or registration groups) in order to deliver these supports. The main classes of support that relate to the delivery of supported accommodation to an NDIS participant are: '*assistance with daily life tasks in a group or shared living arrangement*',[12] '*specialist disability accommodation*' and '*high intensity daily personal activities*'.[13] NDIS participants living in supported accommodation will also receive a number of other supports as part of their NDIS plans. A single provider may deliver these supports to a person, or different providers may deliver them.

7 Registration Rules, section 7(1).

8 As set out in section 6 of the National Disability Insurance Scheme (Code of Conduct) Rules 2018.

9 NDIS Act section 73F(2)(b).

10 NDIS Act, section 73F(2)(c).

11 NDIS Act, section 73F(2)(e) and (g).

12 Registration Rules, section 20(3), Item 15.

13 Registration Rules, section 20(3), Items 31 and 4.

Providers of supported accommodation are not necessarily required to be registered NDIS providers, although they are required to be registered if they are supporting an NDIS participant whose NDIS plan is managed by the NDIA, or if they use regulated restrictive practices during the provision of NDIS supports.[14] They are also required to be registered if they also provide SDA or specialist behaviour support services,[15] at least in respect of those classes of supports.

Providers that are registered to provide *assistance with daily life tasks in a group or shared living arrangement* must be assessed by an NDIS Commission approved quality auditor as meeting the Practice Standards specified in Schedule 1 (Core Module) to the Registration Rules, using a certification audit.[16]

Providers registered to deliver *assistance with daily life tasks in a group or shared living arrangement* are also frequently registered to provide *high intensity daily personal activities*, and therefore must also comply with the Practice Standards set out in Schedule 2 to the Registration Rules. These activities and requirements are described in more detail in the following sections of this chapter.

Providers that are registered to provide only SDA must be assessed by an approved quality auditor as meeting the Practice Standards specified in Schedule 7 to the Registration Rules, using a certification audit.[17] If registered to provide SDA and one or more other classes of supports, providers must be assessed as meeting the Practice Standards specified in Schedules 1 (Core Module) and 7 (Specialist Disability Accommodation) to the Registration Rules, using a certification audit.[18]

One person with disability who was consulted said, "Even though I live with other people, I have my own space and independence. I love the area I am living in, and I know the people in my community."

There are no restrictions in the NDIS Act or rules as to the combination of classes of support for which a provider can apply to be registered. To be registered to provide a class of supports, providers must undergo a verification or certification audit in which an approved quality auditor will assess whether they meet the Practice Standards relevant to that class of supports.[19]

Certification audits are intended to be for the assessment of providers applying for registration to deliver supports that are more complex and involve higher risk to people with disability. This type of audit should involve a review of policies, site visits and direct feedback from NDIS participants about their experience with the supports and services. A certification audit has 2 stages. The first stage is a desktop audit of the provider's policies, guidelines, qualifications and other documentation in relation to the Standard being reviewed. The second stage involves an inspection of the sites, facilities, and equipment and services used, as well as interviews with people who receive the supports or services from the provider, the key personnel, or workers delivering the services.

NDIS Practice Standards

The Practice Standards are a series of requirements that set out the standard of services that a registered NDIS provider must comply with to become and remain a registered NDIS provider. They also provide a guide to any NDIS provider about what quality in the delivery of supports and services to NDIS participants involves. Each standard is defined by an outcome statement that focuses on the experience of the participant. Each standard is built from a high-level participant outcome, supported by a series of quality indicators[20] that set out how the outcome might be achieved, again focusing on participants.

The Practice Standards consist of a Core Module and several supplementary modules that apply according to the types of supports and services NDIS providers deliver.

14 Registration Rules, section 7(2).

15 Registration Rules, sections 7(1) and 7(3).

16 Registration Rules, sections 20(1), 20(2) and 20(3), Item 15.

17 Registration Rules, sections 20(1), 20(2) and 20(3), Item 31.

18 Registration Rules, sections 20(1), 20(2) and 20(3), Item 31.

19 Registration Rules, section 20(1).

20 Set out in the National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018.

The **Core** Module covers:

- rights of, and responsibility for, participants
- governance and operational management
- the provision of supports
- the support provision environment.

The **supplementary** modules cover:

- high intensity daily personal activities
- specialist behaviour support
- implementing behaviour support plans
- early childhood supports
- specialised support coordination
- specialist disability accommodation.

There is also a module for those supports and services that require a **verification** assessment, where the Core Module does not apply. This module is for lower-risk supports, including where there is other regulation in place, such as for allied health supports.

Each module has:

- a series of high-level, participant-focused outcomes
- for each outcome, quality indicators that auditors will use to assess a provider's compliance with the Practice Standards.

Core Module

Schedule 1 to the Registration Rules contains the Core Module of the NDIS Practice Standards. Relevant to the Inquiry, the Core Module includes the following Practice Standards, which require providers to demonstrate:

- **Person centred supports:**[21]
  1. Each participant can access supports that promote, uphold and respect their legal and human rights.
  2. Each participant is enabled to exercise informed choice and control.
  3. The provision of supports promotes, upholds and respects individual rights to freedom of expression, self-determination and decision-making.
- **Independence and informed choice:**[22] Each participant is supported by the provider to make informed choices, exercise control and maximise their independence in relation to the supports provided.
- **Freedom from violence, abuse, neglect, exploitation or discrimination:**[23] Each participant can access supports free from violence, abuse, neglect, exploitation or discrimination.
- **Governance and operational management:**[24] Each participant's support is overseen by robust governance and operational management systems relevant and proportionate to the size and scale of the provider and the scope and complexity of the supports being delivered.
- **Quality Management:**[25] Each participant benefits from a quality management system relevant and proportionate to the size and scale of the provider, which promotes continuous improvement of support delivery.
- **Complaints management and resolution:**[26]
  1. Each participant has knowledge of and access to the provider's complaints management and resolution system.
  2. Complaints are welcomed, acknowledged, respected and well managed.
- **Incident management:**[27] Each participant is safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, responded to, well-managed and learned from.

21 Registration Rules, Schedule 1, clause 3.

22 Registration Rules, Schedule 1, clause 6.

23 Registration Rules, Schedule 1, clause 7.

24 Registration Rules, Schedule 1, clause 9.

25 Registration Rules, Schedule 1, clause 11.

26 Registration Rules, Schedule 1, clause 13.

27 Registration Rules, Schedule 1, clause 14.

Module 1: High intensity daily personal activities

Schedule 2 to the Registration Rules sets out Practice Standards relating to complex bowel care, enteral feeding and management, severe dysphagia management, tracheostomy management, urinary catheter management, ventilator management, subcutaneous injections, and complex wound management. These Practice Standards indicate that it is the responsibility of the provider that each participant requiring specific care receives appropriate support that is relevant and proportionate to their individual needs.

Module 5: Specialist Disability Accommodation

Schedule 7 to the Registration Rules contains the Practice Standards relating to SDA, including the following relevant Practice Standards:

- **Conflict of interest:**[28] Each participant's right to exercise choice and control over other NDIS support provision is not limited by the participant's choice of SDA dwelling.
- **Service agreements with participants:**[29] Each participant is supported to understand the terms and conditions that apply to their SDA dwelling and the associated service or tenancy agreements.
- **Enrolment of SDA dwellings:**[30] Each participant's SDA dwelling meets the requirements of the design, type, category and other standards that were identified through the dwelling enrolment process.
- **Tenancy management:**[31] Each participant accessing an SDA dwelling is able to exercise choice and control and is supported by effective tenancy management. The associated Quality Indicators[32] for this standard include filling vacancies, documenting arrangements for working with other providers, acting on allegations of violence, abuse, neglect, exploitation or discrimination, and dealing with changes in needs or circumstances together with a person.

Incident Management Systems

Registered NDIS providers are also subject to the condition of registration that they implement and maintain an incident management system that is appropriate for their size and the classes of supports or services they provide, and meets the requirements set out in Part 2 of the Incident Management Rules.[33]

A provider's incident management system should cover incidents broader than those that are defined as reportable incidents.[34] The system must be documented, and accessible to the provider's workers, NDIS participants and their families, carers and advocates.[35] The system must establish procedures to be followed in identifying, managing and resolving incidents, as well as how those incidents should be assessed. These procedures must consider how persons with disability will be involved in the management and resolution of incidents,[36] and provide that incidents are assessed by considering the views of persons with disability affected by the incident.[37]

The Incident Management Rules also set out obligations aimed at ensuring providers have incident management systems that are operating effectively and safeguarding participants, by requiring that systems provide for periodic review[38] and allow for the collection of statistical and other information relating to incidents that would allow the provider to review incidents, identify systematic issues, and report information relating to complaints to the NDIS Commissioner when requested by the NDIS Commissioner.[39]

28 Registration Rules, Schedule 7, clause 4.

29 Registration Rules, Schedule 7, clause 5.

30 Registration Rules, Schedule 7, clause 6.

31 Registration Rules, Schedule 7, clause 7.

32 National Disability Insurance Scheme (Quality Indicators) Guidelines 2018, clause 72.

33 NDIS Act, section 73F(2)(g).

34 The definition of a reportable incident is set out in section 73Z(4) of the NDIS Act and sections 16 and 17 of the Incident Management Rules.

35 Incident Management Rules, section 12(1).

36 Incident Management Rules, section 10(1)(e).

37 Incident Management Rules, section 10(3) and (4).

38 Incident Management Rules, section 10(6).

39 Incident Management Rules, section 12(5).

Complaints Management and Resolution Systems

Registered NDIS providers are subject to similar requirements in relation to managing complaints. A condition of registration is that they must implement and maintain a complaints management and resolution system that is appropriate for their size and the classes of supports or services they provide, and meets the requirements set out in Part 2 of the Complaints Rules.[40]

The Complaints Rules require providers to ensure that their complaints management system enables any person to make a complaint to the provider, provides for an easy and accessible process to make and resolve complaints, and provides appropriate support and assistance to any person who wishes to make, or has made, a complaint.[41] This support and assistance extends to advising complainants, and any affected person with disability, about how complaints can be made to the NDIS Commissioner, and providing assistance in contacting the NDIS Commissioner. Neither the complainant, nor any person with disability affected by an issue raised in a complaint should be adversely affected as a result of the making of that complaint.[42]

A provider's complaints management system must be documented, and accessible to its workers, NDIS participants and their families, carers and advocates.[43] The documented system must record information about complaints, any action taken to resolve them, and the outcome of any action taken.[44] The system should also ensure complainants and affected persons with disability are kept informed about the progress of the complaint, and are involved in the resolution of the complaint.[45]

The Complaints Rules also require providers to have complaints management systems that allow for the collection of statistical and other information relating to incidents that would allow the provider to review incidents, identify systematic issues, and report information relating to complaints to the NDIS Commissioner when requested by the NDIS Commissioner.[46]

A person with disability we consulted with said: "I have rights at my home. I can come and go. I can talk to people and mingle. I have the right to privacy – I have my own key. I have the rights to feel safe – I feel safe at home. If I am not feeling safe I will tell staff. I have the right to speak up and feel I can do this. I have the right to make a complaint – I would talk to my house manager or my family. I feel I am respected at home...I have the right to make choices".

40 NDIS Act, section 73F(2)(e).

41 Complaints Rules, section 8(1).

42 Complaints Rules, section 8(4).

43 Complaints Rules, section 10(1).

44 Complaints Rules, section 10(2).

45 Complaints Rules, section 8(5) and (6).

46 Complaint Rules, section 10(4).

Chapter 3:

Supported accommodation in the NDIS

The NDIA determines a person's eligibility to participate in the NDIS, and the NDIS Plan they will receive to enable them to access the reasonable and necessary supports and services they need.

NDIS participants will receive funding in their NDIS plan for support to live in their accommodation where they have high support needs due to their disability, and need support at home all or most of the time. In the NDIS, this type of funding is referred to as SIL.

Just about every NDIS participant living in a group home receives SIL in their NDIS plans. Some people with disability may live in group homes but not receive SIL in their NDIS plans, for example children and young people who are NDIS participants and may be in out of home care or voluntary out-of-home care arrangements.

When people have particularly high support needs and need to live in houses that are designed to cater for their specific needs, they may also receive SDA in their NDIS plan. SDA covers the housing that a person lives in where it is a necessary form of accommodation relating to the specific disability needs of the person. It is separate to the supports or services that a person with disability receives to assist them with their daily support needs, and to other costs associated with rent and board. Not everyone who receives funding for SIL supports and lives with other participants will be funded for SDA.

Funding for supported independent living

An NDIS participant's plan will include the home and living option which best meets a participant's needs and goals. SIL is one type of home and living support funded under the NDIS. It can be funded if a person lives on their own, or if they live with other NDIS participants in a group home. SIL is funded in the Core Supports budget of an NDIS participant's NDIS plan.

Usually SIL supports will involve:

- help with personal care tasks
- help to build skills in things like meal preparation and cooking, cleaning, and developing a routine
- help to action any behaviour support plans
- help to develop social skills
- support with supervision, personal safety and security
- support to administer medication if needed
- support to attend medical appointments
- community access that is not routine or regular
- support to get to and from community access activities. For example, to visit family or friends outside of the home.[47]

As at 30 June 2022:

$27.6bn
was provided in support to **534,655** NDIS participants.

32%
($8.776bn) of this funding was provided to 26,950 or **5%** of NDIS participants, for supported independent living.

47 NDIA Supported Independent Living Guideline. **Supported Independent Living | NDIS**

These activities are expressed as specific activities that involve doing something for someone, or supporting them to do a task, however this type of support also involves direct and incidental engagement between a person with disability and their support workers when they are at home.

Rent, board and lodging costs, as well as groceries and utilities, are not funded by the NDIS and are usually paid by the NDIS participant directly to the provider. Some of these expenses will be managed through a 'house' account where residents each provide a personal contribution for expenses that are shared equally by all residents.

If SIL is the appropriate option for an NDIS participant, the NDIA will determine how much funding to include in their NDIS plan to meet the costs of that support. The NDIA will use a range of information to determine the level of funding including the roster of care submission from an NDIS provider, as well as assessments and other information about the person's needs.

An NDIS provider chosen by the person to deliver their support will prepare the 'roster of care' submission. They must consult with the participant, or their nominee, to compile the information that needs to be included in the roster of care submission. This submission describes the types of supports an NDIS participant is able to receive from their chosen SIL provider, but it does not determine the final amount or type of support an NDIS participant will get in their plan. The roster of care is usually only needed once by the NDIA. If a participant had SIL approved in a previous plan and their support needs stay the same, the same support is generally continued in the next plan.

When determining the amount of SIL funding, the NDIA will look at the participant's day-to-day support needs to determine how many hours of support the participant needs (the days of the week, and the times of the day when support is needed). For example, they will look at any new assessments or reports about the participants' disability support needs which describe how often and when they need support. Once the NDIA has determined what hours of support the participant needs in a typical week, they will then work out the ratio of support for these hours, in order to provide a funding amount in the plan.

The person's chosen provider then determines the staffing for the residence based on the combined support needs of all the NDIS participants that will be living there.

If one person's needs change, or they move to another residence, providers must adjust the supports they provide in the residence as a whole, based on the support needs of each person living there.

Funding for specialist disability accommodation

SDA is a support funded under the Capital budget in an NDIS participant's plan. The amount of funding budgeted in the NDIS plan for SDA is determined by the type, category and location of the SDA – which will also be described in a person's plan.

When a person has SDA in their NDIS plan a maximum budget is provided. A participant can choose the type, category or location of their accommodation within that budget.

If a person is looking for a new place to live using their SDA funding they connect with SDA providers directly using various channels to identify an appropriate place. If a person needs help with finding an SDA provider, they can use a support coordinator if there is funding for that in their NDIS Plan.

> One person with disability who was consulted talked about their dream home: "My dream home would be a nice place where I'd have internet and enough spots for DVDs and I'd live with my partner, just the one other person. I would like to have support at night time and during the day so we can get to where we need to go. I'd want to live somewhere close to public transport and a Shopping Centre."

SDA dwellings must be 'enrolled' by the NDIA before they can be made available to NDIS participants.

Once a suitable SDA dwelling has been identified, service and tenancy agreements are established between the participant and the SDA provider. The NDIS participant will advise the NDIA where they will be living and a service booking is made against the SDA component of their plan for that address. The SDA provider then claims the funding for the accommodation from the plan.

The NDIS participant can choose the SIL provider they wish to deliver their daily supports in the dwelling. The SIL provider can be the same as the SDA provider, or a different provider may be chosen to deliver the SIL supports. The extent to which this choice can be exercised in practice, particularly where a person may be moving onto a house where other people are already living and have SIL supports from a provider, is explored later in this report.

The primary responsibility for supporting NDIS participants to exercise choice and control in their accommodation lies with SDA providers, by virtue of the 'Tenancy Management' standard in the SDA NDIS Practice Standard Module. This includes understanding the distinction between the provision for SDA and other supports that might be delivered in the residence, and how vacancies are filled – including how each participant's views, preferences and needs will be taken into account.

To demonstrate compliance with the Tenancy Management standard, providers should also have policies and procedures in place that are accessible to participants, and tenancy arrangements should be documented. Tenancy arrangements should provide for matters including how the SDA provider will work with other providers (such as SIL providers), how concerns about an SDA dwelling will be addressed, how potential conflicts involving participants will be managed (including responding to violence, abuse or exploitation), and how changes to a participant's circumstances or supports will be addressed. SDA providers should also work with other providers, such as SIL providers, to ensure the shared living arrangement works for all tenants.

These arrangements currently only apply to registered NDIS providers that are registered for SDA and providing support to an NDIS participant in an SDA enrolled property. They do not apply to other providers when an NDIS participant receives their supported accommodation in arrangements such as private rental or from other housing providers.

These are important considerations for the quality of the experience of a person with disability living in a group home, and they should apply regardless of whether the supports are being provided in an SDA dwelling or through another type of arrangement.

Types of supported accommodation

Supported accommodation can be provided in a range of settings, for example:

- a suburban house (SDA or otherwise) where a group of people with disability live together, each with their own bedroom (sometimes with ensuite), sharing a common living room, kitchen, bathroom and garden, and with an area of the house used as office space for staff
- a number of suburban houses (as above) located in relatively close proximity to each other, sometimes with direct links between each of the houses (for example through a garden gate), with a team leader or manager overseeing supports across the network
- a cluster of units or villas on a single parcel of land, with each unit occupied by one or more resident who each have their own bedroom. The units are connected by a common area for shared meals and recreation, and include an office area that is separate for staff
- larger houses that have been purpose built to accommodate a number of people with disability who may have specialised support needs, sometimes on a bigger scale than a usual suburban home, with accommodation spread across multiple wings or floors, with each resident having their own room, and with interconnecting common areas for residents to share meals or for recreation
- larger facilities that are located on parcels of land that are separated from the local community (for example by a gate), with individual houses co-located on the grounds. The grounds usually have an administration building, and may have other buildings designed for recreation or to provide ancillary supports such as therapy. These properties sometimes have houses on site where one person who has very significant challenging behaviours might live alone. These houses are generally 'secure' in that there is not free access in or out of the house, and there is close monitoring of activities within the house
- larger facilities with a similar configuration to a private hospital or aged care facility.

Supported accommodation models can be relatively isolated environments for the people living in them, either because the support needs of the residents are such that they depend on support workers for most or all of their engagement with other people, or because of the nature of the building – which may be separated from the rest of the surrounding community. Some residents may have limited connection with family, friends or neighbours, or their access to their community may be only in connection with another NDIS support or service.

Luke has a bookcase full of bowling trophies. He can't bowl anymore because his knees are troubling him. Luke says he loves where he lives, particularly his room which has everything he needs. He describes how he feels about it by giving a double thumbs up. He used to live in a large older building close by with more than 40 people. When he talks about where he used to live, he makes a double thumbs down gesture. In Luke's room there is a large portrait of him. It was a 50th birthday present to Luke from Dave who has supported Luke for more than 15 years. Luke is very proud of this painting because it shows that is his place.

Supported accommodation can be provided with funding through the NDIS (for example a funding contribution to SDA), or it can be:

- private rental arrangements leased by the SIL provider, or by a group of NDIS participants (no examples of the latter were observed through this Inquiry)
- leases of state- or territory-owned properties
- leases through a community housing provider
- property owned by the SIL provider.

Choosing an NDIS provider to deliver SIL

The principle of choice and control within the NDIS recognises the participant's right to make their own decisions about what is important to them, and to decide how they would like to receive their supports and from whom.

One of the objects of the NDIS Act is to "enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports".[48]

Two of the general principles guiding actions under the NDIS Act are that people with disability:

- should be supported to exercise choice, including in relation to taking reasonable risks, in the pursuit of their goals and the planning and delivery of their supports[49]
- have the same right as other members of Australian society to be able to determine their own best interests, including the right to exercise choice and control, and to engage as equal partners in decisions that will affect their lives.[50]

The term 'choice and control' is not to ensure that participants make a choice that others might agree is the 'best' choice, or even a 'good' choice, but that the participant makes their own choice. Participants should receive any necessary support to make an informed choice, but they need not make a risk-free choice or a choice that another person might make on their behalf. They may also decide to have others make certain decisions for them.

In the context of supported accommodation, participants can choose the same provider to provide their support and some or all of their other supports, or they can choose different providers for each of their supports.

48 NDIS Act, S3(e)

49 NDIS Act, S4(4)

50 NDIS Act, S4(8)

51 Registration Rules, Schedule 6 Clause 5

All NDIS providers, including unregistered providers, must comply with the NDIS Code of Conduct. One of the obligations for all NDIS providers and workers under the NDIS Code of Conduct is that they act with integrity, honesty and transparency. The NDIS Commission's guidance on the NDIS Code of Conduct sets out requirements in relation to addressing and managing conflicts of interest, for example if an NDIS participant chooses a provider to deliver one or more of their supports, including supports that might involve making decisions about changes to supports. There is a specific practice standard in relation to conflict of interest in the NDIS Practice Standards that applies to registered NDIS providers of specialist support coordination.[51]

An NDIS participant's choices about the provider they want to deliver their SIL supports can have an impact on the choices of other people that they live with. It is important that no one person's choice compromises the quality or safety of supports that other participants receive, and that all NDIS participants living together in a group home are able to make decisions equally about their SIL provider.

The way in which SIL is funded would suggest that although it is technically possible for NDIS participants living in a group home to each choose different providers, in practice this is not what occurs. Certainly there were no examples of this kind observed through the Inquiry.

A number of factors might point towards the importance of considering the preferences and needs of NDIS participants who live together in a group or shared living arrangement collectively, as well as individually – which is a different concept than would be the case for most other NDIS supports and services. For example:

- **Support workers:** Some participants and their families or supporters may have concerns if another resident in the group home chooses a different SIL provider who brings in support workers with whom they do not feel comfortable or safe.
- **Predictability in who is coming and going from the house:** Predictability can be particularly important for some participants to be and feel safe. If there are multiple providers involved in support within one group home this can mean many different rosters operating concurrently, or regularly adjusting. For some people changes to their environment or routines could lead to behaviours that may involve risk of harm to themselves or others. Changes driven by the choices of a person's co-residents may make them individually, and the residents of the group home collectively, less safe if the changes are not carefully coordinated and managed.
- **Awareness of the needs and preferences of all residents:** In some group homes, a number of residents may have behaviours of concern that involve risk of harm to themselves, other residents and/or support workers. In these circumstances, it may be particularly important for all of the support workers supporting any of the residents to understand and be trained in the behaviours and other specific support needs of all of the residents, not just the resident they mainly support.
- **Managing changes to who lives in a house:** Difficulties arising from new providers and workers and other changes being introduced into a participant's home may be more likely when the residents change, and one or more new residents move into the group home.

In circumstances where having more than one SIL provider supporting residents in a group home arrangement might present an unacceptable risk to the quality or safety of supports, there may be other ways in which participant choice and control could be maximised without allowing a free, individual choice of SIL provider. For example, residents could choose their SIL provider, but do so as a group rather than individually. Residents could also choose a SIL provider that gives people more direct choice over the particular support workers that work in the residence.

Increased choice could also be achieved by considering the supports that are provided in the house as a whole and those that are more specific to each of the people living there.

People living in supported accommodation

The range of people living in supported accommodation is extremely diverse, and includes:

- people who have profound intellectual, physical and sensory disability with limited or no ability to undertake most tasks of daily living without support, including basic communication. They may be unable to express their views without significant engagement, and are unlikely to complain about their support themselves. They usually rely on others to make major decisions about their lives

Michael is 60 years old. He has lived in a group home most of his life. He has recently been diagnosed with dementia. He uses a wheelchair and must sit in a reclined position to help him breathe. He needs support with everything he does. He has a PEG for all his food and hydration. He has seizures associated with his epilepsy multiple times a day and is closely monitored by support staff in his home. He has a device he uses to play music that he takes everywhere with him. He likes to be in the living room so he can be part of whatever is going on during the day.

- people who have mild intellectual or psychosocial disability and are able to do most tasks of daily living themselves, with guidance. They access the community by themselves, actively express their views, and are able to complain about their support. They make all the decisions about their lives themselves, often with guidance about the options available to them.

Mary is 55 years old. She goes on the bus at 7am every day to the local café for a coffee and then to shop for the day. She gets up at 5am to be ready to catch the bus. If she misses the 7am bus she has to wait for an hour before the next one comes. The support worker assists with running the house, and supporting each of the women with their needs, such as reminding them about medication or planning for an outing or helping work through a problem, like assisting Mary to raise the issue of the bus shelter with Council.

Although there is considerable diversity in the types of people living in these settings, the people living in these settings represent a significant proportion of people in the NDIS with the most complex needs associated with their disability.

There is extensive information in the NDIA Quarterly reports about NDIS participants accessing SIL and all other NDIS participants. The information in this section is derived from that data,[52] and reflects only a small sample of it.

Over **70%** of NDIS participants who are funded for SIL have been assessed as having a low level of function[53] compared to 26% of all NDIS participants. A low level of function means a person has high support needs, and needs more NDIS supports and services to enable them to do many of their daily activities.

The following graph shows the percentage of all NDIS participants that have been assessed as having low, medium or high function, compared to those NDIS participants with SIL in their plans.

52 **Archived quarterly reports 2021–22 | NDIS**

53 The NDIA records each NDIS participant's Level of Function based on a range of tools including the World Health Organisation Disability Assessment Schedule (WHODAS 2.0) which is a generic assessment instrument for health and disability applicable across cultures, in all adult populations and the Paediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT) designed for use with children and youth.

Figure 1: Assessed level of function: NDIS Participants with SIL compared to all NDIS Participants

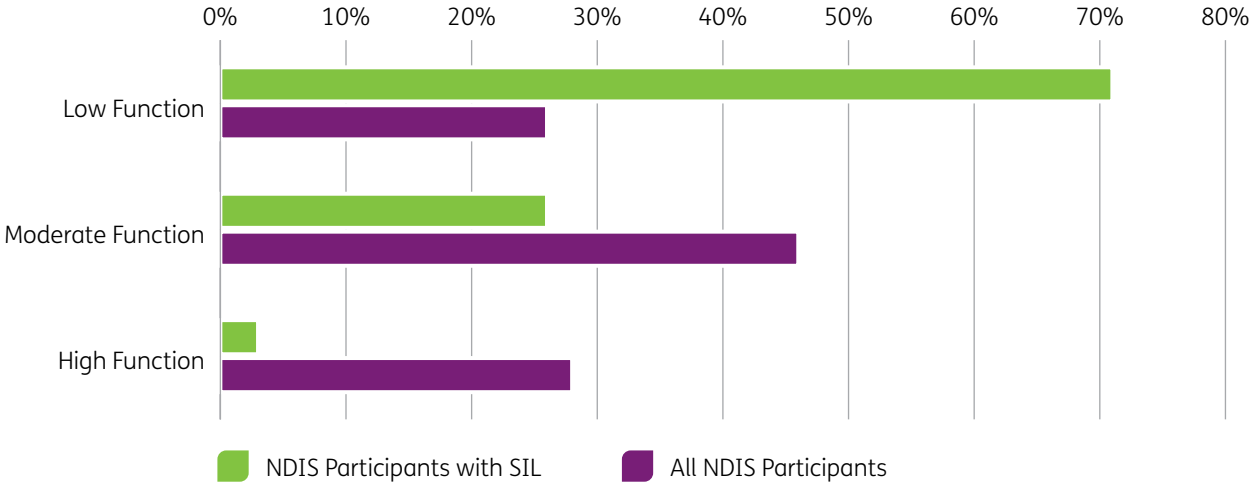
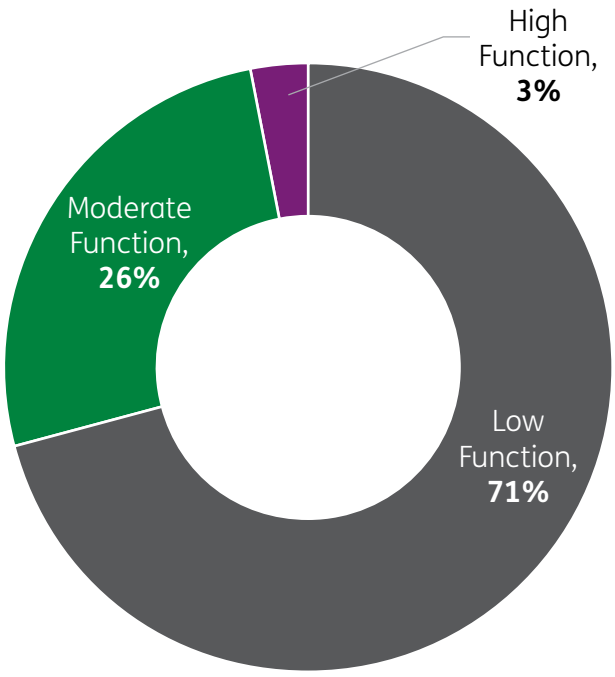


Table 1: Assessed level of function: NDIS Participants with SIL compared to all NDIS Participants

Assessed Level of Function	All NDIS Participants with SIL	% of NDIS Participants with SIL	% of All NDIS Participants
Low Function	19,250	71%	26%
Moderate Function	7,075	26%	46%
High Function	625	3%	28%
Total	**26,950**	**100%**	**100%**

26% of participants accessing SIL have a moderate level of function, with 15% of these people being at the 'low' end of moderate. This compares with 46% of all NDIS participants who have a moderate level of function, where 23% of those people are at the 'high' end of moderate.

Figure 2: Assessed level of function: NDIS Participants with SIL



People living in supported accommodation are mainly adults with a primary disability of intellectual disability. More than **50%** of people with SIL in their plans have intellectual disability as their primary disability, compared to **18%** of the total NDIS participant population.

The following graph shows the primary disability percentages of all NDIS participants compared to that of NDIS participants with SIL in their plans.

Figure 3: Primary Disability: NDIS Participants with SIL compared to all NDIS Participants

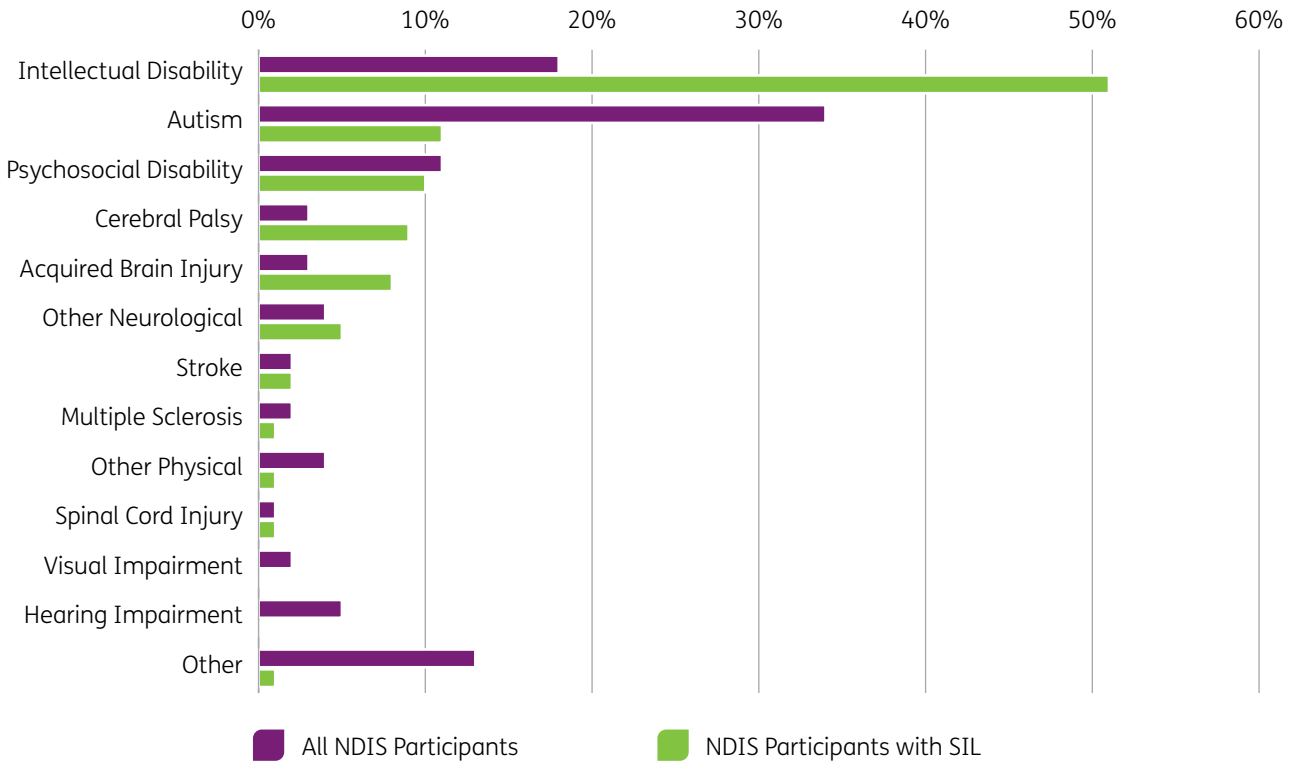


Table 2: Primary Disability: NDIS Participants with SIL compared to all NDIS Participants

Primary Disability Group	All NDIS Participants	NDIS Participants with SIL	All NDIS Participants – Counts	NDIS Participants with SIL – Counts
Intellectual Disability	18%	51%	96,469	13,786
Autism	34%	11%	182,494	3,059
Psychosocial Disability	11%	10%	56,559	2,797
Cerebral Palsy	3%	9%	17,206	2,416
Acquired Brain Injury	3%	8%	16,675	2,095
Other Neurological	4%	5%	21,094	1,321
Stroke	2%	2%	8,114	518
Multiple Sclerosis	2%	1%	9,528	282
Other Physical	4%	1%	19,368	212
Spinal Cord Injury	1%	1%	5,563	173
Visual Impairment	2%	0%	9,633	85
Hearing Impairment	5%	0%	24,615	11
Other	13%	1%	67,337	195
Total	**100%**	**100%**	**534,655**	**26,950**

People with SIL in their NDIS plans are an older cohort than the total NDIS population, with more than half (**58%**) of people with SIL being over the age of 45, compared to 25% of the NDIS participant population.

The following graph shows the percentage of all NDIS participants in each age band compared to the percentage of NDIS participants with SIL in their plans.

Figure 4: Age Range: NDIS Participants with SIL compared to all NDIS Participants

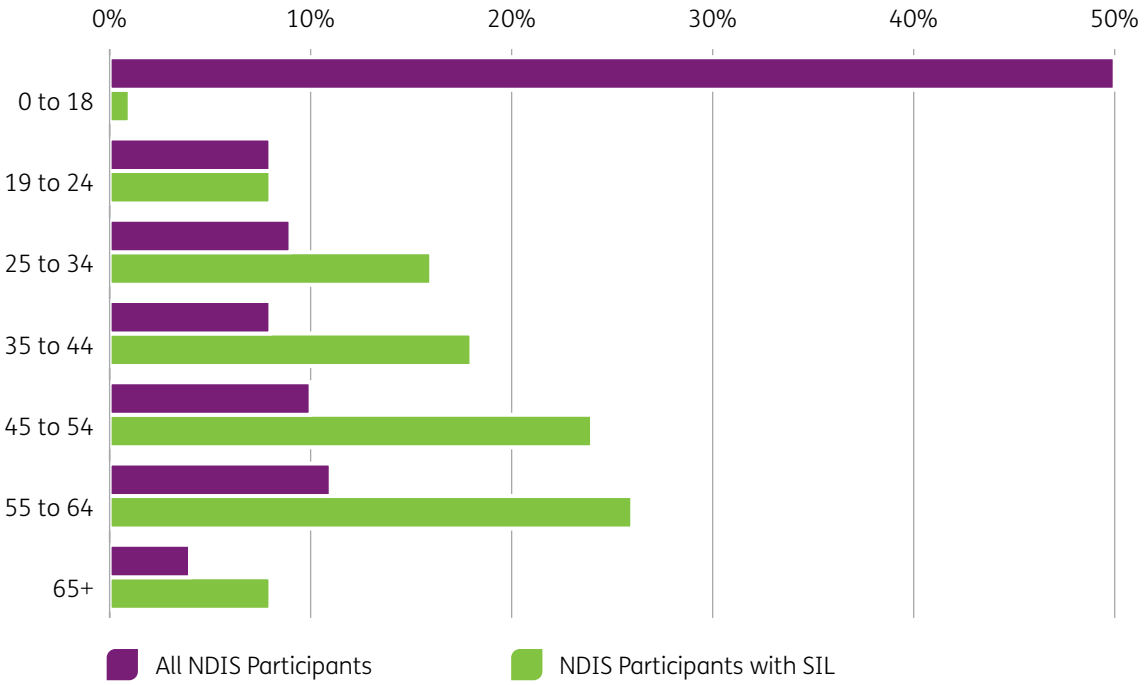


Table 3: Age Range: NDIS Participants with SIL compared to all NDIS Participants

Age Group	% of All NDIS Participants	% of NDIS Participants with SIL	All NDIS Participants – Counts	NDIS Participants with SIL – Counts
0 to 18	50%	1%	265,893	212
19 to 24	8%	8%	44,006	2,057
25 to 34	9%	16%	47,166	4,181
35 to 44	8%	18%	43,206	4,737
45 to 54	10%	24%	51,377	6,431
55 to 64	11%	26%	61,011	7,055
65+	4%	8%	21,996	2,277
Total	**100%**	**100%**	**534,655**	**26,950**

There are more men than women with funding for SIL. The following pie chart shows the proportion of NDIS participants who identify as male, female or other/unspecified gender receiving SIL.

Figure 5: NDIS Participants with SIL: Gender

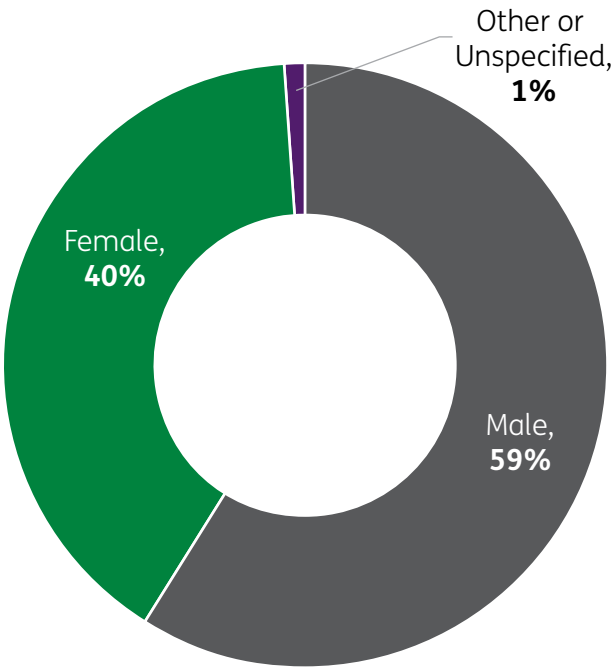


Table 4: NDIS Participants with SIL: Gender

Gender	NDIS Participants with SIL	% of NDIS Participants with SIL
Male	15,987	59%
Female	10,738	40%
Other or Unspecified	225	1%
Total	**26,950**	**100%**

In terms of NDIS Plan budget values, people accessing SIL have average NDIS plan budgets that are significantly higher in value than those NDIS participants who are not funded for SIL. This is consistent with the previous data which indicates that this population of people with disability generally have higher support needs than other NDIS participants who do not live in supported accommodation. As at 30 June 2022, the average plan budget:

- across all active NDIS participants was $68,800
- for all NDIS participants not accessing SIL was $53,500
- for all people accessing SIL was $358,000.

Average plan budgets for people with SIL funding vary across primary disability groups. The following graph shows the average annualised plan budgets by primary disability type for all active participants, those not receiving SIL, and those with SIL in their NDIS plans.

Figure 6: Average Annualised Plan Budgets by Primary Disability: NDIS participants with SIL

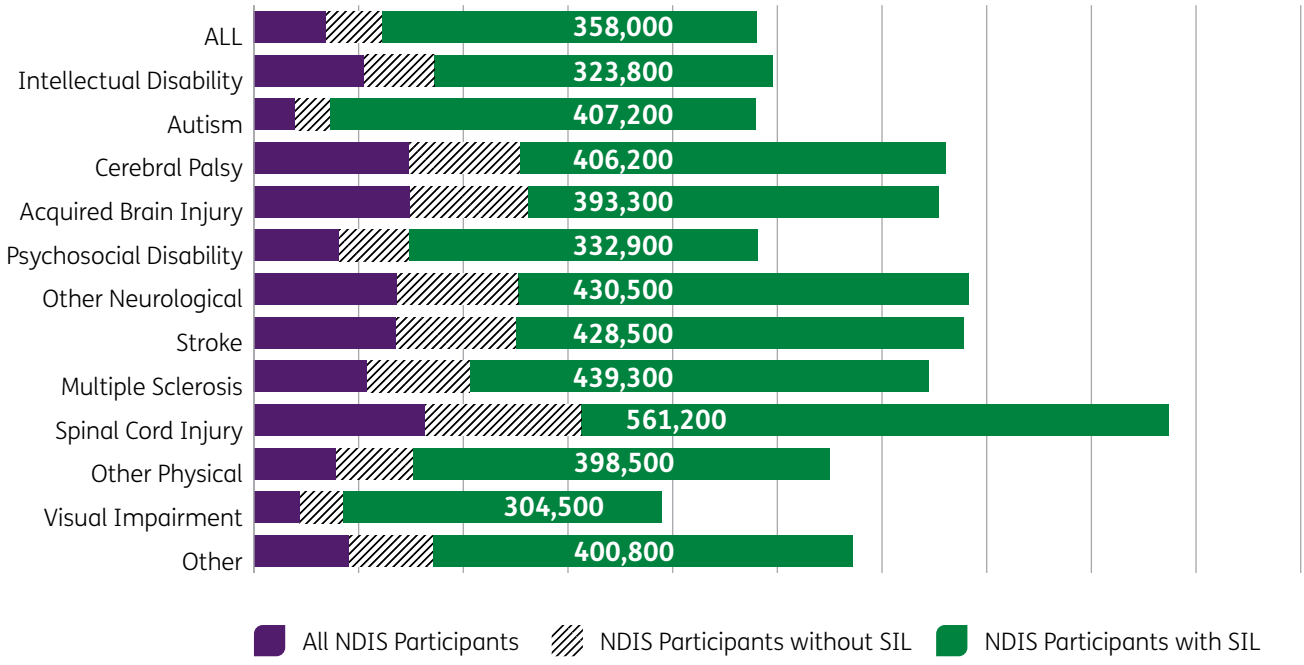


Table 5: Average Annualised Plan Budgets by Primary Disability: NDIS participants with SIL

Primary Disability	All NDIS Participants	NDIS Participants without SIL	NDIS Participants with SIL
All	68,800	53,500	358,000
Intellectual Disability	104,400	67,800	323,800
Autism	39,100	32,800	407,200
Cerebral Palsy	148,100	106,000	406,200
Acquired Brain Injury	148,200	113,000	393,300
Psychosocial Disability	80,600	67,500	332,900
Other Neurological	136,100	116,400	430,500
Stroke	134,800	114,700	428,500
Multiple Sclerosis	108,000	97,900	439,300
Spinal Cord Injury	162,700	149,900	561,200
Other Physical	77,600	74,100	398,500
Visual Impairment	43,600	41,300	304,500
Other	90,200	80,600	400,800

The number of NDIS participants with SIL in their plans has remained relatively consistent since the transition of state and territory systems was concluded in the main by 2019–20. Given the higher support needs of people living in supported accommodation, it is most likely that they were receiving supports in state and territory systems before the NDIS started. Most people living in supported accommodation now will therefore have transitioned into the NDIS when it started in each state and territory.

Each year new NDIS participants enter the NDIS and receive SIL funding, but these numbers are low compared to the total number of people entering the NDIS in each year.

In 2021–22, **26,950** NDIS participants received SIL in their NDIS Plans, which is 5% of all NDIS participants. Of this number, **1,630** people received SIL in their NDIS plans for the first time (noting that being funded for SIL does not always mean people will live in a group home).

The following graph shows the growth in the number of NDIS participants for the period 2016–17 to 2021–22, compared to the growth in NDIS participants receiving SIL in their NDIS plans.

Figure 7: Active NDIS Participants: 2016 to 2022

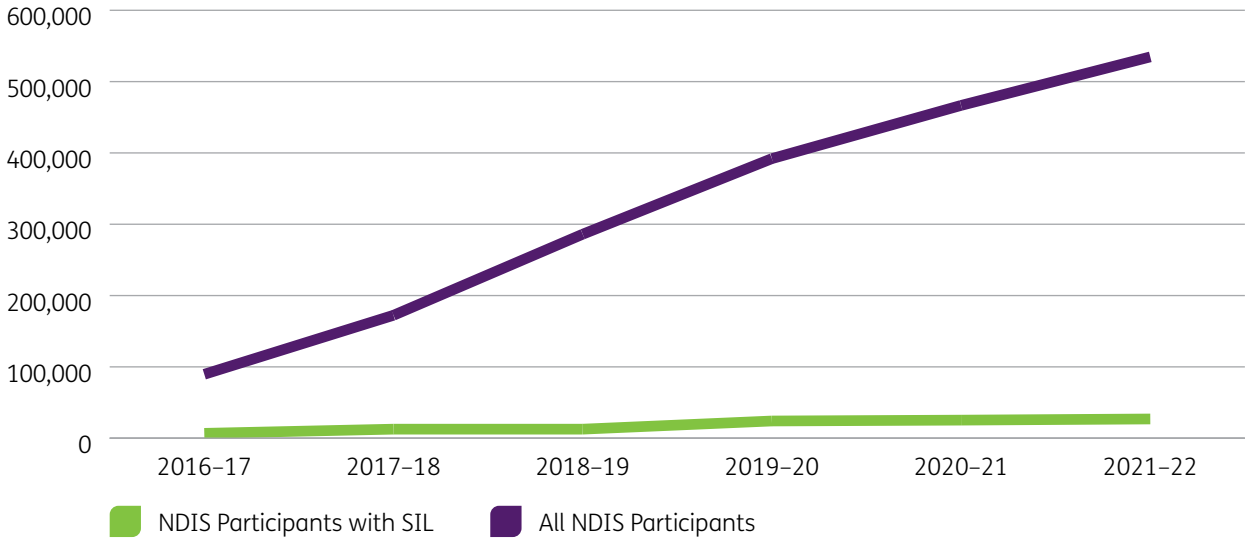


Table 6: Active NDIS Participants: 2016 to 2022

Active NDIS Participants: 2016 to 2022	2016–17	2017–18	2018–19	2019–20	2021–21	2021–22
All NDIS Participants	89,610	172,333	286,015	391,999	466,619	534,655
NDIS Participants with SIL	6,796	12,663	21,052	24,119	25,320	26,950

The supported accommodation market

The vast majority of NDIS participants have the SIL component of their NDIS Plan managed by the NDIA, and therefore use registered NDIS providers.

In 2021–22, **91%** of total payments for SIL were made against the 'core support' component of NDIS participant's plans that were agency managed, and were made to registered NDIS providers.

The remaining **9%** of total payments were made through a plan manager. This means funding could have been used to pay any provider to deliver those supports, being either a registered NDIS provider or a provider that may not be a registered NDIS provider. A very small proportion of payments for SIL were made directly by NDIS participants who were self-managing their NDIS plans. The plan manager is a registered NDIS provider.

In addition to 'Core Support', NDIS participants may also be funded for 'Capacity Building' as part of their NDIS plan. This includes things such as support coordination and specialist behaviour support services. They may also receive funding for 'Capital', which includes SDA.

In 2021–22:

- **100%** of payments for SDA were made against plans managed by the NDIA. This reflects the requirement that only registered NDIS providers must provide SDA
- **72%** of payments for support coordination were made to registered providers where that part of an NDIS participant's plan was agency managed, 26% were through a plan manager and 2% went to self-managing participants. This compares to **25%** of all NDIS participants whose capacity building was agency managed.

This data[54] suggests that while the majority of NDIS participants accessing SIL had the SIL part of their plan managed by the NDIA, a higher number of these people had either a plan management or self-management arrangement for the capacity building component of their Plan.

The reason for this variation is unclear. It may be related to the way in which SIL funding is determined, and how the NDIA manages the payment of that funding based on the 'roster of care' model.

54 NDIA Quarterly Report Q4 2021–22.

Registered providers are paid for the supports they provide to NDIS participants by claiming through the NDIA's portal, against service bookings that they establish in the system for the SIL supports they have agreed to provide.

More than **1,000** registered NDIS providers billed the NDIA for SIL supports in the 2020–21 period. This ranged from large providers supporting more than 250 NDIS participants with their SIL supports, to small providers delivering SIL to 5 people or less. These providers were paid the vast majority of the expenditure against NDIS participants' plans for SIL.

The following chart shows the proportion of NDIS providers that are providing SIL supports based on the number of NDIS participants that they provide SIL supports to, from 5 or fewer NDIS participants to 500 or more NDIS participants.

Figure 8: Proportion of SIL Providers based on the number of NDIS Participants with SIL supported

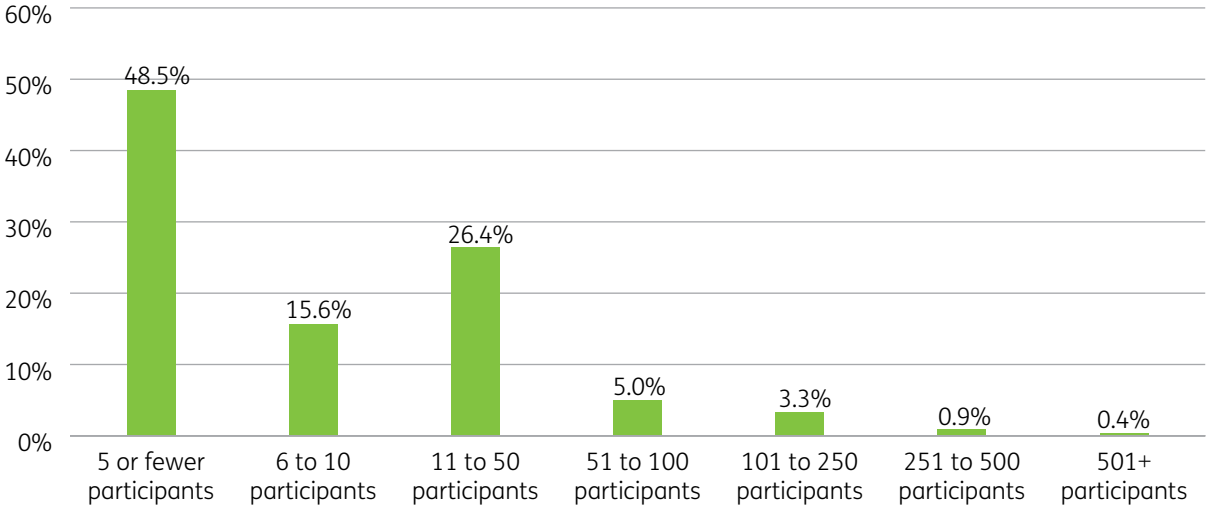


Table 7: Proportion of SIL Providers based on the number of NDIS Participants with SIL supported

Proportion of SIL Providers	SIL Providers
5 or fewer participants	48.5%
6 to 10 participants	15.6%
11 to 50 participants	26.4%
51 to 100 participants	5.0%
101 to 250 participants	3.3%
251 to 500 participants	0.9%
501+ participants	0.4%

The following chart shows the proportion of NDIS participants who are receiving SIL supports based on the number of NDIS participants that their provider supports in SIL overall.

Figure 9: Proportion of NDIS Participants with SIL by provider scale (for SIL)

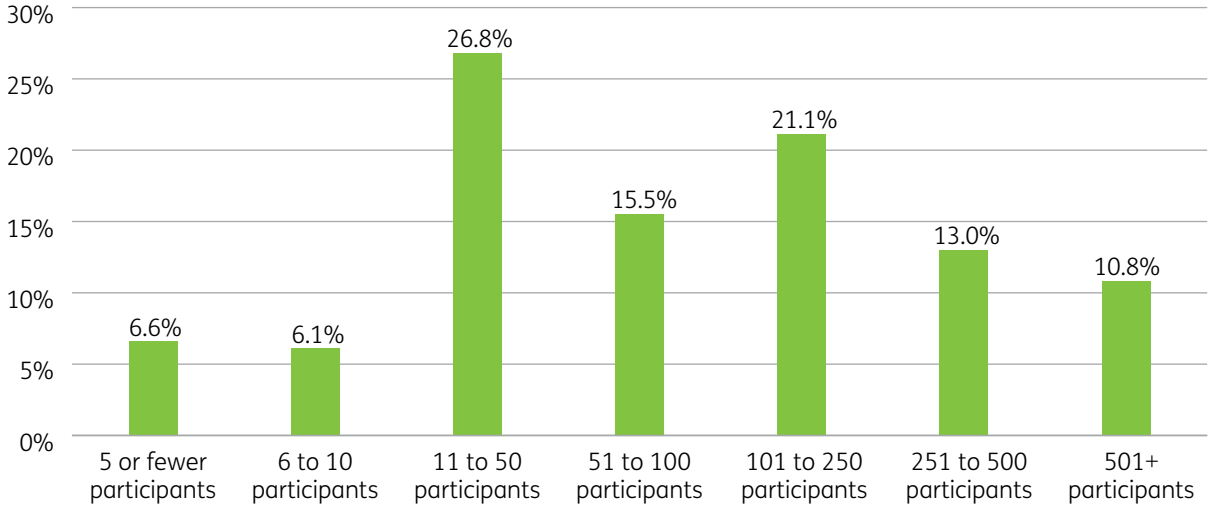


Table 8: Proportion of NDIS Participants with SIL by provider scale (for SIL)

Proportion of NDIS Participants with SIL: Scale of their providers	NDIS Participants with SIL
5 or fewer participants	7%
6 to 10 participants	6%
11 to 50 participants	27%
51 to 100 participants	16%
101 to 250 participants	21%
251 to 500 participants	13%
501+ participants	11%

The majority of the 1,000 providers delivering SIL supports deliver those supports to small numbers of NDIS participants, with **48.5%** of providers supporting 5 or fewer people. From review of a sample of these providers, the Inquiry identified that they appear to be mainly locally based providers in that they provide supports in a specific geographic area, and they provide a range of other supports to NDIS participants, mainly assistance with personal care and activities in the community. Many have been providing disability or other social supports for some time and have broadened the supports that they offer in recent years. A few of these providers are new providers that have established since the NDIS commenced.

It is expected that many of the providers delivering SIL supports to a small number of NDIS participants are not delivering those supports in a group home setting.

The attribution of these smaller providers to the SIL market has been made using data available through the NDIA billing systems. As a result it will include ad hoc claims that are related to SIL, for example the provision of a one-off short-term accommodation for a person with disability, rather than an ongoing support arrangement in a group home setting.

There are also around 2,000 NDIS participants with SIL in their NDIS plans where their SIL provider is not able to be identified, and so is not included in this data. This is either because these NDIS participants:

- are new to the NDIS and have not yet paid for any SIL supports, or
- are part of the 9% of NDIS participants who manage their SIL supports either through a plan management arrangement or because they self-manage their NDIS plans in whole or part.

Not all of these people will live in group home accommodation.

Although a significant proportion of these providers provide supported accommodation on a small scale, **45%** of people living in supported accommodation receive their supports from medium to large providers (for example providers that are supporting more than 100 NDIS participants with SIL supports).

The vast majority of these larger providers are well established providers specialising in supports to people with disability, have been delivering these supports for many years, and were funded by state and territory governments through specialist disability programs that existed prior to the NDIS. It is expected that the majority of people receiving supported accommodation supports from these larger providers have been supported by them for some time.

There is some variation between the larger and smaller providers when it comes to the plan management arrangements for the NDIS participants they support. A higher proportion of NDIS participants receiving some of their supports from smaller providers of SIL partly manage their NDIS plans through a plan management or self-managing arrangement. It is most likely that these smaller providers deliver capacity management elements of an NDIS participant's plan, rather than their core accommodation supports.

The following chart shows the types of NDIS plan management arrangements for NDIS participants who receive their SIL supports from small, medium or large providers.

Figure 10: Plan Management arrangements for NDIS Participants with SIL by provider size

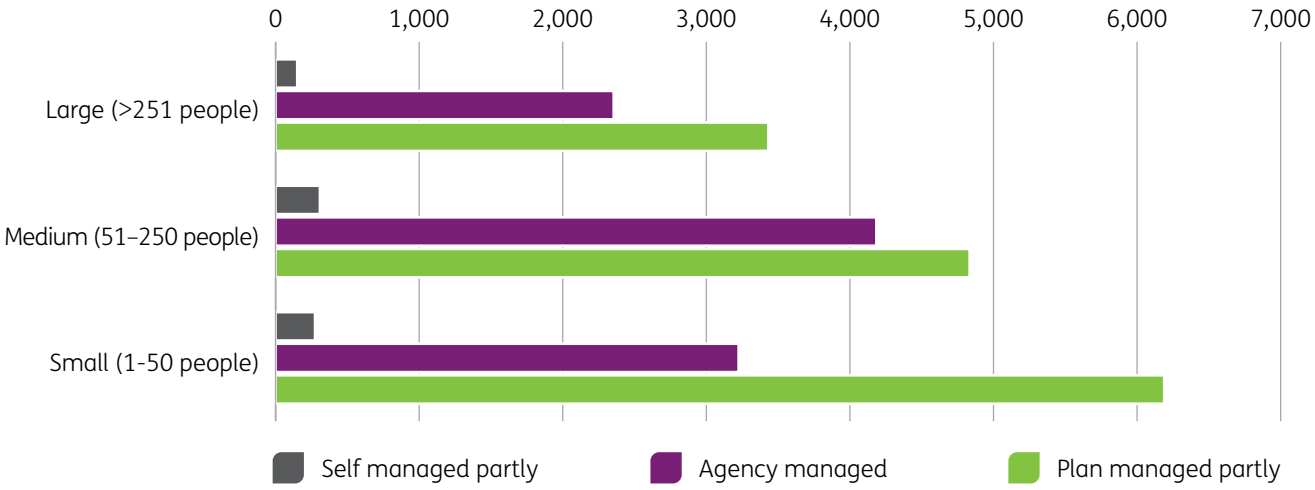


Table 9: Plan Management arrangements for NDIS Participants with SIL by provider size

Plan Management Type	Small (1–50 People in SIL)	Medium (51–250 People in SIL)	Large (More than 251 People in SIL)
Self Managed Partly	275	309	151
Plan Managed Partly	6,189	4,834	3,432
Agency Managed	3,225	4,184	2,355
Total	**9,689**	**9,328**	**5,938**

There is no significant difference between the demographics or the support needs of the NDIS participants who are supported across the small, medium or large providers that comprise this part of the NDIS market.

The nature of the SIL market will require further examination by the NDIS Commission together with the NDIA to obtain a more precise view of the providers that are involved in the provision of group home supports, and how else they engage with the NDIS participants to whom they provided supported accommodation. This is in addition to the significant amount of information that the NDIS Commission has about registered NDIS providers through the registration function.

This is an important piece of work to assist both agencies with their core functions, and to enable appropriate targeting of some of the activities arising from this Inquiry, particularly how the NDIS Commission approaches and pursues some of the education and regulatory design initiatives that are described in later parts of this Report. These activities should be conceptualised and deployed in a way that is reflective of the diversity of the supported accommodation market, and the way that NDIS participants interact with that market not only in supported accommodation, but overall. A proportionate approach to education and regulatory design for this market would be consistent with the Quality and Safeguards Framework within which the NDIS Commission operates.

For example, the Board of a small organisation supporting a small number of NDIS participants in supported accommodation may be able to engage individually with all of those people to get their feedback about their supports. It would not be feasible for the Board of a large organisation to obtain this information from each person, so there would be a number of mechanisms for gathering feedback, and systems for analysis of that feedback.

The NDIS Commission will undertake further work with the NDIA to build a deeper understanding of the composition of the supported accommodation market, to assist in developing and targeting activities arising from this Inquiry.

The providers covered by this Inquiry

The providers that were included in this Inquiry were determined based on:

- whether the NDIS Commission had received notifications of reportable incidents and received complaints related to supported accommodation provided by the provider
- the provider having a significant market share in respect of supported accommodation, either nationally or in a specific jurisdiction
- the provider delivering supported accommodation across a wide geographic area including in regional and metropolitan locations.

The providers that are included in this Inquiry are each significant providers in the NDIS market and during 2021–22 delivered around **4%** of all funded NDIS supports and services with a value of **$1.223bn**.

They supported **14,781** NDIS participants of whom a third, or **4,850** people, engaged these providers to deliver their SIL supports.

The NDIS participants receiving SIL supports from these 7 providers represent **18%** of all NDIS participants receiving SIL across Australia.

The payments that they made for these supports in 2021–22 represented **12%** of total payments for SIL in 2021–22.

The providers included in the Inquiry would be considered to all be large providers, supporting more than 250 NDIS participants with their SIL supports at the time that they were selected for inclusion in the Inquiry. Only one of the 7 providers supported slightly fewer than 250 NDIS participants during 2021–22.

The following chart shows the proportion of NDIS participants that each of the 7 providers supported with SIL, compared to the total number of NDIS participants that they provided supports to in the 2021–22 period.

Figure 11: Inquiry providers – NDIS Participants supported in 2021–22 (SIL and all supports)

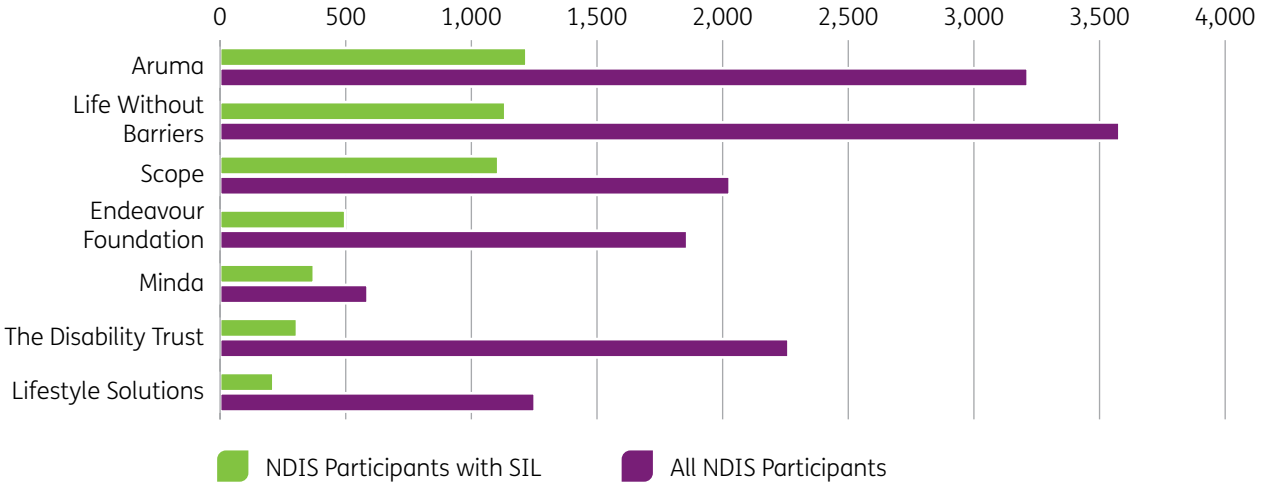


Table 10: Inquiry providers – NDIS Participants supported in 2021–22 (SIL and all supports)

Inquiry Providers	NDIS Participants with SIL	All NDIS Participants
Aruma	1,219	3,214
Life Without Barriers	1,135	3,579
Scope	1,107	2,028
Endeavour Foundation	498	1,859
Minda Incorporated	373	587
The Disability Trust	306	2,262
Lifestyle Solutions	212	1,252
TOTAL	**4,850**	**14,781**

The Inquiry providers deliver NDIS supports and services across Australia. Some are national or multi-jurisdictional providers with significant service delivery in multiple states and territories, while others operate mainly, or exclusively, in one state or territory.

Table 11: Inquiry providers – state and territory SIL operations

Provider	State and Territories
Aruma	New South Wales, Victoria, Queensland, Australian Capital Territory (ACT)
Endeavour Foundation	Mainly Queensland, also New South Wales and Victoria
Life Without Barriers	All states and territories
Lifestyle Solutions	New South Wales, Victoria, Queensland, Western Australia, Northern Territory (NT), Tasmania
Minda Incorporated	South Australia
Scope	Mainly Victoria, also New South Wales
The Disability Trust	New South Wales and ACT

They also deliver a wide range of supports and services with most of them being registered for all classes of support that are higher risk, or relate to specialist supports and services such as specialised support coordination, specialist behaviour support, and high intensity daily personal activities. More information about the registration of each of the providers covered by this Inquiry is available from the NDIS Commission's Provider Register.

The following table shows the total amount spent on SIL in the NDIS for the each financial year from 2017–18 to 2021–22, and the total SIL payments to the 7 providers included in this Inquiry. It also shows the percentage of the amount paid to the 7 providers compared to the total expenditure on SIL.

Table 12: Inquiry providers – NDIS SIL payments 2017–18 to 2021–22

NDIS SIL Payments ($M)	2017–18	2018–19	2019–20	2020–21	2021–22
All SIL Payments	2,220	4,102	6,702	7,930	8,776
SIL Payments to Inquiry Providers	194	486	744	846	1,018
% Inquiry	**9%**	**12%**	**11%**	**11%**	**12%**

The following table shows the total number of NDIS participants who had SIL funding in their NDIS plans for the each financial year from 2017–18 to 2021–22, and the total NDIS participants supported with SIL by the 7 providers included in this Inquiry. It also shows the percentage of the NDIS participants supported with SIL by the 7 providers compared to the number of NDIS participants funded for SIL.

Table 13: Inquiry providers – NDIS Participants supported with SIL 2017–18 to 2021–22

NDIS Participants with SIL	2017–18	2018–19	2019–20	2020–21	2021–22
All Participants with SIL	12,663	21,052	24,119	25,320	26,950
NDIS Participants with SIL: Inquiry	1,328	3,052	3,470	4,704	4,850
% Inquiry	**10%**	**14%**	**14%**	**19%**	**18%**

The following table shows the total number of NDIS participants who were supported by the 7 providers for the each financial years from 2017–18 to 2021–22, and the NDIS participants supported with SIL by those providers. It also shows the percentage of the NDIS participants supported with SIL compared to the number of NDIS participants these providers support.

Table 14: Inquiry providers – NDIS Participants supported by the Inquiry providers 2017–18 to 2021–22

NDIS Participants Supported by the Inquiry Providers	2017–18	2018–19	2019–20	2020–21	2021–22
All NDIS Participants – Inquiry	10,697	15,884	16,964	16,105	14,781
NDIS Participants with SIL – Inquiry	1,328	3,052	3,470	4,704	4,850
% SIL	**12%**	**19%**	**20%**	**29%**	**33%**

Of the 14,781 NDIS participants that the Inquiry providers delivered supports to during 2021–22:

- 21% of SIL participants also received support coordination from the same provider (within the range of 0% to 54% across the 7 providers);
- 9% of SIL participants also received behaviour support from the same provider (within the range of 0% to 25% across the 7 providers), and
- 18% of SIL participants also receiving SDA from the same provider (within the range of 7% to 66% across the 7 providers).

The following chart shows the total number of NDIS participants supported by these providers in the 2021–22 period, and the proportion of NDIS participants that they supported with SIL, SDA, behaviour support and support coordination.

Figure 12: Inquiry providers – NDIS Participants receiving SIL and other supports

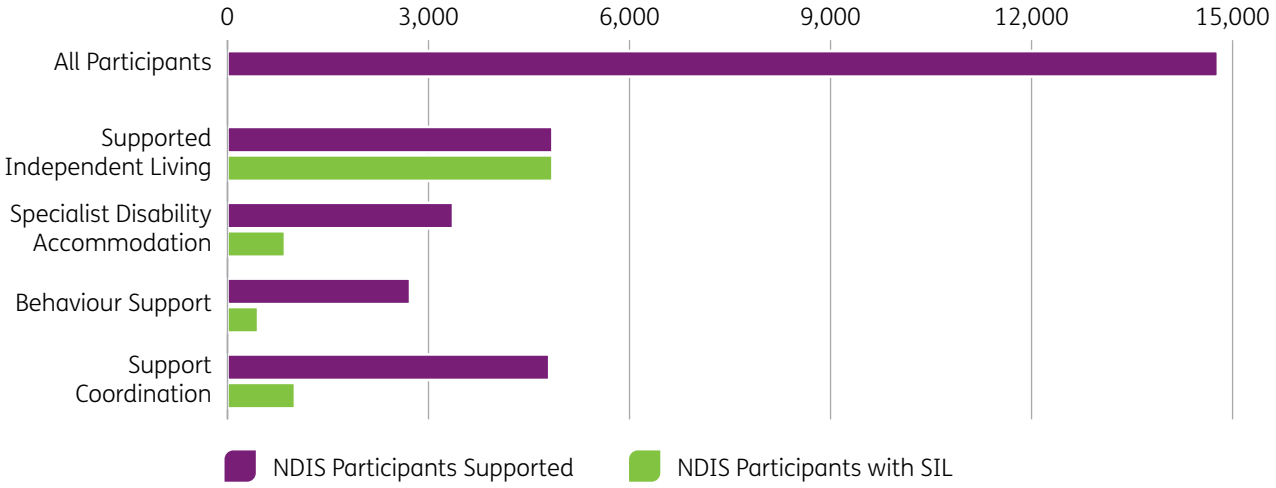


Table 15: Inquiry providers – NDIS Participants receiving SIL and other supports

SIL and Other Supports: Inquiry Providers	All NDIS Participants Supported	NDIS Participants with SIL
Support Coordination	4,802	1,007
Behaviour Support	2,725	457
Specialist Disability Accommodation	3,366	858
Supported Independent Living	4,850	4,850
All Participants	14,781	

There is some difference between the characteristics of the NDIS participants that the 7 providers covered by this Inquiry support in SIL, compared to all NDIS participants receiving SIL. This variation does not appear to have any material impact on the nature of the reportable incidents and complaints examined through this Inquiry and described in Chapter 4.

There is a higher proportion of people with intellectual disability as their primary disability supported by the 7 providers at 66%, compared to all NDIS participants receiving SIL at 51%; the range across the 7 providers being from 52% to 79%. The 7 providers support a lower proportion of people with a primary disability of psychosocial at 4.5% compared to all NDIS participants receiving SIL at 10% – the range across the 7 providers was from 0.5% to 13%.

The following figure shows the primary disability types of NDIS participants supported by the 7 providers covered by this Inquiry compared to all NDIS participants with SIL.

Figure 13: Primary Disability – NDIS Participants receiving SIL from the Inquiry Providers compared to all NDIS participants with SIL

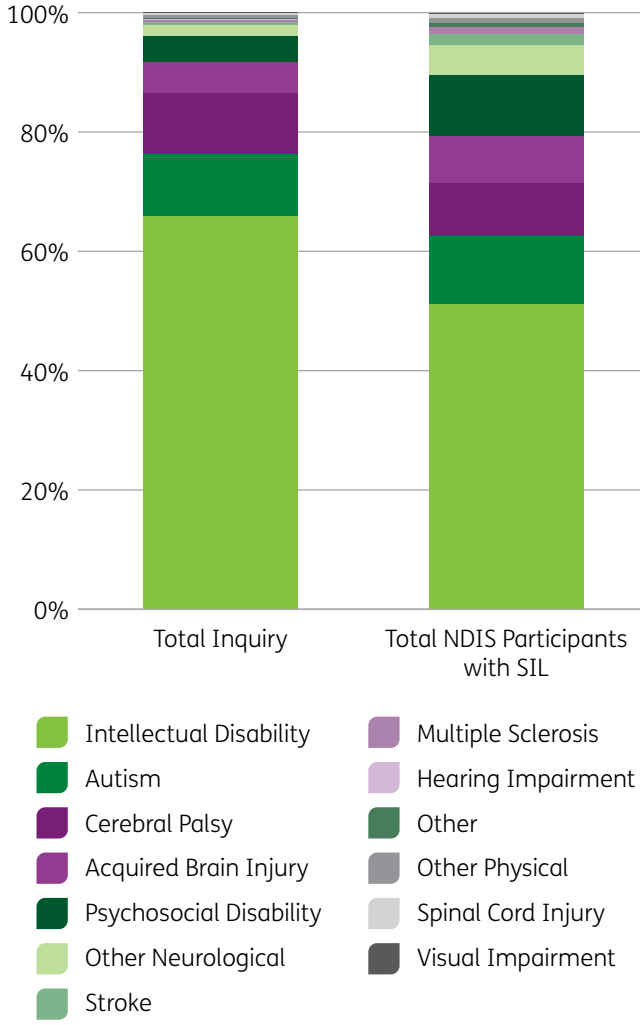


Table 16: Primary Disability – NDIS Participants receiving SIL from the Inquiry Providers compared to all NDIS participants with SIL

Primary Disability Group	Total Inquiry	Total NDIS Participants with SIL
Intellectual Disability	65.9%	51.2%
Autism	10.4%	11.4%
Cerebral Palsy	10.3%	9.0%
Acquired Brain Injury	5.0%	7.8%
Psychosocial Disability	4.5%	10.4%
Other Neurological	1.9%	4.9%
Stroke	0.5%	1.9%
Multiple Sclerosis	0.4%	1.0%
Hearing Impairment	0.0%	0.0%
Other	0.3%	0.7%
Other Physical	0.5%	0.8%
Spinal Cord Injury	0.2%	0.6%
Visual Impairment	0.2%	0.3%

There is a slightly older cohort of NDIS participants supported by the 7 providers compared to all NDIS participants receiving SIL, with 68% of NDIS participants receiving SIL from the 7 providers aged over 45, compared to 58% of all NDIS participants with SIL.

The following figure shows the age ranges of NDIS participants supported by the 7 providers covered by this Inquiry, compared to all NDIS participants with SIL.

Figure 14: Age Range – NDIS Participants receiving SIL from the Inquiry Providers compared to all NDIS participants with SIL

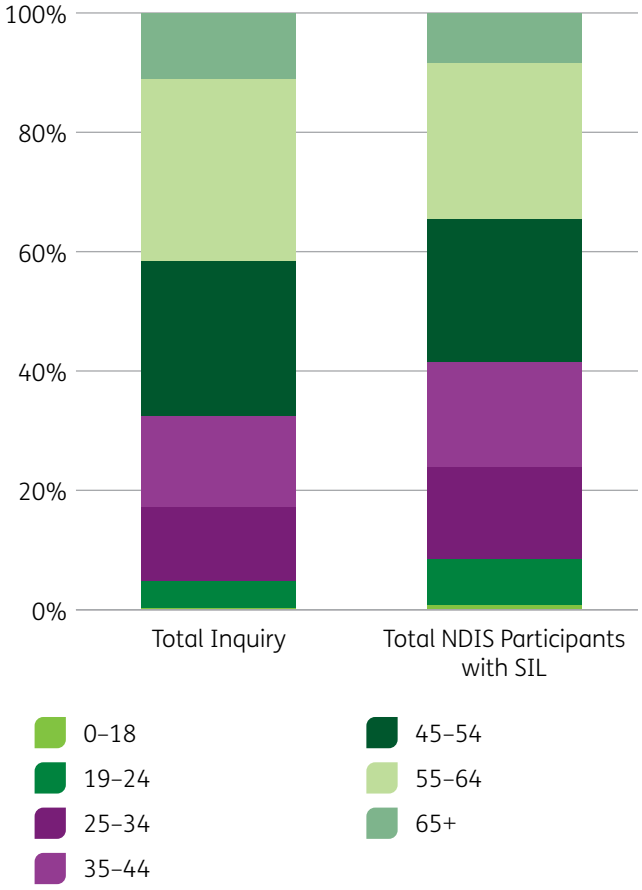


Table 17: Age Range – NDIS Participants receiving SIL from the Inquiry Providers compared to all NDIS participants with SIL

Age Range	Total Inquiry	Total NDIS Participants with SIL
0–18	0%	1%
19–24	4%	8%
25–34	12%	16%
35–44	15%	18%
45–54	26%	24%
55–64	31%	26%
65+	11%	8%

Chapter 4:

Reportable Incidents and Complaints

The NDIS Commission receives information about the incidents that are required to be reported by registered NDIS providers, or through the complaints it receives about a provider.

The NDIS Commission reviews the reportable incident notifications it receives and oversees providers' management and resolution of the reportable incidents.

When the NDIS Commission receives complaints about NDIS supports and services, the Commission works with complainants, NDIS providers and any other relevant people to resolve those complaints.

The NDIS Commission has a range of regulatory powers that it can use in relation to reportable incidents and complaints, including requiring the provider to investigate and report to the NDIS Commission in relation to the incident, or to take action to resolve a complaint. The NDIS Commission can also take compliance and enforcement action if it appears through examination of a reportable incident, or while working to resolve a complaint, that a provider has breached its obligations under the NDIS Act, the Practice Standards or the NDIS Code of Conduct, or a worker has breached their obligations under the NDIS Code of Conduct.

As registered NDIS providers, each of the 7 providers in this Inquiry is required to maintain:

- **Incident management systems**[55] that cover all acts, omissions, events or circumstances that occur in connection with providing supports or services to a person with disability and have, or could have, caused harm to the person with disability. Of all incidents that are covered by the provider's incident management system, the following incidents must be notified to the NDIS Commission as reportable incidents if they occur in connection with the provision of NDIS supports or services by the provider:
  - The death of a person with disability.
  - Serious injury of a person with disability.
  - Abuse or neglect of a person with disability.
  - Unlawful sexual or physical contact with, or assault of, a person with disability.
  - Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity.
  - The use of a restrictive practices in relation to a person with disability, other than where the use is in accordance with authorisation of a state or territory in relation to the person.
- **Complaints management systems**[56] to manage and resolve complaints about the supports and services they provide. These systems must make sure that people can easily make a complaint and that all complaints are dealt with fairly and quickly. They must provide information to people about how to make a complaint to them, as well as to the NDIS Commission, and they must keep records about the complaints they receive.

One of the reasons that NDIS providers are required to have these systems is to ensure that they use the information they collect through them to understand the things about their practice that are impacting the people with disability they support, to get to the bottom of why these things are happening, and to treat the issue so that it can be prevented from happening again.

As the incident management system that providers are required to maintain contains *every* incident relevant to them, not only those that come to the attention of the NDIS Commission, they can be expected to have insights into broader trends around incidents that relate to the people they support than would be available to the NDIS Commission.

In their complaints systems, providers will also record complaints that the NDIS Commission does not receive, although unlike incidents, a provider's complaints system may not hold every complaint about them, because some complaints may be made directly to the NDIS Commission, or depending on the issue, another relevant body.

55 *NDIS (Incident Management and Reportable Incident) Rules 2018*

56 *NDIS (Complaints Management and Resolution) Rules 2018*

In addition to examining reportable incidents and complaints held by the NDIS Commission, the Inquiry also reviewed:

- policies, procedures and other documents relating to incident and complaint management from each of the providers, including reviewing third-party auditor assessment of these policies and procedures undertaken as part of the provider's registration
- other information from the providers about their quality improvement plans, governance, risk management and assurance models
- other information available to the Inquiry including from residents and their support workers gathered through site visits to supported accommodation provided by the 7 providers.

An aspect of this Inquiry was to assess the adequacy of these policies, procedures and plans with the particular purpose of determining whether they are effective in enabling the provider to know what is happening for people, why it is happening, and how they can take action to address the underlying issue.

This chapter deals with the sections of the Terms of Reference that relate to the examination of reportable incidents and complaints that are the subject of the Inquiry.

Reportable incidents that are about the use of URPs were not required to be examined in detail under the Terms of Reference. The URPs that were identified for the Inquiry were linked to the NDIS participants identified as being the impacted person in a reportable incident or complaint in a group home delivered by the provider. Therefore URP figures are for NDIS participants that are subject to URPs and at least one complaint or reportable incident relevant to the Inquiry. These have been compared with all URPs notified to the NDIS Commission by the provider. The NDIS Commission's systems do not currently allow for the linking of other URPs to supported accommodation sites.

Identifying the reportable incident and complaints to be examined

The matters examined through this Inquiry included only those matters notified to or received by the NDIS Commission, not any of the other matters contained in the providers' systems. This Inquiry involved the examination of:

- **6,269 reportable incidents notified to the NDIS Commission** by these providers over the period 1 July 2018 to 30 September 2022 where it was determined that the incident impacted an NDIS participant receiving supported accommodation that was in a group home setting from that provider (the reportable incidents)
- **851 complaints made to the NDIS Commission** about supports in group homes provided by these providers (the complaints).

Appendix F explains the sources of the data used for the Inquiry.

The description of the reportable incidents examined by the Inquiry reflects the initial 24-hour notification of the reportable incident made to the NDIS Commission by the provider. As the provider's investigation of an incident progresses from that 24-hour notification, it is acknowledged that these matters may have changed, for example where an allegation may have subsequently been proven not to be true, or the provider becomes aware of new information about the incident.

Reportable incidents are more easily able to be analysed thematically than complaints, because reportable incidents are notified to the NDIS Commission against clearly defined categories that must be reported, as set out in the NDIS Act. Providers apply the guidance available from the NDIS Commission to determine what should be reported, and reportable incidents are notified in the form that the NDIS Commissioner requires.

For complaints, the initial complaint description given by the complainant was examined. As with incidents, it is acknowledged that the nature of the complaint may change as the NDIS Commission works with the complainant, and also as the issue is worked through with the provider. Examining the original complaint has assisted with considering any connection between individual complaints and reportable incidents.

There have been challenges with undertaking the analysis required for this Inquiry described in Chapter 6 of this Report, including finding possible solutions to those challenges to assist with future analyses.

Verifying the matters to be examined

As this Inquiry relates to group homes, it was necessary to link reportable incidents and complaints to group home locations where the people who were the subject of the reportable incident or complaint lived.

To enable a consistent group home site based analysis, the 7 providers each gave the Inquiry addresses for supported accommodation residences where 3 or more people with disability to whom they were delivering supported accommodation supports were living together. All providers gave the Inquiry a full property listing for group homes that met these parameters. These addresses were reconciled with the addresses held by the NDIS Commission, and also the NDIA for NDIS participants.

In addition to the reportable incidents and complaints that could be linked to those group homes, there were other reportable incidents and complaints that were in the NDIS Commission data that related to group homes settings associated with each provider. The NDIS Commission was not able to link these matters to the group home site list given by the provider, or any other specific site. Where these matters clearly related to a group home setting they were nonetheless included in the examination of matters undertaken by the Inquiry.

In all, reportable incidents and complaints were linked to more than **1,075 group home locations** across all states and territories.

To assist with examination of the reportable incidents and complaints, the Inquiry analysed data about reportable incidents and complaints by physical address, to identify those group homes that had a relatively high number of reportable incidents and complaints. The reportable incidents and complaints related to these addresses were compiled chronologically and used to provide some structure for the Inquiry in reviewing a significant volume of matters.

Reportable incidents that are unauthorised uses of restrictive practices were not included in the following data, and are described separately.

Gianna is 29 years old. She didn't speak when she moved into her villa 4 years ago. She hadn't spoken since she was a child. She's grown confident in her home, and with the guidance of her support staff over these years now talks all the time. She repeats everything she says 4 or 5 times to make sure she gets the information across. She makes lists of things that she wants to do like take swimming lessons, go shopping, or get a goldfish. She spends a lot of time on the lists and they are very precise. She knows her rights and what she wants, and is very consistent in communicating those things. She feels safe in her home. She can come and go as she pleases but doesn't want to have a key. She's worried if she has a key someone who has harmed her before will get in and harm her again.

Reportable Incidents and Complaints examined

The following table shows the number of reportable incidents and complaints received by the NDIS Commission about the providers included in this Inquiry for the period 1 July 2018 to 30 September 2022. It shows the number of matters that relate to group homes compared with the total number of reportable incidents and complaints received by the NDIS Commission about the providers.

Table 18: Matters examined in this Inquiry compared to all matters relating to the 7 providers

Matters examined in the Inquiry	Inquiry related Matters	All other matters	TOTAL	% of all matters
Reportable Incidents (excluding URPs)	6,269	1,074	7,343	85%
Complaints	851	402	1,253	68%
TOTAL	**7,120**	**1,476**	**8,596**	

The majority of reportable incidents and complaints about these providers relate to incidents and issued that occurred in group homes:

- **85%** of reportable incidents notified by these providers occurred in group home settings, of which the most frequently notified were:
  - serious injury of a person with disability
  - abuse of a person with disability
  - neglect of a person with disability
  - unlawful physical contact.

The following graph shows the reportable incidents notified to the NDIS Commission by category, and the proportion of those matters that occurred in group homes, as compared to other settings.

Figure 15: Reportable Incidents by type – Inquiry providers

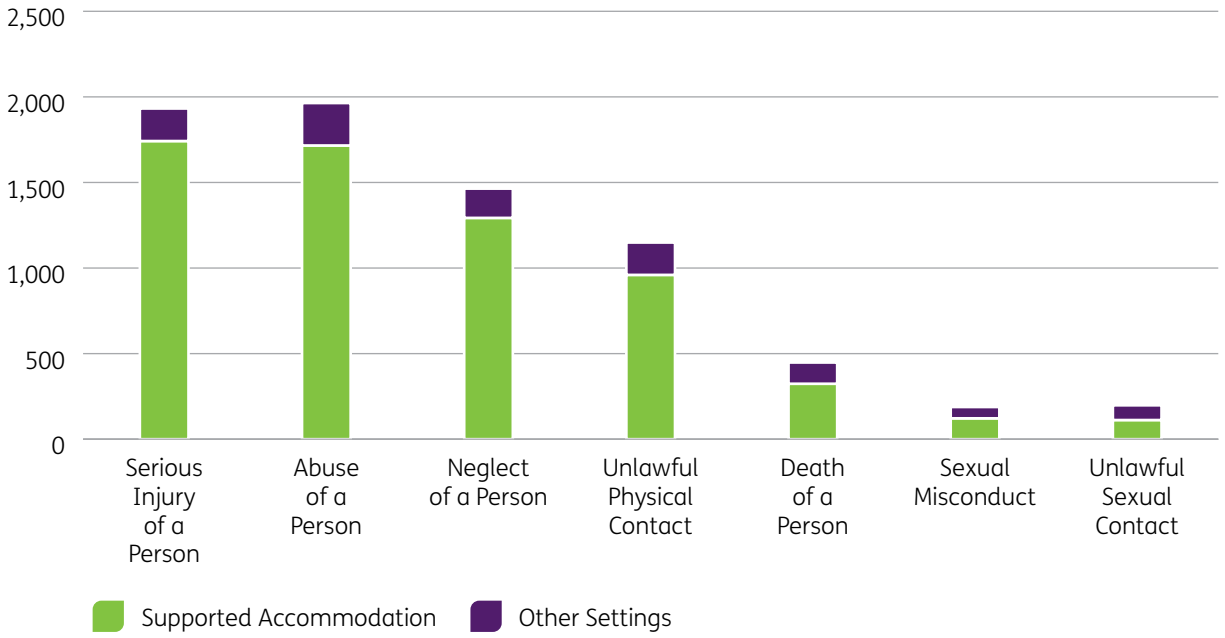


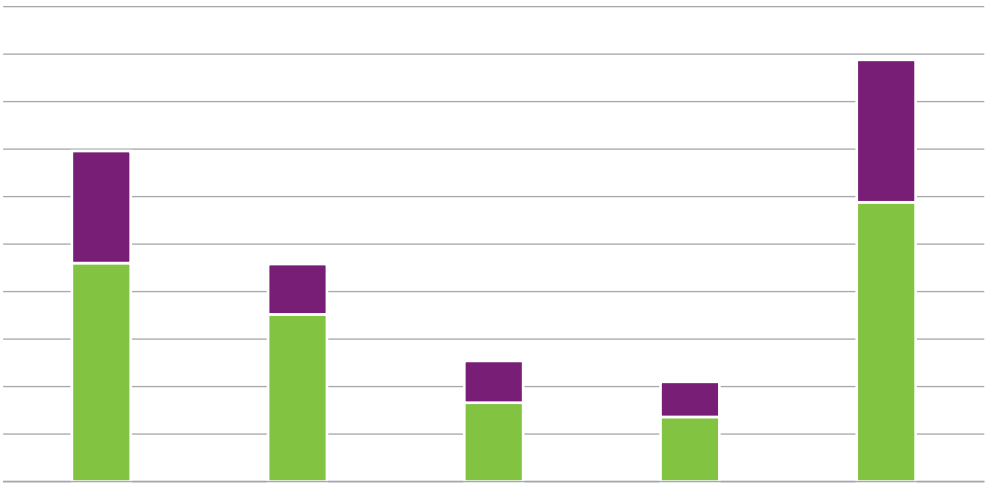
Table 19: Reportable Incidents by type – Inquiry providers

Reportable Incident Type	Supported accommodation	Other Settings
Serious Injury of a Person	1,742	190
Abuse of a Person	1,716	248
Neglect of a Person	1,293	171
Unlawful Physical Contact	960	189
Death of a Person	324	124
Sexual Misconduct	122	66
Unlawful Sexual Contact	112	86
Total	**6,269**	**1,074**

- 68% of complaints about supports and services delivered by these providers related to group home settings. The most frequently made were about:
  - provider practice
  - alleged abuse or neglect
  - provider policies and procedures.

The following graph shows the complaints made to the NDIS commission by type, and the proportion of those matters related to issues in group homes, as compared to other settings.

Figure 16: Complaints about supported accommodation supports by type – Inquiry providers



	Provider Practice	Alleged Abuse or Neglect	Policies and Procedures	Worker Capability	Other
Other Settings	118	53	44	37	150
Supported Accommodation	230	176	83	68	294

Table 20: Complaints about supported accommodation supports by type – Inquiry providers

Type	Complaints about supported accommodation	Other Settings
Provider Practice	230	118
Alleged Abuse or Neglect	176	53
Policies and Procedures	83	44
Worker Capability	68	37
Other	294	150
Total	**851**	**402**

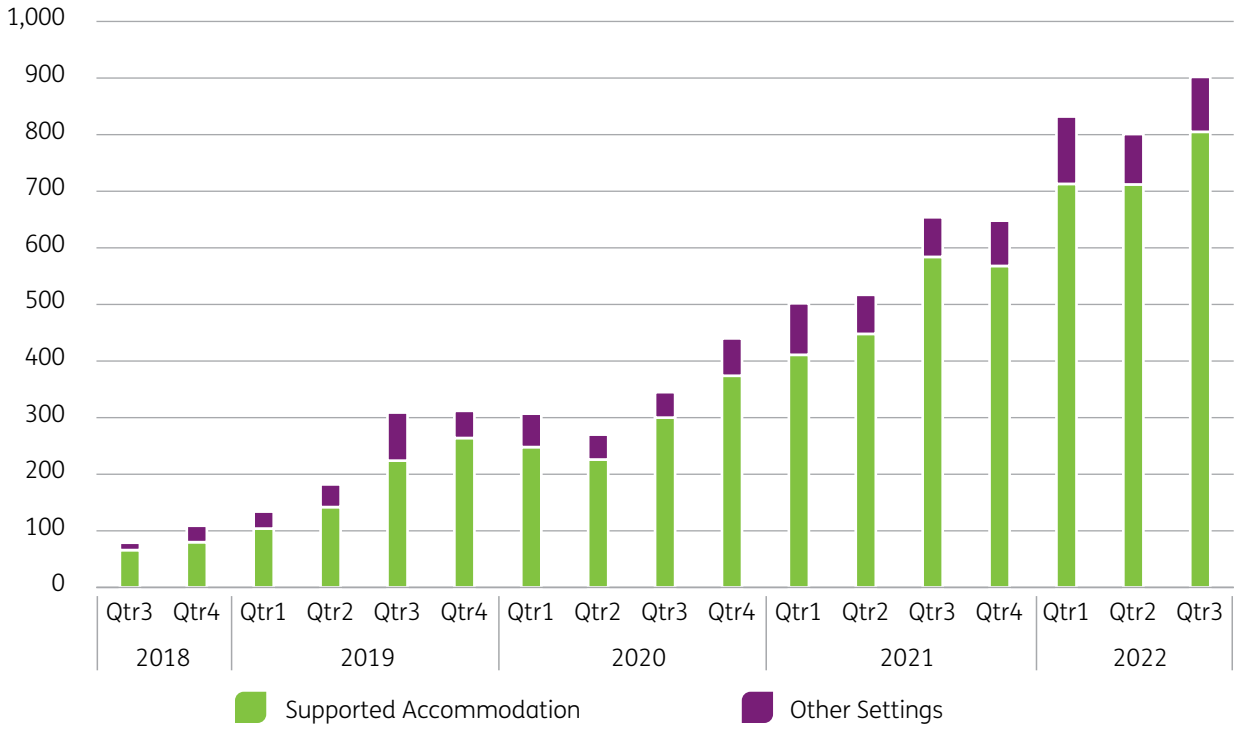
The pattern of both reportable incidents and complaints received by the NDIS Commission by or about these providers largely reflects the transition points associated with the NDIS Commission's progressive establishment across Australia.

For reportable incidents, the progressive increase in the number of matters notified to the NDIS Commission each quarter since 1 July 2018 reflects a few factors:

- Firstly, the progressive commencement of the NDIS Commission in each state and territory, which triggered the requirement to notify reportable incidents in each jurisdiction.
- Secondly, the progressive compliance of providers with this obligation in the period following transition.
- Thirdly, different approaches to reportable incident notifications by providers over time, which are explored later in this report.

The following graph shows the reportable incidents notified by the 7 providers each quarter from 1 July 2018 to 30 September 2022. It shows reportable incidents linked to group homes, and those that occurred in other settings.

Figure 17: Reportable incident numbers by quarter: Inquiry providers

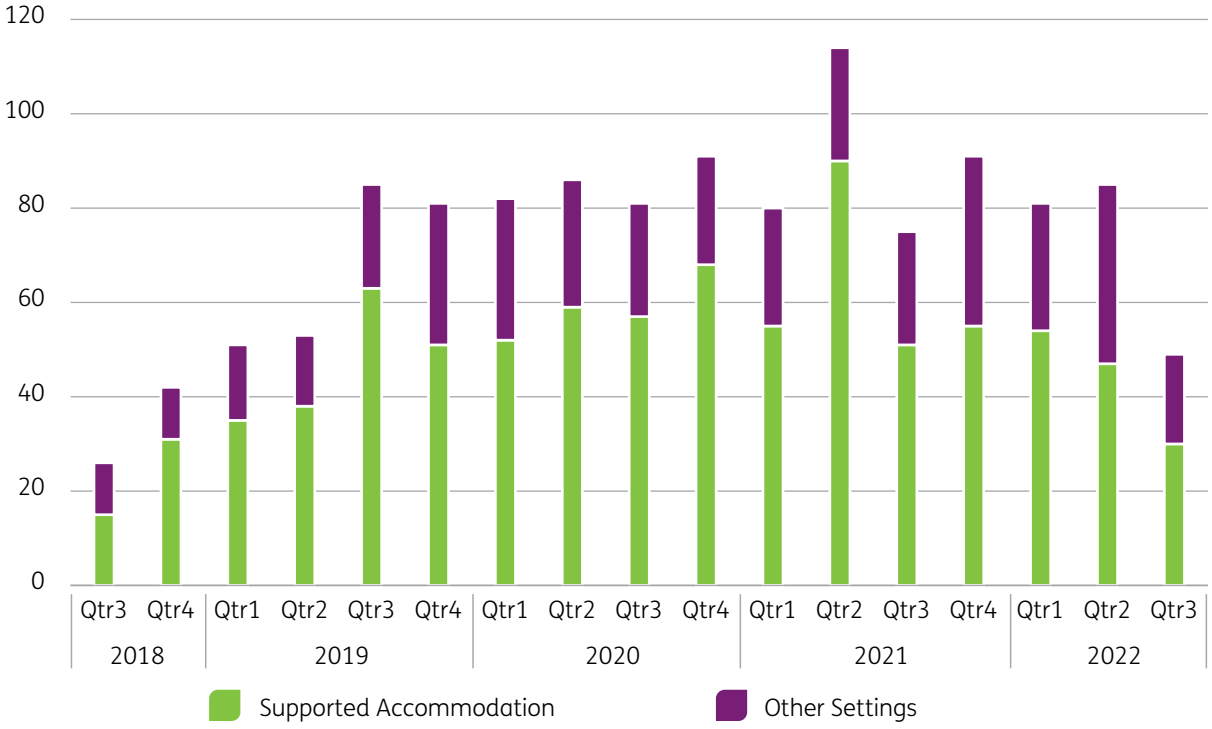


As with reportable incidents, the volume of complaints received by the NDIS about these providers has increased progressively, and appears to be largely associated with the commencement of the NDIS Commission in each state and territory. There was a slight increase in the volume of complaints received in Quarter 2 of 2021, more than half of which were from Victoria. In Quarter 2 of 2021, supported accommodation services that had been 'in-kind' under the Victorian Government's bilateral agreement with the Australian Government transitioned into the NDIS, and therefore came under the NDIS Commission's jurisdiction for the first time. It is expected that this slight increase relates to the change.

While the majority of complaints about these providers related to group home settings, there were proportionately more complaints about supports and services in other settings than was the case for reportable incidents.

The following graph shows the complaints made to the NDIS Commission about the 7 providers each quarter from 1 July 2018 to 30 September 2022. It shows complaints linked to group homes and those that are about other settings.

Figure 18: Complaints numbers by quarter: Inquiry providers



Anyone can make a complaint to the NDIS Commission about an NDIS support or service. Complaints about the NDIS supports and services delivered by the 7 providers have been received mainly from family members or friends of a person with disability, or from an advocate, support worker or other providers. The following table shows the source of complaints about supported accommodation relating to the 7 providers included in the Inquiry, compared with the source of complaints received overall by the NDIS Commission. For the source of complaints received by the NDIS Commission a typical range is shown as published in the NDIS Commission's Activity Reports covering the period from 1 July 2020 to 30 September 2022.

Table 21: Source of complaints

Complainant	Inquiry related Complaints	Complaints received by the NDIS Commission
Person with disability	3%	23–29%
Family member or friend of a person with disability	40%	15–22%
Support worker or service provider	22%	17–22%
Others including guardians and advocates	23%	21–27%
Government bodies (such as state or territory complaints bodies, or the NDIA)	6%	4–5%

Of the complaints examined through the Inquiry, only **3%** had been made by people with disability themselves. This compares with a typical range of 23–29% for all complaints received by the NDIS Commission that are made directly by a person with disability.

By contrast, the proportion of complaints made by family members or friends of people living in supported accommodation provided by the 7 providers was **40%**. This compares to a typical range of 15–22% of all complaints that are made directly by a family member or friend of a person with disability to the NDIS Commission.

It is likely that the rate of complaints from people with disability reflects the nature of the people who are living in group homes, as described in Chapter 3. That is, many people living in group homes may more frequently rely on others to raise issues on their behalf. Although people with disability may not complain themselves as frequently as others raise issues on their behalf, that does not mean they are satisfied with every aspect of their support.

The higher rate of complaints from family or friends of people with disability living in group homes across these 7 providers suggests a high level of engagement between NDIS participants and their family and friends.

It was observed through the Inquiry that for some providers the rate of complaints about supports in group homes was relatively low. The Inquiry did not look at rates of complaints that had been received by the providers themselves. However, the Inquiry did review the policies and procedures that these providers have in place for the management of complaints, and discussed at some length with the providers how they apply those policies and procedures.

Overall, those policies and procedures, and the associated material to promote them among people with disability and their supporters, appear to be appropriate for the size of the provider and the breadth of the supports and services provided. Where the rate of complaints about a provider was relatively low it could because some people living in group homes having limited connections with families and friends to raise things on their behalf. It may also be due to the approach taken by these providers to addressing feedback from people with disability and their supporters when an issue arises.

Complaints are not the only means by which a provider can get feedback about the quality of the supports and services it provides. The Inquiry observed that providers with relatively lower rates of complaints had arrangements in place to obtain feedback from the people they support and their supporters, including through governance structures. Also, the senior management of these organisations had a very strong and regular connection with frontline operations.

When it comes to the delivery of supports to people with disability living in group homes, it is important that all providers delivering supported accommodation consider how to better establish ways of understanding the perspectives of the residents, and how they might apply their perspectives to the provision of supports. For example, the Governance and Operational Management practice standard encourages providers to provide for opportunities for people with disability to contribute to the governance of the organisation, and have input into the development of organisational policy and processes – including those regarding the protection of their rights.

Frank moved into his current home when his mother died 2 years ago. He is 42 years old. He lives with 10 other people. He usually uses an eye gazer to communicate but it is broken. His therapist is bringing the new part next week. In the meantime, support workers who know Frank's communication style check in with him regularly throughout the day to make sure he is getting what he needs. Frank goes next door to the day program 3 days a week. On other days there are activities arranged at the residence, or he sits in his wheelchair in the large open common room in a space that has things that are important to him on the wall.

The current channels used by supported accommodation providers, and the NDIS Commission itself, to enable people with disability to make complaints could be improved, so that people with disability living in group homes who may have communication impairments, or difficulty using the phone or internet, are better enabled to raise issues.

Where people do not have regular contact with family or friends to raise issues on their behalf, access to advocates and the involvement of other providers, and where they exist, community visitors, are also important mechanisms to identify and address issues affecting the quality of supports for people living in these settings.

All providers of supported accommodation should review their policies and procedures, and the channels they use to obtain, record and respond to feedback, including complaints, to take account of the needs of people with higher support needs living in group home settings. This includes building an awareness of the NDIS Commission and its role with these people and their networks.

Complaints about supported accommodation and possible causes

In terms of the complaints received by the NDIS Commission, the most common types of issues are described in this section. While these types of complaints were common, not all of the providers necessarily had complaints made about them in relation to every one of these issues.

In the complaints examined by the Inquiry, it was often the case that people contacted the NDIS Commission with a very general complaint. It may be that they were 'not happy' with the supports provided, or they considered that the provider wasn't taking their concerns seriously. Complaints made to the NDIS Commission do not need to be about a specific issue, action or event. Sometimes a complaint will reflect a general concern about communication, or a deterioration in the relationship between the person making a complaint and the provider.

In the context of supported accommodation, effective communication, and open and transparent relationships between a person with disability and their provider – or a person's family and other supporters and their provider – is absolutely fundamental. This is due to the reliance of the person with disability on these supports for many aspects of their lives, including support to make community connections and engage with informal supports.

The process of resolving a complaint in these circumstances can often assist the complainant in being more specific about their concerns and what needs to change to address them. It can also be instrumental in re-setting the relationship between the person with disability, their supporters and the provider, so that expectations are clearer going forward, and some trust is restored.

As the NDIS Commission matures its complaints function, and as the volume of complaints that it receives grows over time, it will be important that the NDIS Commission does not place a lesser priority on complaints that are not specific to a particular issue action or event, particularly when they relate to supports provided in group home settings.

Most of the complaints received about the 7 providers as examined by the Inquiry were about:

Provider Practice

- The general quality of the experience with the supported accommodation service provided. For example, staff not paying enough attention to a person's individual needs, or staff not being sufficiently familiar with a person's support needs, such as not providing supports in line with existing plans such as a behaviour support plan.
- Poor communication with the person or their family or friends about support arrangements, including when there are changes, or to follow up on a complaint, or about an incident and the providers' management of that incident. For example, not supporting a person to attend appointments outside the house or using agency staff too regularly where they are not familiar with a person's needs.
- Concerns that the provider is using medication or other inappropriate measures to manage a person's behaviours.

One family member who was consulted said: "...could be more help required and more engagement from support workers it is hard because I don't see it {Person} can be difficult to engage with but will tell you. Staff are not encouraging. They are doing what the person want but no encouraging, expanding and diversifying what they can do".

Alleged Abuse or Neglect

- Verbal abuse by support workers.
- Disrespectful behaviour and/or conduct of support workers, including where a person doesn't feel safe or comfortable with a support worker. For example, support workers treating people living in the house like 'children', telling them to go to the toilet when they don't need to, or to sit still and not move around the house, or putting children's programs on the TV during the day.

- Undue influence over a person by a support worker, such as denying a person access to their belongings or requiring them to do something they don't want to do.

Policies and procedures

- Alleged negligence, including failure to provide adequate personal care (hygiene) or to address a person's behaviours and avoid impacts on others. For example, concerns that the provider is neglecting a person's personal hygiene because of insufficient staffing ratios in the house on some shifts, or that they are not following a person's behaviour support plan resulting in impacts on other residents.
- Failure to provide appropriate supervision for a person. For example, a support worker leaving a shift early without back up supports, meaning that the person with disability was left alone until the next support worker starts their shift.
- Failing to take a person's preferences and rights into account when providing supports, and providing generally inadequate support in the view of the complainant. For example a person was upset because the only support worker available to assist them was a male worker and they did not want intimate supports from that worker.

The following types of complaints were also received about these providers but not as frequently as the types described above, and only for some providers:

- A person wanting to change aspects of their support, or wanting to move and not being supported to do so, or transition to a new accommodation place being handled poorly.
- A provider making changes to supports without notice, such as bringing in new support workers without telling a person or their family before the change occurred.
- Failing to be transparent in financial matters, such as how the funding in their NDIS plan would be used.

A small number of complaints were also received about serious injuries sustained by a person with disability, as well as alleged abuse (physical and sexual) by support workers where the complainant alleged the incident was not reported to Police, or acted on by the provider. From the Inquiry's examination of these matters, they appear to relate to a reportable incident notified to the NDIS Commission by the provider.

Sarah moved into her house a year ago. She used to live with her mum but it was getting very difficult to manage all of Sarah's supports in their small unit and to give them both some personal space. Sarah has an intellectual disability and doesn't speak. She uses a wheelchair and has a vision impairment. Her Mum takes her to music therapy every week and stays to settle Sarah back at home. Sarah is getting along well with the other people at home. Sarah communicates with her eyes. She is clearly delighted when someone comments on her outfit and her beautifully painted fingernails. She likes to look good when she goes out.

Underlying causes of complaints

This Inquiry examined a relatively small number of complaints (850) compared to the total number of complaints received by the NDIS Commission overall, being more than 23,000 complaints received since 1 July 2018. The main causes of the complaints that were examined by the Inquiry appear to fall into 3 main categories:

- The **capability and culture of the workforce**, including the extent to which some support workers and management reflect the values and principles of the provider, and have the interests and quality of life of the people they support at the centre of how they undertake their work. There is also a capability question. Mainly it seems driven by the extent of information that support workers need to be across when supporting a person with high support needs, and how this can be problematic when new staff (such as agency staff) are engaged at short notice to fill shifts.
- The **nature of supported accommodation settings** and the manner in which resources are applied to enable safe and quality supports. This particularly includes how the perspectives and preferences of all people living together in a group are taken into account, equally. It also concerns the appropriateness of the accommodation for some people, and whether the people that live together in a group are suitably compatible, to avoid incidents and issues that frequently arise.

- **Inadequate transparency and communication** about the supports that will be delivered, how and why they might change, and how serious incidents and issues affecting a person are being managed, and indeed, why they occurred in the first place. Many complaints would be avoided if there was clearer communication with a person with disability and/or their supporters, and if service agreements were clearer – and presented in a form that was accessible to the person with disability and their supporters.

These themes are largely common across the 7 providers, and strongly align with the evidence about what impacts on best practice in group homes, as described in Chapter 5.

> One person with disability who was consulted talked about something they didn't like about their group home: "I've got just 2 people that can't talk and I don't sleep well, but I'm moving soon so I'll be happy. I have one person that has seizures at night and that wakes me up and I don't go back to sleep until 4 or 5 in the morning. And one just puts me down, just asking me to do stuff and I said no, and that makes me get upset a little bit. I've got pretty nice staff now, I used to didn't have a nice staff, but now I've got a really good staff now and I really liked that, so I had about 3 not nice staff".

Reportable incidents in supported accommodation

In terms of the reportable incidents received by the NDIS Commission from the providers covered by the Inquiry, the incidents fell into the categories described below. The categories are listed from most notified to least notified, and the types of incidents within each category are described from the most common to the least common. In the following description of the types of incidents:

- 'Most' means the majority of reportable incidents examined related to these types of incidents and they were common across all providers.
- 'Some' means there were a number of these types of incidents examined but they were not common across all providers.
- 'Few' means there a small number of these types of incidents were received but they were not common, and may have related to only one provider.

Serious injury of people with disability

Most reportable incidents about serious injury of a person with disability involved:

- an altercation with another person with disability
- unexplained bruising, cuts or abrasions on a person with disability, where a provider noticed the bruising, cut or abrasion but did not know how the person sustained the injury, including a provider seeking medical attention for a person to treat or check the injury
- falls involving a person with disability.

Some reportable incidents about serious injury of a person with disability involved:

- a person having a seizure, or sustaining an injury arising from a seizure, or having to be hospitalised due to a seizure
- injury arising from the use of equipment such as hoists, or near misses associated with the use of equipment
- self-harm by a person with disability.

A few reportable incidents about serious injury of a person with disability involved:

- medication issues, such as a person having a reaction to their medication, or being given the wrong medication, or the wrong dose, including a provider seeking medical attention to treat or check the error.

Abuse of a person with disability

Most reportable incidents about abuse of a person with disability involved:

- verbal abuse of a person with disability by a support worker
- rough handling of a person with disability by a support worker
- verbal or physical abuse (for example pushing or shoving a person) of a person with disability by another person with disability.

Some reportable incidents about abuse of a person with disability involved:

- emotional or psychological abuse by support workers through coercion, or undue influence
- failure of support workers to respond to an accident or injury.

A few reportable incidents about abuse of a person with disability involved:

- financial abuse of a person with disability by support workers
- physical abuse of a person with disability by support workers.

Neglect of a person with disability

Most reportable incidents about neglect of a person with disability involved:

- inadequate supervision of a person with disability for a short period
- inadequate support by not providing personal hygiene support to a person with disability in a timely way over a short period, or in one instance
- medication omissions, such as not providing a person's medication when required.

Some reportable incidents about neglect of a person with disability involved:

- not assisting a person with disability to access health or medical support in a timely way
- not providing a support to a person with disability in a timely way.

A few reportable incidents about neglect of a person with disability involved:

- neglectful treatment of a person with disability by another provider.

Unlawful physical contact with or assault of a person with disability

Most reportable incidents about unlawful physical contact were about:

- an alleged assault of a person with disability by another person with disability, often a person they live with
- alleged assault of a person with disability by a support worker, including for example rough handling of a person with disability.

Death of a person with disability

Most reportable incidents about the death of a person with disability concerned people who had died in hospital or at home following deterioration associated with known medical condition (such as cancer). This includes people who had been receiving palliative care.

A few of the deaths of people with disability that were notified to the NDIS Commission were unexpected deaths, where the person died at home.

Unlawful sexual contact with or assault of a person with disability

Most reportable incidents about unlawful sexual contact involved:

- an alleged sexual assault of a person with disability by another person with disability
- an alleged sexual assault of a person with disability by support worker.

Sexual misconduct

Most reportable incidents about unlawful sexual contact involved:

- support worker allegedly breaching professional boundaries
- alleged misconduct towards a person with disability by another person with disability.

A few of the reportable incidents about sexual misconduct involved a person with disability being exposed to pornographic material by a support worker.

Unauthorised restrictive practices

The NDIS Commission regulates NDIS providers' use of regulated restrictive practices in relation to people with disability, for the purposes of reducing and eliminating the use of those practices.

A restrictive practice means any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability. Under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Restrictive Practices and Behaviour Support Rules), certain restrictive practices are subject to regulation. A restrictive practice is a regulated restrictive practice if it is or involves seclusion, a chemical restraint, a mechanical restraint, a physical restraint or an environmental restraint.

The use of a restrictive practice is 'unauthorised' if its use has not been authorised in accordance with any applicable state or territory requirements for authorisation, and/or it is not used in accordance with a behaviour support plan for the participant. Providers must report every instance of a restrictive practice, including each individual use, until evidence of authorisation (if required) and the behaviour support plan are lodged with the NDIS Commission.

The Terms of Reference for this Inquiry did not involve consideration of the use of all restrictive practices in group homes beyond those notified to the NDIS Commission as a reportable incident. As such, it has not examined arrangements of people with disability in supported accommodation who may have a behaviour support plan that contains the use of a restrictive practice.

The URPs that were examined in the Inquiry were about people with disability who had also been identified as being the impacted person in a reportable incident or complaint, in a group home covered by the Inquiry. Therefore, URP numbers shown in the charts below are for NDIS participants living in group homes that are subject to URPs and at least one other reportable incident or complaint relevant to the Inquiry. These have been compared with all URPs notified to the NDIS Commission by the 7 providers for NDIS participants in all settings. The NDIS Commission's systems do not otherwise currently allow for the linkage of URPs to group homes.

In 2021–22, providers covered by this Inquiry notified the NDIS Commission of **261,546** instances of the use of a URP across all their NDIS supports and services. These URPs were used on **1,458** NDIS participants, or **10%** of the **14,781** NDIS participants supported by these providers in that year.

750 of the NDIS participants that were the subject of the use of a URP have been identified as being the subject of at least one reportable incident or complaint captured by this Inquiry. This is **24%** of all the NDIS participants that were identified as being the subject of a reportable incident or a complaint examined by this Inquiry, and **15%** of the people receiving SIL supports from the 7 providers. **68%** (179,296) of URPs reported by the 7 providers during 2021–22 were related to these **750** NDIS participants.

The following chart shows the number of people subject to URPs and at least one other reportable incident or complaint that the providers supported in SIL, compared with the total number of NDIS participants supported in total.

Figure 19: Proportion of NDIS participants subject to Unauthorised Use of Restrictive Practices

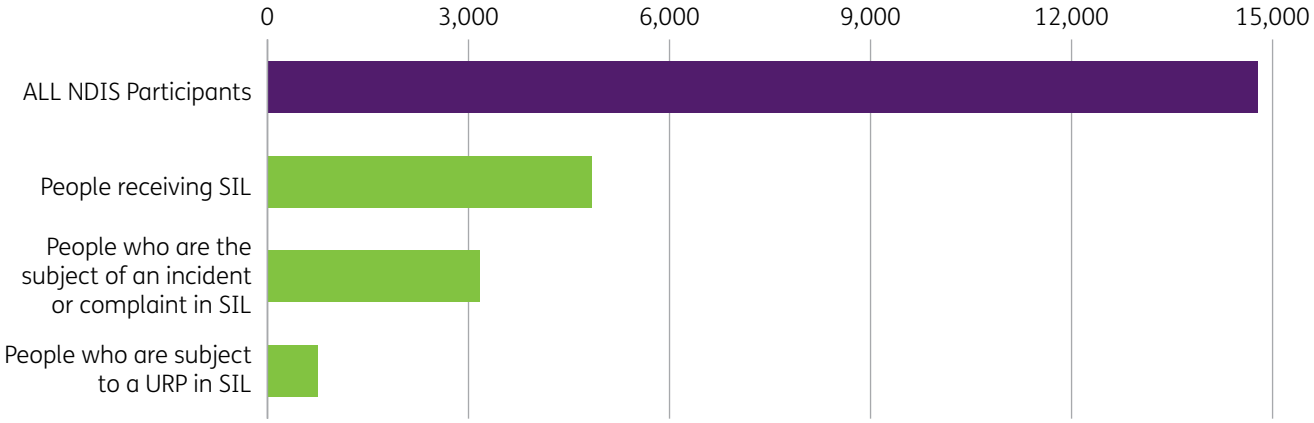


Table 22: Proportion of NDIS participants subject to Unauthorised Use of Restrictive Practices

NDIS participants subject to a URP	NDIS participant count
People who are subject to a URP in SIL, and one other RI or complaint	750
People who are the subject of an incident or complaint in SIL	3,169
People receiving SIL	4,850
All NDIS Participants	14,781

The NDIS Commission has an extensive program of work to address the use of restrictive practices including:[57]

- continuing to lead work with states and territories on authorisation processes, with the objective of accelerating the work to achieve national consistency, as set out in the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (National Framework) endorsed by all governments in 2014
- targeted compliance action with providers who are implementing URPs
- building the capability of the workforce implementing restrictive practices
- increasing the number and competence of behaviour support practitioners, and improving the quality of behaviour support plans
- reviewing the interaction of the regulatory requirements in relation to behaviour support and reportable incidents, particularly reconsidering the regulatory requirements to prevent the oversight of uses of restrictive practices in relation to a participant being split between the NDIS Commissioner's reportable incidents and behaviour support functions
- working with the Aged Care Quality and Safety Commission (ACQSC) and the Australian Commission on Safety and Quality in Healthcare (ACSQHC) on the *Joint Statement in the Inappropriate Use of Psychotropic Medicines to Manage Behaviours of people with disability and older people*[58] and address the important issue of inappropriate use of psychotropic medicines among people with disability and older people, and the commitment to collaborative action to reduce it.

The NDIS Commission is continuing to work with state and territory governments to achieve national consistency in the authorisation of the use of restrictive practices. The NDIS Commission has a range of compliance initiatives underway and planned to address the practices of providers – both implementing providers and specialist behaviours support providers – to achieve a reduction in the use of restrictive practices for NDIS participants, and ultimately their elimination.

Observations arising from the examination of reportable incidents

The NDIS Commission guidance on reportable incidents is comprehensive, and providers are aware that it is available. All of the 7 providers had incident management policies and procedures that referenced how they would apply the guidance to determine which incidents are reportable incidents and should be notified to the NDIS Commission.

Nevertheless, there was variation in the approach that each of the 7 providers took to the incidents that they notified to the NDIS Commission as reportable incidents.

Some of the providers notified the NDIS Commission of incidents that would ordinarily be captured within their own incident management systems but which would not, according to the NDIS Commission's guidance, necessarily meet the threshold for notification. Other providers had a higher threshold for reporting, and interpreted the NDIS Commission's guidance as requiring only the most serious incidents to be notified. A number of the providers very regularly engage with NDIS Commission reportable incidents teams to determine whether certain incidents should be notified as reportable incidents or not.

The providers with higher rates of reporting told the Inquiry that the NDIS Commission's policy of 'when in doubt report', and sometimes inconsistent advice from NDIS Commission officers regarding whether an incident should be notified or not, was in part the reason for their rates of notification.

57 **Unauthorised uses of restrictive practices in the NDIS report | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)**

58 **Historic collaboration to address inappropriate use of psychotropic medicines | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)**

One provider notified a significantly higher number of incidents than any other provider, and another had significantly lower rates of incident notification compared to other providers. In both cases the providers have indicated that they will be reviewing their reportable incident policies to make sure that these align with the NDIS Commission's guidance. The NDIS Commission will work with them on this.

The following observations are made about the reportable incidents examined:

Worker conduct

A significant number of reportable incidents notified to the NDIS Commission related to the conduct of workers, particularly:

- support workers exercising undue influence over a person with disability, mainly by coercing or manipulating a person with disability into doing something that the support worker wants them to do, which may or may not be what the person with disability would prefer
- verbal and psychological abuse of a person with disability by a support worker, for example yelling at a person with disability, swearing at a person with disability, or using demeaning language.

Every worker providing NDIS supports and services is a Code-covered person for the purposes of the NDIS Code of Conduct. The NDIS Code of Conduct[59] requires that any person employed or otherwise engaged by an NDIS provider must, among other things:

(a) act with respect for individual rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions, and

(c) provide supports and services in a safe and competent manner with care and skills, and

(e) promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability, and

(f) take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of people with disability.

Verbal abuse, and coercive or manipulative behaviour on the part of support workers is undoubtedly an incident for the purposes of the Incident Management Rules. Accordingly, such incidents should be recorded in the provider's incident management system and notified to the NDIS Commission as abuse of a person with disability. The NDIS Commission's guidance describes these types of incidents under the abuse of a person with disability reportable incident category as:

Psychological or emotional abuse – verbal or non-verbal acts that cause significant emotional or psychological anguish, pain or distress including verbal taunts, threats of maltreatment, harassment, humiliation or intimidation, or a failure to interact with a person with disability or acknowledge the person with disability's presence.[60]

The cumulative impact of verbal abuse and undue influence on the psychological wellbeing of NDIS participants is a significant issue for providers to address. It has a particular impact on people with disability when perpetrated by support workers because support workers have a high standing in the lives of people with disability. Support workers are significantly relied upon for most aspects of a person's daily life, but also represent an important relationship for people with disability that develops from daily and close engagement.

These issues have a significant impact on the rights of people with disability, their quality of life, and psychological and emotional wellbeing. This in turn impacts other key aspects of the person's life, such as their confidence to exercise choice and control, and to pursue their goals.

Psychological or emotional abuse of a person with disability may also impact the person's motivation and confidence to raise issues about their supports and services, which may contribute to the relatively lower rates of complaints in group homes over other settings.

59 NDIS (Code of Conduct) Rules 2018

60 NDIS Commission Reportable Incidents: Detailed Guidance for Registered NDIS Providers June 2019.

During the site visits undertaken by this Inquiry, there was repeated evidence of strong, positive and mutually respectful relationships between residents of group homes and their support workers. In these examples, it was clear to the Inquiry how impactful these positive relationships are on the quality of life of people with disability, and how influential support workers are in supporting people with disability to engage in an authentic and direct way with others around them, where they require support to do so.

It is critical that providers immediately address the conduct of people they employ or otherwise engage who do not have the attitude or aptitude to work with people with disability in a respectful and positive manner. Providers should utilise tools, such the NDIS Workforce Capability Framework, to recruit staff who have the capabilities to make a positive difference to the quality of life of the people they are employed or engaged to support.

The NDIS Commission will initiate a compliance campaign in 2023 with the objective of explaining and highlighting the seriousness this conduct, with the objective of eliminating conduct that involves psychological or emotional abuse of a person with disability, including verbal abuse.

Incidents that are about NDIS participant actions

There were a significant number of reportable incidents associated with participant on participant altercations. These incidents were mainly low level physical or verbal abuse, with patterns of incidents occurring over a long period of time.

Some incidents can be very significant in terms of the immediate impact on both the participant who is the subject of the incident, and the participant perpetrating it. They can be one-off incidents, or – most commonly – sustained incidents that persist over a long period of time.

These incidents are represented in the reportable incidents numbers about abuse, serious injury, or unlawful sexual or physical contact depending on the nature of the incident or the impact of it on the affected person, which can include the person with disability perpetrating the conduct.

The incidents can arise from the way in which a person's supports are provided, including:

- the nature of the setting they are being supported in
- how effectively a provider adjusts supports to address the issues leading to the incident, or following it, to avoid any future issues
- whether they have the right plans in place to guide how support is provided
- whether the support workers in the group home have the capabilities needed to manage the circumstances that lead to an incident occurring
- whether the incidents are occurring because the people who are living together are not compatible.

Of all the people affected by reportable incidents notified to the NDIS Commission by the 7 providers, there were a relatively small number of people who were regularly identified as the impacted person across a number of reportable incidents. In almost all cases, the reportable incidents were about people who had been the subject of repeated abuse by a co-resident, or a person's behaviour resulted in harm to themselves.

The Inquiry has examined reportable incidents and complaints at an address level for those group homes that have high number of reportable incidents. There is considerable variability in the reportable incident data when considered at a residence level.

Providers are required to report incidents for each person that is impacted, and for each incident as it occurs. There can be an accumulation of incidents over an extended period of time linked to one group home, but the relationship between these incidents may not be readily apparent to the NDIS Commission, due to the way that reportable incidents may be notified by the provider.

A provider may make adjustments to the way that support is provided that rectifies the cause of the incident, for example through a behaviour support intervention. There may then be no reportable incidents about the participants, or related to the residence for some time, or again.

There are higher rates of incidents associated with residences that are of a larger configuration. It appears from the nature of the reportable incidents that these incidents are mainly related to the more specialised support needs of the people who live in these settings, particularly medication requirements and mobility issues. In these settings there are much higher rates of reportable incidents associated with falls and seizures, or near misses related to equipment use.

These reportable incident patterns are important for the NDIS Commission to monitor, with connections to be made between the reportable incident function and behaviour support where that is relevant.

These types of incidents also directly relate to the capacity of a provider to make the necessary adjustments to supports that may be needed to address the risk of harm in settings with high rates of participant to participant altercations. This is discussed further in Chapter 6.

When resourcing allows, the NDIS Commission will work to improve its systems so that its ability to analyse reportable incident data is enhanced, including analysis of the relationship between information available through the reportable incidents functions and other functions of the NDIS Commissioner.

Deaths

Any death of an NDIS participant that occurs in connection with the provision of NDIS supports or services by registered NDIS providers must be notified to the NDIS Commission as a reportable incident. There are a number of bases on which there could be a connection between a death and the provision of NDIS supports or services. For example, the death could occur while the supports or services are being provided; or while supports or services should have been being provided but were not provided; or the death could occur in the course of implementing a plan (e.g. a mealtime management plan) developed by a registered NDIS provider (e.g. a speech pathologist).

It is important that NDIS providers assess, manage and resolve any reportable incidents that occur, including any death of a participant.

The NDIS Commission reviews the reportable incident notifications it receives and oversees the providers' management and resolution of the reportable incidents. The NDIS Commission has a range of regulatory powers that it can use in relation to reportable incidents, including requiring the provider to investigate and report the incident to the NDIS Commission. The NDIS Commission can also take compliance and enforcement action if it appears that a provider has breached its obligations under the NDIS Act, the Practice Standards or the NDIS Code of Conduct, or a worker has breached their obligations under the NDIS Code of Conduct. These powers apply in relation to all categories of reportable incidents, including deaths.[61]

It is also important that both the NDIS Commission in its regulatory role, and NDIS providers, address the causes of and contributors to deaths of people with disability, to prevent avoidable deaths.

The NDIS Commission is aware, from research[62] it commissioned about reviews that preceded its operation, that there are a number of risks to the lives of people with disability where no action was taken to reduce those risks. In 2020, the NDIS Commission embarked on a significant program of work, informed by this research, to target these risks. This included:

- increasing awareness and knowledge of the risks among NDIS providers and support workers
- disseminating resources to increase provider and worker skills in addressing high risk areas such as polypharmacy, mealtime supports, supporting people with communication impairment, and vaccination
- focusing compliance work on how NDIS providers review their practices arising from incidents to prevent the risks that are known to contribute to preventable deaths.

61 For example, the 2 civil penalty proceedings the NDIS Commission has commenced relate to deaths of participants that were the subject of reportable incident notifications. These deaths did not occur in connection with NDIS supports or services provided by any of the 7 providers included in this inquiry.

62 **2019 Report: Scoping review of causes and contributors to deaths of people with disability in Australia | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)**

Lucy likes to water the plants in the courtyard outside the big dining room window at her house. It calms her down when things happen in the house that she doesn't like, such as someone watching the TV when she wants it to be quiet. Her efforts have resulted in a lush wall of green around the courtyard. Lucy lives with Mark and Jack. Scott used to live there too but he died of cancer 6 months ago. Lucy spoke at Scott's funeral. She tells the story of speaking at the funeral by using hand gestures. She cries when she talks about it but she is proud she stood in front of all those people to share her feelings about Scott. Lucy says it's sad having his bedroom closed up and that she can't image someone else being in that room.

The NDIS Commission is interested in working with providers to address the systemic issues that result in the early death of people with disability, such as higher rates of chronic illness. To this end, the NDIS Commission is engaged in work being led by the Australian Government Department of Health to implement the *National Roadmap for improving the Health of People with Intellectual Disability*.[63]

In the context of this Inquiry, most of the deaths that were notified to the NDIS Commission were about a person who died as a result of a chronic condition (such as cancer) and had been receiving treatment in hospital, or a person who was being supported in palliative care at the time of their death.

Where a death was a sudden death and the person died at home, those deaths were the subject of internal investigation by a provider or coronial oversight. Most deaths of people at home related to coronary or respiratory issues connected to a person's diagnosed medical condition.

For some deaths, the NDIS Commission may have had an active investigation underway or be engaging with the provider around its handling of the incident, or about the conduct of a worker. The Inquiry noted these matters, but did not seek to duplicate the existing actions of the NDIS Commission.

The NDIS Commissioner intends to undertake a comprehensive inquiry into deaths that have been notified to the NDIS Commission which would be comparable to the state based reviews that were considered in the Scoping Review undertaken in 2019, within the context of the NDIS Commissioner's powers and functions.

The nature of reportable incidents

There is a widely held view among stakeholders that all incidents reported to the NDIS Commission concern events that should be reported to Police, or where the NDIS Commission should take enforcement action, such as banning a provider or imposing a civil penalty.

The vast majority of incidents examined through this Inquiry did not relate to events of that nature.

In the few incidents examined through the Inquiry that did relate to criminal conduct, these had all been reported to the Police, whether the incident was about the conduct of a worker, or in some instances perpetrated by another person with disability. Similarly, those that concerned the misconduct of workers appeared to have been handled satisfactorily by the providers, including by the provider undertaking an investigation and disciplinary action where appropriate. A number of these incidents have also involved investigation by the NDIS Commission.

The NDIS Commission guidance on reportable incidents sets out the types of incident that each category of reportable incident covers. For neglect, this includes supervisory neglect that involves intentional or reckless failure. There are a high number of reportable incidents that are notified about 'supervisory neglect' that would not be considered as intentional or reckless. Following is one example.

63 **National Roadmap for Improving the Health of People with Intellectual Disability | Australian Government Department of Health and Aged Care**

A provider notified the NDIS Commission of 5 separate reportable incidents of neglect of a person with disability in relation to 5 NDIS participants who were in a bus at a petrol station while the support worker driving the bus paid for petrol. The worker was away from the bus for a very short time, and there does not appear to have been any specific requirement for these participants to be left unsupervised for such a short period. This event was notified by the provider as supervisory neglect because there was not another support worker in the bus at the time. The provider considered that it should be notify the NDIS Commission because usually the NDIS participants would have at least one support worker supervising them at all times while in the community.

As discussed previously, there are a significant number of reportable incidents notified as abuse that involve verbal abuse of a person with disability by another person with disability. Following is one example.

A provider notified a reportable incident involving a person with disability swearing at a co-resident. The resident who was being sworn at went into the garden to avoid the person who was swearing. The person who had been swearing was asked to stop by the support worker. The person who had been swearing went into their room which overlooked the garden and stared at their co-resident in the garden. The person in the garden felt intimidated by their co-resident looking at them through their window and was afraid to come back into the house.

There are many reportable incidents of these types of abuse and neglect notified to the NDIS Commission. As they are reportable incidents, they are required to be notified within 24 hours of key personnel becoming aware of the incident, with a full report of the incident and the provider's management of it then notified within 5 days of the incident. These reports are required for each person affected, or potentially affected, by the incident.

All registered NDIS providers should regularly review their practices, incident management policies and procedures, and the incidents that they are notifying to the NDIS Commission, to ensure that these align with the NDIS Commission's guidance.

These reports drive a high volume of matters into the NDIS Commission. From the Inquiry, it seems that the way in which these matters are received by the NDIS Commission is not efficient or sufficiently focused, to enable the NDIS Commission to perform its reportable incident function in an effective way. That function, as defined in section 181F of the NDIS Act, includes to:

(f) *support registered NDIS providers to develop and implement effective incident management systems and to build provider capability to prevent and manage incidents;*

(g) *collect, correlate, analyse and disseminate information relation to incidents, including reportable incidents to identify trends or systemic issues.*

There are quite a number of incidents notified to the NDIS Commission about the same incident – but reported for multiple participants, each of whom may have been impacted or potentially impacted by the incident, or present at the time that the incident occurred in circumstances where the incident directly affected other participants.

For example, it may be alleged that a worker has stolen money or property from one participant in one residence, so reportable incidents may be notified for every participant that the support worker is known to work with.

There may also be multiple reportable incidents about the same event. This is appropriate where there is more than one provider with a responsibility for responding to an incident. For example, one provider reported that a person had returned home after their day program with a large bruise on their arm, and that they could not say how the bruise came about. The NDIS Commission also received a reportable incident from the person's day program provider about the person tripping on the leg of a chair and falling on to the corner of an adjacent wall. The provider reported that the person had received first aid treatment at the time of the incident.

Some of the providers also use the reportable incident function to notify the NDIS Commission of issues they might raise about the quality of support being provided to an NDIS participant by another provider. They may notify the NDIS Commission that the other provider has failed to adequately respond to an issue they have raised about the management of an incident. This is not an appropriate use of the reportable incident function, and should instead be made as a complaint.

The NDIS Commission should receive notifications of matters that affect more than one participant, as well as multiple reports of the same incident. However, the way in which these are notified to the NDIS Commission should be reviewed so that the NDIS Commission is able to more easily link incidents. The NDIS Commission should also consider ways of streamlining provider notification arrangements, to reduce duplication including subsequent requests of information from the NDIS Commission in reviewing the management of any particular incident.

The issue here is not whether the NDIS Commission should adjust what is required to be reported, but rather whether some adjustments to the Incident Management Rules are needed so that the requirements are proportionate to the regulatory response that might be required as a result of the incident including:

- *when* an incident is reported
- the form of the report that a provider uses to make a notification
- whether in every circumstance an individual report should be notified for every person affected by a common incident, or whether one report should be provided identifying all people affected
- whether every instance of an incident that is persistent over a short period of time should be notified each time it occurs, or whether one report should be provided setting out how many times the incident has occurred, for example over a 24-hour period.

NDIS providers and their representative bodies often refer to the regulatory burden associated with the reportable incident function which takes time away from direct support. The reporting burden was raised by some of the providers covered by this Inquiry.

Although the NDIS Commission does not intend to alter its advice to providers about the reportable incidents that should be notified, it is clear that some refinement to this function would have benefit for both the providers and the NDIS Commission, and ultimately, the people with disability affected by them.

All incidents need to be recorded and responded to by provider regardless of any changes that may be made in the future to the notification of reportable incidents. The changes proposed for consideration in this report do not seek to change what is notified as a reportable incident, only when a notification might be required to be made, and the form of the notification.

The NDIS Commission is reviewing its reportable incident function, and in the course of that work will review the guidance to registered NDIS providers about what incidents should be notified as they relate to the categories of reportable incidents defined in the NDIS Act.

The NDIS Commission will also consider whether changes to the Incident Management Rules would be appropriate to adjust the notification timeframes for some incidents, and what is required to be reported for some incidents.

Chapter 5:

Best Practice in supported accommodation

The terms of reference for the inquiry specified that the Inquiry Lead is to: *identify, through an examination of local and international resources, models of best practice for the delivery of supported accommodation that might be appropriate for consideration by the NDIS Commission in its capacity building work with providers and in the context of development of any future amendments to relevant practice standards and quality indicators.*

The NDIS Commission, together with Mr Rogers, determined that this component of the Inquiry would delivered through a literature review, and be commissioned from a body that had recognised expertise in researching models of best practice and supported accommodation for people with disability, and related subjects.

The Living with Disability Research Centre at La Trobe University was subsequently commissioned to deliver this element of the Inquiry, with the project to be led by Professor Christine Bigby.

Professor Bigby and Professor Julie Beadle-Brown previously conducted a substantial realist review of the international literature on group homes. Their review, 'Improving quality of life outcomes in supported accommodation for people with intellectual disability: What makes a difference' was published in the *Journal of Applied Research in Intellectual Disability* in 2018. Their review took account of available literature published in English to the end of 2014.

Professor Bigby's approach to the literature review commissioned for this Inquiry was to review the literature published in English between January 2015 and February 2022. This has the effect of updating the previous review conducted by Professors Bigby and Beadle-Brown and published in 2018. This updated review primarily involved a rapid focused narrative review of 64 papers identified through various searches, which are described in detail in Professor Bigby's review.

In October 2022, Professor Bigby finalised the review, 'Evidence about Best Practice in Supported Accommodation Services: What Needs to be in Place?'. It is included at the web links in **Appendix D** to this report.

This chapter summarises Professor Bigby's findings and discusses how the NDIS Commission will apply them in the context of this Inquiry. Professor Bigby's review should be read in full for a detailed discussion of the literature and Professor Bigby's findings.

Focus of the review

Professors Bigby and Beadle-Brown's review published in 2018 studied the available literature in relation to evidence about which variables affect the quality of life of people with intellectual disability living in group homes. It reviewed the strength of supporting evidence for the variables thought to influence quality of life outcomes, and sought to identify their relative influence on quality of life. The review summarised propositions in the literature about what makes a difference to quality of life outcomes in group homes in the following 5 clusters:

- frontline staff and managerial working practices reflect values and principles of organisation and place quality of life outcomes at the centre
- culture
- organisational characteristics, policies and processes
- the necessary but not sufficient resources and setting are available
- external environment.

Having assessed the available evidence for more than 60 propositions across these 5 clusters, Professors Bigby and Beadle-Brown identified the following 10 propositions as having the strongest or most promising evidence about what makes a difference to quality of life outcomes for service users in group homes:[64]

1. Staff practice reflects Active Support.
2. Staff practice compensates, as far as possible, for inherently disadvantageous characteristics of service users, particularly severity of disability and challenging behaviour.

64 2018 article, Table 3, p193.

3. Frontline management uses all aspects of practice leadership.
4. Service culture is coherent, enabling, motivating and respectful.
5. There are strong organisational policies and practice in the area of HR (that support frontline leaders and recruitment of staff with the right values).
6. There are processes to assist staff to focus their practice on engagement of service users.
7. Staff are trained in Active Support, and training has both classroom and hands-on components.
8. There are adequate resources for sufficient staff with the right skills to enable people to participate in meaningful activity and relationships but not too many that they obstruct participation.
9. Supported living options offer services users more choice and control.
10. Settings are small (1–6 people), dispersed, homelike.

Professor Bigby's review for this Inquiry built on the earlier review by including a review of the more recent literature. It aimed to identify models of best practice that the NDIS Commission might consider in its capacity building work with providers and the development of relevant practice standards and quality indicators. It sought to answer the following key questions:

- What are the most important components that influence the quality of life of adults living in supported accommodation?
- What obstructs or facilitates the presence of the components that positively influence quality of life in supported accommodation?
- What do adults living in supported accommodation and their families consider necessary for a good quality of life?
- What should be included in a best practice framework based on evidence about components that influence quality of life in supported accommodation?
- What evidence is missing that should inform a best practice framework?

Lisa is a team leader of a cluster of 2 group homes and 2 small units where 8 men with intellectual and psychosocial disability live. She's just started her shift when we meet her but she came in an hour early to have a coffee with Ian who lives by himself in one of the units. She had supported Ian to go out to dinner with a friend the night before. He wanted to talk with her about the good time he had, and to gossip about his friend. She tells us that Ian prefers her to assist him with social activities. She often has to assist Ian at short notice, like accompanying him to dinner last night which she hadn't planned and had to do on her own time. She is concerned that Ian needs a much bigger network, so she is working with Ian and a couple of other staff members to build his relationship with them so he feels comfortable with them supporting his social life as well as Lisa.

Key elements of best practice

Components of a best practice model

Professor Bigby's review identified 3 components of a best practice model for group homes as follows:

1. **Foundation components:** These components are universal and relevant to all people living in all group homes. They are the responsibility of staff working in group homes and the organisations that manage them.
2. **Specialist components:** These components are interventions or additional supports that should be available to an individual living in a group home if and when they are needed. They are provided by staff or professionals who are not based in a group home and may not necessarily be employed by the organisation managing the group home.
3. **Collaboration and coordination components:** These components involve collaboration and coordination between staff and services involved with a person in a group home, and planning and decision-making support with every individual in a group home. These components underpin effective use of individualised funding schemes and optimise holistic and consistent support for people with disabilities.

Professor Bigby's review identified that there is substantial evidence about some foundation components of best practice that make a difference to the quality of life of people with intellectual disabilities in group homes, but that there remain gaps in knowledge in relation to specialist components of best practice and there is very little research on collaboration and coordination components in the context of group homes. This is relevant to how specialist and foundation components of the best practice framework work together, and warrants further exploration.

Key concepts of 'Active Support' and 'Frontline Practice Leadership'

Before outlining the elements of a best practice framework proposed by Professor Bigby's review, 2 key concepts need to be explained:

Active Support – Active Support can be defined as 'an enabling relationship by which staff and other carers provide graded assistance to ensure success – assistance that is tailored to the needs, pace and preferences of the individual is delivered in a person-centred, warm and respectful way and making the most of all the opportunities available at home, in school, in the community and at work'.

Active Support is a staff practice that has 2 components:

- The first is the way staff provide support to the person: staff offer real activities; staff offer choice; staff create opportunities for the person to be engaged; staff give the right type and amount of assistance; and staff ensure the message is clear about what is being offered.
- The second component is the way staff interact with the person: staff notice and respond to the person's communication; staff respect the person in all interactions; and staff create opportunities for friendly interactions.

Active Support makes the abstract concept of person-centred practice more specific and concrete for staff to learn. It brings together values and skills which are underpinned by theory and empirical evidence. It translates complex knowledge into skills that can be taught to frontline workers without tertiary education.

Training in Active Support focuses on the 4 essentials of practice:

1. *Every moment has potential* – for people to be engaged, wherever and whenever people and staff interact.
2. *Graded assistance to ensure success* – there is no hierarchy of different types of assistance, the focus is on finding the right type of assistance for each individual for that task.
3. *Maximising choice and control* – respecting preferences and choices of the person being supported.
4. *Little and often* – some people need frequent opportunities to experience new things, and short periods of engagement rather than lengthy continuous periods.

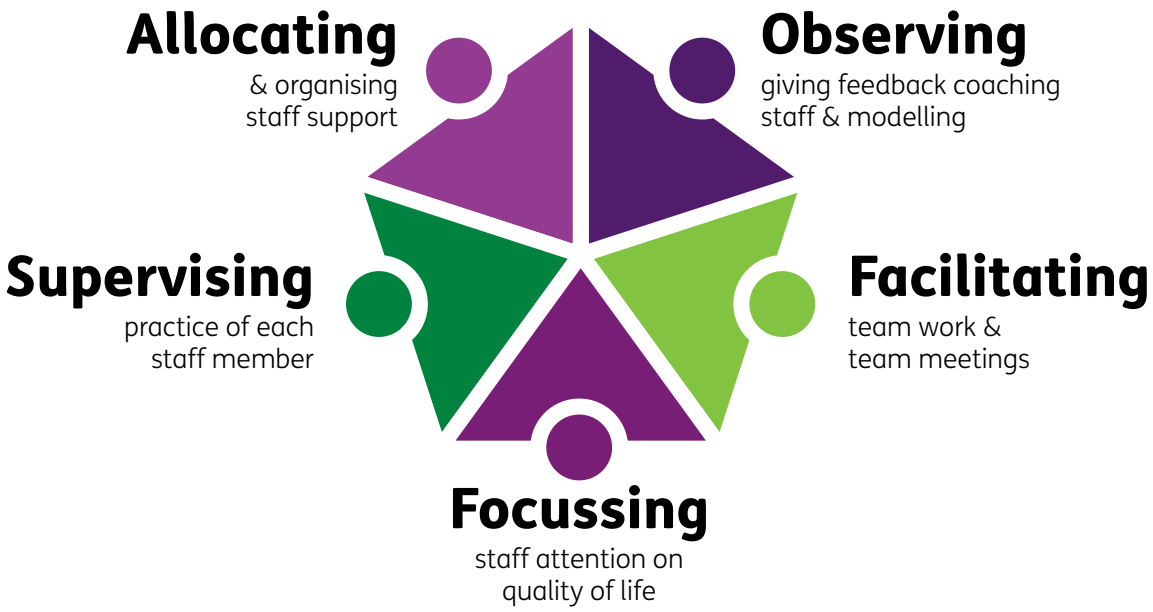
These essentials of Active Support are depicted in the following diagram:

Frontline Practice Leadership – Frontline Practice Leadership is a particular style of frontline management which leads, rather than manages, practice in group homes. It is a model of leadership for frontline managers who manage frontline support staff. Frontline Practice Leadership involves the following 5 tasks:

1. Focusing staff attention on the overall quality of life of the people supported.
2. Allocating and organising staff to provide the support people need, when they need it, to maximize their quality of life.
3. Observing, giving feedback, coaching, modelling to shape up the quality of staff support.
4. Supervising the practice of each staff member individually.
5. Facilitating teamwork and team meetings to share information, and ensure consistency and teamwork.

These components of Frontline Practice Leadership are depicted in the following diagram:

There is no one formula for Frontline Practice Leadership. However, to provide Frontline Practice Leadership, frontline managers must be close to frontline staff; they must know the staff and the people supported; they must be present during the provision of support; and they must have time in their role to regularly observe staff.



Professor Bigby's proposed elements of a best practice framework

Professor Bigby provided the following summary of the proposed elements of a best practice framework, the evidence about each element, and advice to the NDIS Commission in relation to each element:

Components of a best practice framework

1. Staff practice of Active Support

What makes a difference: Good Active Support staff practice that supports engagement of people with intellectual disabilities in meaningful activities and social interactions, choice and control, communication, community inclusion, learning and development. Active Support is also a proactive strategy for supporting people with behaviours of concern, and underpins many behaviour support plans.

Evidence: Active Support is an evidence informed practice. There is strong evidence that staff use of Active Support positively influences the quality of life (QoL) for all people in group homes, across the domains of personal development, emotional wellbeing, autonomy, interpersonal relationships, and social inclusion. As an evidence informed practice that can be learned by frontline staff, Active Support integrates the application of rights-based values and a range of support skills, including communication, support for choice, task analysis, and adjusting support to the needs of the person.

Advice: Active Support should be a key component of a best practice framework for group homes that support people with intellectual disabilities. As a specific person-centred, evidence informed practice it should be explicitly named and included the NDIS Quality and Safeguards Commission Practice Standards and the NDIS Workforce Capability Framework rather than being subsumed under the generic nomenclature of person-centred practice.

2. Staff practice that supports healthy lifestyles and access to healthcare

What makes a difference: Staff practice that promotes healthy lifestyles and supports people to get the healthcare they need, identifies early signs of health problems, supports communication with health professionals, and supports action on health professionals' advice.

Evidence: There is strong evidence about the roles that staff in group homes play in supporting people to lead healthy lifestyles and supporting access to the healthcare they need, and the significance of this support to QoL. There is no overarching evidence informed support model that encompasses the health-related tasks, which articulates the roles of group home staff in meeting healthy lifestyle and healthcare needs, that sets out how these roles fit together, how staff should work in collaboration with external experts, or identifies the skills group home staff require to fulfil health related roles.

Advice: The absence of an overarching evidence informed model to support healthy lifestyles and access to healthcare that could be embedded into group home staff practice is a major gap in knowledge. Research is required to develop and test a holistic best practice model of support for health of people in group homes.

3. Staff practice with families

What makes a difference: Staff who acknowledge the role of families of people in group homes and collaborate with them where appropriate.

Evidence: There is minimal evidence about the practice of group home staff working collaboratively with family members of adults in group homes or the QoL benefits of this. However, this is an important component raised by families. There is some research about the benefits of a key worker role in this regard but very little evidence about their roles in the current context. Group home cultures that are cohesive, respectful, enabling, and motivating are likely to be more open and collaborative with family members.

Advice: There is scant evidence about the benefits of collaboration between staff and families for the QoL of people in group homes or about the practice necessary to do this well. Research in this area would fill an important gap in practice knowledge.

4. Gaining the perspectives of people who live in group homes

What makes a difference: Having control over one's own life, relationships with staff, continuity of staff, and staff knowledge about the people they support.

Evidence: There is very little evidence that the perspectives of people who live in group homes have either been sought or are collectively taken into account in the design and delivery of services. The limited literature suggests their perspectives reflect to some extent those of families, the intent of disability policy, and the aims of some elements of best practice.

Advice: The Commission should support research about the perspectives of people who live in group homes about their services and effective strategies for including their perspectives in the design and delivery of group home services.

5. Positive staff culture

What makes a difference: Staff culture that is cohesive, respectful, enabling and motivating, where staff perceive there is strong leadership and staff practice is attentive, responsive, flexible and pays attention to the dignity and comfort of the people they support as well as their inclusion and engagement needs.

Evidence: There is strong evidence that group homes which have a culture that is cohesive, respectful, enabling and motivating have better QoL outcomes. There is emerging evidence that this type of culture is associated with good Active Support practice and strong Frontline Practice Leadership.

Advice: The Commission should support ongoing research about the association between culture, good Active Support practice and QoL outcomes in group homes and support the further development of measures of culture as indicators of quality in group homes.

6. Staff who are competent and satisfied with their work

What makes a difference: Staff trained in Active Support, who have confidence in management and who are satisfied with their work and more likely to remain in their role.

Evidence: There is strong evidence that if group homes have staff who are trained in Active Support and who are confident in their management there is more likely to be good Active Support, which is indicative of good QoL outcomes. There is strong evidence that Active Support training should include a theory and hands-on component. There is some evidence that staff who experience strong Frontline Practice Leadership and practice good Active Support are more satisfied with their work and more likely to remain in their role. There is some evidence that staff turnover is associated with poorer QoL for people in group homes.

Advice: Training in Active Support should be included in the NDIS Workforce Capability Framework and requirements for Active Support training included in practice standards for staff working in group homes with people with intellectual disabilities.

7. Staff practice enabled by Frontline Practice Leadership

What makes a difference: Frontline managerial practices that support frontline staff to focus on QoL of the people they support, work as a team, organise support on each shift, regularly observe and provide feedback to staff about their practice, coach staff, model good practice, and supervise staff.

Evidence: There is evidence that the 5 tasks of Frontline Practice Leadership encapsulate these frontline managerial practices. There is robust evidence that strong Frontline Practice Leadership positively influences the quality of Active Support practice by staff and QoL in group homes.

Advice: There should be more explicit reference in the NDIS Workforce Capability Framework to the evidence informed competences of Frontline Practice Leadership to assist in strengthening understanding of this enabling component of best practice. Specific and targeted training in the 5 tasks of Frontline Practice Leadership should be included in practice standards for frontline managers of group homes.

8. Senior organisational leaders who value direct staff practice and implement structures and processes to support and maintain it

What makes a difference: Senior organisational staff who value and understand practice and put in place structures to support and maintain Active Support, Frontline Practice Leadership, train all staff in Active Support and monitor practice using observational techniques.

Evidence: There is strong evidence that the values held by senior organisational leaders about practice, and their actions, are predictors of good Active Support practice and QoL in group homes. There is most evidence about the significance, at the organisational level, of providing overarching support for practice, embedding staff training in Active Support (both the theory and practical application), in organisational processes, and structuring Frontline Practice Leadership so it is close to direct support staff and there is sufficient time for frontline managers to carry out all 5 tasks. There is growing evidence that paperwork is an increasing burden on frontline staff and managers that detracts from providing good direct support. Not all paperwork is of equal value, and in particular, evidence indicates that paperwork such as policies, procedures and staff self-reports are not good indicators of the quality of practice in group homes – observation of practice is a more robust approach to measuring or monitoring quality. A simple observational tool based on a complex research measure has been developed for *Observing Staff Practice* which yields a score about quality of staff practice, and could be incorporated into external audit requirements as well as being used internally for quality assurance.

Advice: Expectations about the training in Active Support for all direct support staff, and the tasks and structuring of Frontline Practice Leadership, should be included in practice standards for organisations providing group home services. The Commission should review the volume and type of paperwork it requires from group home staff, frontline managers and organisations, and in particular consider alternative strategies for collecting evidence about practice. This may be the inclusion of observational tools in audits for reaching judgements about the quality of practice, and establishing a practice standard for observed practice quality.

9. Managerial practices that support access to specialist interventions and other forms of additional support

What makes a difference: Managerial practices that support access to specialist interventions, and additional supports as and when they are needed by individuals and which are provided by specialists either internal or external to the organisation.

Evidence: This study did not review the strength of evidence about specialist interventions for people in group homes but noted these were mediated by individual characteristics such as life course stage, health, behaviour and availability of informal support. It also noted the limited evidence about the implementation of specialist interventions in the context of group homes, and that additional support from staff outside group homes is increasingly important in the context of the NDIS where the responsibility of group home staff vis other services is more diffuse.

Advice: It may be useful for the Quality and Safeguard Commission to review the evidence about the effectiveness of specialist interventions and additional supports that complement the support from group home staff in order to understand the extent to which these improve or detract from an individual's QoL. This may be particularly important in the area of behaviour support, which is a common specialist intervention provided by external professionals.

10. Managerial practices that support staff collaboration, service coordination, involvement in planning and support for decision-making

What makes a difference: Staff and managerial practices that support effective collaboration between group home staff and others involved in supporting an individual; that support the coordination of services around an individual; that ensure an individual's involvement in all planning processes about their support, and their receipt of good supported decision-making.

Evidence: There are gaps in evidence about the type of practice that best supports collaboration between group home and external staff, the coordination of services, individual planning and supported decision-making for people in a group home context. However, practice wisdom suggests they underpin effective use of individualised funding schemes and optimise holistic and consistent support for people with disabilities. Evidence does suggest that group homes with a cohesive culture, which is open to outsiders and where there is strong Frontline Practice Leadership, are all likely to facilitate collaboration between internal and external staff and thus the implementation of specialist interventions.

Advice: There is a need for research that addresses knowledge gaps about collaboration between group home and external staff, and effective planning and coordination of services and models for provision for supported decision-making for individuals in group homes.

11. Design of group homes which support good QoL practice

What makes a difference: Group home designs where there are 6 or less people, the staff resources reflect the support needs of the people supported, and people living together are compatible, and have similar levels of support needs in term of their adaptive behaviour.

Evidence: There is strong evidence about the first 2 of these factors, small size and staff resources commensurate to the support needs of the people supported. There are gaps in evidence about assessing or ensuring the compatibility of people living together in a group home, other than evidence about the negative impact of grouping together people with behaviours of concern or people with very different levels of ability.

Advice: No more than 6 people living together under one roof or on one site should be reflected in service design standards. Research should be undertaken to further understanding about determinants of compatibility of people living together in group homes and tools to facilitate choice of compatible house mates.

There is strong evidence for a group of elements of the best practice framework proposed by Professor Bigby's review relating to what support workers, frontline managers and senior organisational staff do and how they do it, including the skills and practices, and the values and culture, required to support good quality of like in group homes. The examination of the reportable incidents and complaints, and the underlying causes of these bear out this research.

The following elements of the best practice framework proposed by Professor Bigby's review are relevant:

- Active Support practice by staff supporting people with intellectual disabilities in group homes (element 1).
- Positive staff culture, with emerging evidence that cohesive, respectful, enabling and motivating cultures are associated with good Active Support practice and strong Frontline Practice Leadership (element 5).
- Staff trained in Active Support who have confidence in management and who are satisfied with their work (element 6).
- Frontline Practice Leadership involving frontline managerial practices that support frontline staff to focus on the QoL of the people they support and that positively influences the quality of Active Support practice by staff (element 7).

Senior organisational staff who value and understand practice, and put in place structures to support and maintain Active Support and Frontline Practice Leadership (element 8).

Bruce is 45 years old and has multiple sclerosis. Bruce's mobility, his cognition and short-term memory have been affected by the disease. He is a boilermaker by trade and is proud that he attained that qualification. He's looking forward to Christmas so he can go home and have "more than a few" beers with his Dad. Bruce says he is a bit bored. He wants to go out more but can't decide what to do. He really likes his support workers and says that the best thing about living where he is, is them. He explains that they spend time with him and he has someone to talk to on the days he doesn't go out, and they help him remember things he forgets.

There is also strong evidence for the element of the best practice framework proposed by Professor Bigby's review relating to the design and staffing of group homes, where there should be 6 or fewer residents and staff resources should be commensurate with the support needs of the residents (element 11).

Professor Bigby's review also identified that there is evidence that paperwork is a growing burden on frontline staff and managers that detracts from providing good direct support, and suggested that the NDIS Commission should review the volume and type of paperwork it requires from group home staff, frontline managers and organisations, and in particular consider alternative strategies for collecting evidence about practice.

There are also a number of elements of the best practice framework proposed by Professor Bigby's review that require more evidence and research as follows:

- While there is strong evidence that staff practice that supports healthy lifestyles and access to healthcare is important to QoL in group homes, research is needed to establish the best model for how this should be done (element 2).
- Staff who acknowledge the role of families and collaborate with them is important to families but there is a lack of research about this (element 3).
- There is very little evidence that the perspectives of people who live in group homes have either been sought or are collectively taken into account in the design and delivery of services (element 4).
- There are gaps in the evidence about assessing or ensuring the compatibility of people living together in a group home, other than evidence about the negative impact of grouping together people with behaviours of concern, or people with very different levels of ability. Research should be undertaken about determinants of compatibility of people living together in group homes and tools to facilitate choice of compatible house mates (part of element 11).

Professor Bigby's review did not review the strength of evidence about specialist interventions for people in group homes, but noted that additional support from staff outside group homes is increasingly important in the context of the NDIS and that it might be useful for the NDIS Commission to review the effectiveness of specialist interventions and additional support in relation to QoL outcomes, particularly in relation to behaviour support.

The particular focus of this element is the promotion of managerial practices that support staff collaboration, service coordination and involvement in planning and support for decision-making. Although there is little research on this element, in the context of group homes it is likely to be key to bringing together the specialist and foundation supports that a person requires, and be instrumental in the success of specialist supports such as the implementation of behaviour support plans.

Given the number of reportable incidents and complaints that concern issues with how support workers interpret and apply behaviour support and other specialist plans, this element would benefit from some immediate guidance to providers, while further evidence on the most effective means of embedding this element of the framework is explored.

The NDIS Commission will explore further research on the coordination and collaboration elements of the best practice framework, particularly in relation to behaviour support. In the meantime, the NDIS Commission will also develop material for providers to promote these concepts.

Opportunities to apply the findings

Mandating Active Support and Frontline Practice Leadership

Professor Bigby's review establishes that the evidence is sufficiently strong for the NDIS Commission to commence work to include the elements of the best practice framework relating to Active Support, Frontline Practice Leadership, and senior organisational staff practices in Practice Standards and Quality Indicators that apply specifically to supported accommodation settings. The development of standards that incorporate these concepts and apply them specifically into group home settings is described in Chapter 6.

Professor Bigby recommends that Active Support, as a specific person-centred, evidence informed practice, should be explicitly named and included in the NDIS Practice Standards and the NDIS Workforce Capability Framework, rather than being subsumed under the generic nomenclature of person-centred practice. Similarly, Professor Bigby recommends that the evidence-based competencies of Frontline Practice Leadership should be explicitly referenced in the NDIS Workforce Capability Framework, rather than relying on more generic descriptions of managing, supervising and coaching staff.

The Core Module of the Practice Standards already includes a number of requirements relevant to the provision of person-centred supports and the management of frontline staff, including:

3 Person-centred supports

- Each participant can access supports that promote, uphold and respect their legal and human rights.
- Each participant is enabled to exercise informed choice and control.
- The provision of supports promotes, upholds and respects individual rights to freedom of expression, self-determination and decision-making.

6 Independence and informed choice

Each participant is supported by the provider to make informed choices, exercise control and maximise their independence in relation to the supports provided.

9 Governance and operational management

Each participant's support is overseen by robust governance and operational management systems relevant and proportionate to the size and scale of the provider and the scope and complexity of the supports being delivered.

15 Human resource management

Each participant's support needs are met by workers who are competent in relation to their role, hold relevant qualifications and have relevant expertise and experience to provide person-centred support.

21 Responsive support provision

Each participant can access responsive, timely, competent and appropriate supports to meet their needs, desired outcomes and goals.

These requirements in the Practice Standards are consistent with, and could be achieved by providing, Active Support and Frontline Practice Leadership, but they do not require Active Support or Frontline Practice Leadership.

One family member who was consulted said: "Staff should go further than the basics to create a relationship...There should be more awareness of disability and how to communicate with people with disability."

The quality indicators that support these Practice Standards are also consistent with Active Support and Frontline Practice Leadership, but again, they do not require Active Support or Frontline Practice Leadership, and could better expand on how these concepts are practically applied. For example, the quality indicators in relation to the person-centred supports practice standard require demonstration of the following indicators:

(1) *Each participant's legal and human rights are understood and incorporated into everyday practice.*

(2) *Communication with each participant about the provision of supports is responsive to their needs and is provided in the language, mode of communication and terms that the participant is most likely to understand.*

(3) *Each participant is supported to engage with their family, friends and chosen community as directed by the participant.*

The quality indicators in relation to responsive support provision include the requirement to demonstrate the following indicators:

(1) *Supports are provided based on the least intrusive options, in accordance with contemporary evidence-informed practices that meet participant needs and help achieved desired outcomes.*

(4) *Where a participant has specific needs which require monitoring and/or daily support, workers are appropriately trained and understand the participant's needs and preferences.*

The quality indicators in relation to human resource management include the requirement to demonstrate the following indicators:

(5) *Timely supervision, support and resources are available to workers relevant to the scope and complexity of supports delivered.*

(6) *The performance of workers is managed, developed and documented, including through providing feedback and development opportunities.*

65 **www.activesupportresource.net.au**

66 **www.practiceleadershipresource.com.au**

The development of a set of Practice Standards and quality indicators that apply to registered NDIS providers that provide supports in supported accommodation will enable the incorporation of the elements of the best practice framework recommended in Professor Bigby's review that are supported by strong evidence. Adjustments to the Core Standards, and particularly the Quality Indicators, to emphasise these elements should also be explored.

The following elements of the best practice framework should inform the new Practice Standards and quality indicators:

- Active Support practice among staff supporting people with intellectual disabilities in group homes (element 1).
- Positive staff culture, with emerging evidence that cohesive, respectful, enabling and motivating cultures are associated with good Active Support practice and strong Frontline Practice Leadership (element 5).
- Staff trained in Active Support who have confidence in management and who are satisfied with their work (element 6).
- Frontline Practice Leadership involving frontline managerial practices that support frontline staff to focus on the QoL of the people they support and that positively influences the quality of Active Support practice by staff (element 7).
- Senior organisational staff who value and understand practice and put in place structures to support and maintain Active Support and Frontline Practice Leadership (element 8).

There are evidence-based training resources already available in relation to Active Support and Frontline Practice Leadership.

Professor Bigby references the high quality evidence-based training in Active Support that was developed by Greystanes Disability Services and the Living with Disability Research Centre and funded by the then Australian Government Department of Industry in 2015.[65] New training in Active Support, building on this earlier work, is currently being finalised by the Living with Disability Research Centre, funded by the NDIS Commission. Professor Bigby also references the specific targeted training that is available in Frontline Practice Leadership, developed by the Living with Disability Research Centre and also funded by the NDIS Commission.[66]

Professor Bigby references a simple tool for observing and assessing the quality of staff practice in group homes, that aligns with the more complex Active Support Measure used by researches, that is currently in the final stages of development. Professor Bigby suggests that this 'Observing Staff Support' tool could be incorporated into external quality auditing requirements, as well as being used internally for quality assurance. Professor Bigby suggests that it would be feasible for the practice standards to include minimum quality of practice scored on a reliable tool such as this.

The development of new practice standards and quality indicators through a process of co-design should allow the testing of the standards and indicators, and the training, assessment and audit tools, before they become mandatory for relevant registered NDIS providers to ensure that they work as intended in practice.

The NDIS Workforce Capability Framework identifies a number of core capabilities for workers that are consistent with the principles informing Active Support. These include:

- understand what a good life means to me
- support me to make my own choices
- building my capacity to participate
- observe and respond flexibly to my changing needs
- engage and motivate me.

To have these capabilities, the knowledge required of workers includes knowledge of:

- the key elements that make up an individual's experience of a good life, such as building connections, friendships and intimate relationships, participation in work, education, community life and leisure, and positive health and wellbeing (including a healthy diet, physical exercise, and sexual health)
- diversity of social needs, preferences, and ways of connecting and being included in communities or activities of choice: how this can change over time and at different stages of life
- strategies to support participants to take control and make choices about their supports and how they live their lives
- importance of independence, self-expression and connection to chosen communities to QoL
- factors that contribute to good health such as a good diet, oral health, exercise, sleep and regular check-ups
- the concept of dignity of risk, and practices that support participants to stay safe without limiting their right to independence and choice such as strengthening social connection.

The NDIS Workforce Capability Framework also describes what a worker does and how they do it for each capability. For example:

- for the capability 'Observe and respond to my changing needs', the worker will:[67]
  - review information that explains what I need, how I want to be supported, and check in with me to understand if and how this may need to be adapted in the moment
  - be observant, attentive, and present when working with me
  - be responsive and flexible in how and when you provide support to me
- for the capability 'Engage and motivate me', the worker will:
  - approach my support with hope, optimism and patience
  - focus on, maintain and build my strengths and what I can do rather than what I can't
  - look for opportunities to engage me in meaningful ways to maximise my control and confidence
  - notice and celebrate my progress towards my goals and independence.

As with the current practice standards and quality indicators, the relevant requirements under the NDIS Workforce Capability Framework are consistent with Active Support and Frontline Practice Leadership, but again, they do not require Active Support or Frontline Practice Leadership.

It is only fairly recently that the NDIS Commission finalised the development of the NDIS Workforce Capability Framework. It is currently being implemented with the development of a range of tools and resources.

67 For advanced support work, instead of the first requirement, the advanced support worker will 'Review information on my support needs and plans and check in which me to understand if and how this may need to be adapted in the moment.' The advanced support worker also has an additional requirement to 'Respond to conflict, competing interests or multiple risks in ways that support my interests and needs.'

Rather than seeking to change a relatively new NDIS Workforce Capability Framework, it would be preferable to pursue the mandating of Active Support and Frontline Practice Leadership through the development of new practice standards and quality indicators. These concepts could be incorporated into the NDIS Workforce Capability Framework when it is ultimately reviewed.

Further consideration can be given as to whether and how Active Support and Frontline Practice Leadership should be reflected in the NDIS Workforce Capability Framework once the new practice standards and quality indicators are developed, tested and implemented. By then, NDIS participants, workers and providers will have had more experience in using the NDIS Workforce Capability Framework and they and the NDIS Commission will be in a better position to assess whether and how to incorporate Active Support and Frontline Practice Leadership.

Design of group homes

There is strong evidence for the element of the best practice framework proposed by Professor Bigby's review relating to the design and staffing of group homes, where there should be 6 or fewer residents and the staff resources should be commensurate with the support needs of the residents.

While many of the group homes included in this Inquiry had 6 or fewer residents, a few sites were much larger and had many more residents.

This is commented on in Chapter 6.

Aidan collects musical instruments, balls and hats. He loves showing off his skills on the keyboard and his percussion instruments. Music is the way that he communicates how he is feeling. He uses a wheelchair and gets around the house by touch. There are different textured tapes on the handrails to help him navigate his way into the backyard to kick a soccer ball around, or into the kitchen to get a drink or snack. He has a huge ball pit in his room with balls of all sizes. He uses the ball pit to relax.

The paperwork burden

Professor Bigby's review identified that there is growing evidence that paperwork is a growing burden on frontline staff and managers that detracts from providing good direct support. Professor Bigby suggested that the NDIS Commission should review the volume and type of paperwork it requires from group home staff, frontline managers and organisations and in particular consider alternative strategies for collecting evidence about the quality of practice.

The NDIS Commission's experience and the Inquiry observations do not entirely match Professor Bigby's findings.

The NDIS Commission does not generally mandate specific record-keeping practices, other than in relation to incident management systems and complaints management and resolution systems for registered NDIS providers. Requirements under the NDIS Practice Standards in relation to governance and operational management, risk management, quality management and human resource management are likely to require certain record-keeping. Similarly, the NDIS Practice Standards in relation to support planning and service agreements are likely to require certain record-keeping.

Particularly through its reportable incidents function and also through it complaints function, the NDIS Commission obtains a range of other records from registered NDIS providers. These often include records in relation to medication, nutrition, bowel care, behaviour support and the use of restrictive practices, health and dental care and hospitalisation. They can include records in relation to incidents, including eyewitness accounts of the incident, photographs and records of investigations. They may also include records relevant to an incident or complaint, including staff recruitment, rostering and training records.

These records are often important for the NDIS Commission to fulfil its function of overseeing the registered NDIS provider's management of reportable incidents and to enable the NDIS Commission to manage and resolve complaints. Regardless of the NDIS Commission's interest in these records, it is difficult to see how the provider could fulfil its duties to an NDIS participant without most if not all of these records. Most if not all of these records, and the systems than require them,

are also likely to be necessary for the provider to meet the NDIS Practice Standards in relation to governance and operational management, risk management, quality management, human resource management, incident management and feedback and complaints management.

However, in the course of visiting a number of supported accommodation sites during this Inquiry, it was clear that there are real differences in the nature of record-keeping between providers and sites and that the record-keeping mechanisms and practices at some sites contribute to staff spending a disproportionate amount of their time maintaining records instead of interacting with the participants they are supporting. Problems appear to arise from some or a combination of the following practices:

- the use of paper-based records and forms
- frequent changes to record keeping requirements and forms
- unclear, confusing or duplicative record keeping requirements and forms
- insufficient clarity about the purpose for which a particular record is required
- different record-keeping practices in different sites operated by the same provider
- the physical layout of the home and whether this facilitates or prevents staff from maintaining records while interacting with participants.

Where the particular problems were identified in the course of the Inquiry, these have already been brought to the attention of the provider and further action will be taken if considered necessary.

The NDIS Commission does not support any general instruction or guidance to providers to reduce their record-keeping. However, there is benefit in educating providers about the importance of having stable, consistent, integrated and, where possible, automated record-keeping processes across the provider's supported accommodation sites.

The NDIS Commission will work with NDIS providers to identify and provide guidance and education about best practice in record keeping.

Healthy lifestyles and access to healthcare

Professor Bigby's review found that, while there is strong evidence that staff practice that supports healthy lifestyles and access to healthcare is important to QoL in group homes, research is needed to establish the best model for how this should be done.

Professor Bigby references the research led by Professor Julian Trollor on the Causes and Contributors to Deaths of People with Disability in Australia (the *Scoping Review*), which was commissioned and published by the NDIS Commission in 2019. Professor Bigby also references the work the NDIS Commission has done in response to the *Scoping Review*, including in relation to specific health-related practice standards and educational strategies.

Professor Bigby suggests that many of the strategies are broad and target the entire disability sector, rather than being specifically targeted at group home staff, and that some of the strategies are narrowly focused on specific health conditions. This risks promoting a piecemeal rather than holistic approach to support for people with multiple complex needs living in group homes.

The NDIS Commission's responses to the *Scoping Review* were driven by the findings of the *Scoping Review* in relation to both specific risks and general failings in healthy lifestyles, healthcare and dental care. The NDIS Commission was satisfied that the highest specific risks in relation to dysphagia and choking warranted specific practice standards, resources and training to address them. In July 2021, the NDIS Commission published a broader suite of resources in relation to lifestyle risk factors, the need for regular comprehensive health assessments, and oral and dental health.

The NDIS Commission was also satisfied that the specific risks in relation to chemical restraints and psychotropic medications also warranted specific resources and other action to address them. The NDIS Commission joined with the Australian Commission on Safety and Quality in Healthcare and the Aged Care Quality and Safety Commission to release the 'Joint Statement on the Inappropriate Use of Psychotropic Medicines to Manage the Behaviours of People with Disability and Older People' (Joint Statement) on 21 March 2022. All 3 Commissions are taking action under the Joint Statement to specifically address the misuse of chemical restraints in relation to people with disability and people in aged care.

The resources that the NDIS Commission has published or funded and will continue to develop, publish or fund will contribute to knowledge about risks and skills and training to address those risks.

The NDIS Commission will conduct up-to-date research comparable to the *Scoping Review* to use its reportable incidents data to further inform knowledge about deaths and serious injuries to people with disability in Australia. This research will enable identification of risks and inform targeted responses to those risks.

However, as Professor Bigby's review found, there is no best practice model for how healthy lifestyles and access to healthcare should be supported by staff in group homes.

The NDIS Commission will keep under consideration how best to identify a best practice model for supporting healthy lifestyles and access to healthcare in supported accommodation, as the knowledge about risks and resources to improve skills and training to address the risks increases.

Possible further research

There are other elements of the best practice framework proposed by Professor Bigby's review that Professor Bigby identified require more evidence and research:

- Staff who acknowledge the role of families and collaborate with them is important to families but there is a lack of research about this (element 3).
- There is very little evidence that the perspectives of people who live in group homes have either been sought or are collectively taken into account in the design and delivery of services (element 4).
- There are gaps in evidence about the type of practice that best supports collaboration between group home staff and other people involved in providing specialist supports, and how those supports are coordinated (element 10).
- There are gaps in the evidence about assessing or ensuring the compatibility of people living together in a group home, other than evidence about the negative impact of grouped together people with behaviours of concern or people with very different levels of ability, and research should be undertaken about determinants of compatibility of people living together in group homes and tools to facilitate choice of compatible housemates (part of element 11).

The NDIS Commission will keep under consideration how best to identify best practice models in relation to the role of families, how the perspectives of people with disability are taken into account in design and delivery of services, the determinants of compatibility of people living together in a group home, and how group home and specialist supports are coordinated and providers collaborate to enable individual planning and supported decision-making.

In relation to the sites included in this Inquiry that were much larger and had many more than 6 residents, the Inquiry considers that the NDIS Commission should work with the relevant providers and the NDIA to ensure that the perspectives of the people who live at these sites are sought and taken into account in relation to changes to their living arrangements and the design and delivery of supports in their new homes if they remain in supported accommodation. This includes acknowledging the role of families and that families are involved in these changes.

The NDIS Commission should also work with the relevant providers and the NDIA to identify whether these changes provide a useful opportunity for further research in relation to these elements of the best practice framework proposed by Professor Bigby's review, including researching the issue of compatibility and how the preferences and choices of individuals living in a group home are affected when there are issues with compatibility between residents.

In addition, Professor Bigby's review did not review the strength of evidence about specialist interventions for people in supported accommodation, but noted that additional support from staff outside these settings is increasingly important in the context of the NDIS. Professor Bigby suggested that it might be useful for the NDIS Commission to review the effectiveness of specialist interventions and additional support in relation to QoL outcomes, particularly in relation to behaviour support.

The NDIS Commission's current priorities in relation to restrictive practices and behaviour support remain to be ensuring that all participants who are subject to ongoing uses of regulated restrictive practices have the benefit of behaviour support plans and state or territory authorisation (where required) – in accordance with the relevant NDIS Rules – and improving the quality of behaviour support planning and the implementation of behaviour support plans.

The NDIS Commission will keep under consideration when and how best to review the effectiveness of specialist interventions and additional support in relation to qualify of life outcomes in supported accommodation.

Chapter 6:

Inquiry Observations

Quality standards for supported accommodation

The number and nature of reportable incidents and complaints received by the NDIS Commission about group home settings, and the issues identified about those settings through this Inquiry, indicates that additional regulation of these types of supports is warranted.

Additional regulation could be achieved through the introduction of new standards for supported accommodation that are specific to group home settings. Such standards would be similar to other modules that are currently in the Practice Standards for NDIS supports such as SDA and Specialist Support Coordination.

The introduction of new Practice Standards would allow for specific guidance in how supports would be delivered in these settings, through the establishment of quality indicators. The new Practice Standards would be in addition to the current Core Module which would continue to apply to registered NDIS providers of these supports, and covers important and relevant aspects of practice that apply to all NDIS supports and services including supported accommodation.

The element of the Inquiry that considers best practice for the delivery of supported accommodation establishes that the evidence is sufficiently strong for the NDIS Commission to incorporate the elements of the best practice framework described in Chapter 5 in new Practice Standards specific to these settings.

There should also be some adjustments made to the Core Module and associated quality indicators to incorporate suggestions for practice that are specific to supported accommodation. For example, the practice standard on Service Agreements with Participants[68] already includes an indicator specific to a provider that is delivering SIL.

Additional quality indicators could be added to other Practice Standards in the Core Module, to provide guidance on practice in SIL settings, for example:

- the practice standard on **Independence and Informed Choice**[69] could include quality indicators about how a participant is supported to exercise control over their supports when they live in a group setting. This might include additional indicators about individual support with decision-making, and access to advocacy and informal supports
- the practice standard on **Transitions to or From a Provider**[70] could include quality indicators about the particular approach that should be taken in the context of a change in a person's home and living arrangements, or when a vacancy in a group home is being filled.

Based on the observations made through this Inquiry, as a basis for consideration a new Module to the NDIS Practice Standards relating to the provision of supported accommodation could include the following elements:

- Obtaining and applying participant feedback and satisfaction in accommodation settings, including how participant feedback is shared across all residents and acted where there are implications for all residents.
- Tenancy arrangements for accommodation that is not SDA. This would address the various arrangements for accommodation within which group home support is provided, and where the quality indicators of the SDA standard set out very clearly the obligations for working with other providers managing issues: addressing concerns, and supporting a person when their circumstances change, for example.
- Mainstream support connections, particularly access to health supports, including end-of-life supports.
- Working with other providers including SDA providers, and including the management of supports where one provider has multiple support roles.

68 NDIS (Quality Indicators) Guidelines 2018 section 21(4)

69 Registration Rules, Schedule 1 section 6.

70 Registration Rules, Schedule 1 section 22

Additionally, the following elements of the best practice framework should inform the new Practice Standards and quality indicators as described in Chapter 5:

- Active Support practice among staff supporting people with intellectual disabilities in group homes (element 1).
- Positive staff culture, with emerging evidence that cohesive, respectful, enabling and motivating cultures are associated with good Active Support practice and strong Frontline Practice Leadership (element 5).
- Staff trained in Active Support who have confidence in management and who are satisfied with their work (element 6).
- Frontline Practice Leadership involving frontline managerial practices that support frontline staff to focus on the QoL of the people they support and that positively influences the quality of Active Support practice by staff (element 7).
- Senior organisational staff who value and understand practice and put in place structures to support and maintain Active Support and Frontline Practice Leadership (element 8).

Any new standards would be developed in consultation with people with disability and providers, and would present an opportunity to build the capability and capacity of people with disability in supported accommodation to engage with the existing regulatory model and develop a better understanding of the NDIS Commission and its role.

The NDIS Commission will introduce a new Practice Standard specific to supported accommodation (a new Module to the Practice Standards). The NDIS Commission will develop these new standards in consultation with people with disability and providers, and other stakeholders. The new standards could reflect a number of the elements of the best practice framework that were discussed in Chapter 5 of this Report.

Targeted guidance for providers of supported accommodation that emphasise how the current Core Practice Standards apply in the context of these settings should be developed in light of the issues identified through this Inquiry.

New Standards take time to develop, they require consultation with people with disability and other stakeholders, as well as with state and territory governments. While standards are being developed, the NDIS Commission should could work with those of the 7 providers involved in the Inquiry who are already exploring the application of the elements of best practice framework, to test the application of these elements in practice. These 'pilots' would be evaluated to inform the development of quality indicators to support the new standards.

Piloting approaches to the application of the elements of the best practice framework that do not have as much evidence about their effectiveness as others should also be progressed, particularly the element of the framework that relates to practices that support access to specialist interventions, and additional supports which are provided by other specialists when required by a person living in a group home (element 9).

The NDIS Commission should also promote the Person Centred Active Support (PCAS) resources developed through an NDIS Commission Grant in 2019–20[71] across the sector. This would assist providers who are not yet familiar with Active Support to consider applying elements in their practice in advance of the introduction of the new standards.

While the NDIS Commission works to develop the new standards it will work with providers engaged through this Inquiry to pilot aspects of Active Support and Frontline Practice leadership, and other elements using a co-design approach.

The NDIS Commission will also promote existing Person Centred Active Support tools to educate NDIS providers about the best practice framework ahead of the introduction of new standards.

71 **Person Centred Active Support | Help Disability Care**

To support the introduction of new standards, it is expected that, given the nature of the SIL market, it would be appropriate for the NDIS Commission to explore a tiered set of requirements to reflect the diverse provider scale in the SIL market. This will enable issues that require greater focus for larger providers to be emphasised, such as governance and use of data to enable more proactive approaches to mitigating risks. A tiered approach will also allow for quality indicators to be clearly relevant to the practice of specific groups of providers, rather than being overly general.

Alongside the design and implementation of new standards the NDIS Commission will also:

- adjust how the assessment of registered NDIS providers against the new standards occurs, by introducing additional sampling arrangements for on-site assessments and interviews associated with group home settings (at higher ratios than is currently required for in the NDIS Commission Auditor Guidelines)
- allow for a focus on higher-risk settings in the NDIS, such as supported accommodation, in the design of the Consumer Technical Experts component of the audit scheme, which is currently being developed through an NDIS Commission grant awarded in 2021–22
- provide additional information to approved quality auditors about group home settings and the issues identified through this Inquiry, to guide the mid-term audit focus and registration renewals for providers that are registered for the 'assistance with daily life tasks in a group or shared living arrangement'
- consider, where it is possible to do so within existing resources, monitoring visits to group homes including through the NDIS Commission's reportable incidents and complaints functions, particularly where there are a number of reportable incidents and complaints relating to a particular group home.

The rights of people with disability

Choosing a SIL provider, and other providers

Stakeholders expressed concern about the extent to which providers supporting people in group homes usually provide all the key supports to a person in a group home setting. There is a strong view that this represents a conflict of interest, and places serious impediments on a person exercising choice and control over their NDIS arrangements.

The Inquiry tested this assumption by looking at the extent to which the 7 providers delivered SIL to people as well as SDA (where relevant), their support coordination, and if their supports involve the use of a restrictive practice, specialist behaviour supports. The Inquiry considered whether a higher rate of provision across multiple supports contributed to the themes in reportable incidents and complaints. This is described in Chapter 3.

The Inquiry found no definitive connection between such arrangements and rates of incidents and complaints, or their causes.

In considering the number and nature of the reportable incidents and complaints about the providers where the proportion of people receiving SIL and these other supports from them was high, it was in the following circumstances where this *may* have contributed to issues:

- In larger residential settings where people received SIL, SDA and support coordination, there appeared to be a higher number of complaints made about the provider's poor communication with the person or their family about support arrangements, including when there were changes to that support, the use of casual staff or rostering issues (that is, not enough staff available, or staff not being familiar with the needs of a person), or when following up on a complaint. However, the rate of such complaints is not sufficient to be definitive that the combination of supports from the same provider is the driver of these issues, as opposed to other factors. It is more likely related to the setting itself, and the support needs of residents rather than any combination of supports. This is described in further detail below.
- For some providers with a higher proportion of people that they supported with both SIL and support coordination, or SIL and SDA, the rate of complaints received by the NDIS Commission about supported accommodation was lower than for other providers. The Inquiry was unable to conclude whether the combination of supports was the reason for this difference, or whether it related to other factors such as people not being aware of how to complain, or not having people to assist them in raising issues. The NDIS Commission will engage further with those providers to explore this.

Where providers delivered both SIL supports and specialist behaviour support services, there appeared to be a lower rate of URPs reported, however in the context of the data limitations for analysis of URPs, this observation is inconclusive. The extent to which an 'in-house' behaviour support function promotes positive behaviour support practice, is more efficient in developing and maintaining contemporary behaviour support plans that meet the behaviour support needs of the person with disability, or most importantly leads to a reduction or elimination of the use of such practices, requires further exploration by the NDIS Commission as part of its program of work to address the use of restrictive practices.

In this Inquiry it is not evident that providing both SIL and SDA to a person exacerbates issues in the quality and safety of supports for NDIS participants.

In fact, it appears to be that where the SDA is not also provided by the SIL provider, there are some impediments to resolving issues for people in a timely way where those issues impact on the quality of their supports or their safety, or where a person wishes to make changes to their supports. This seems to be particularly difficult where the person wants to keep receiving their SIL from the same provider, but wishes to change the place they live, or things about the place they live. This appears to be because the SIL provider does not have the levers available to them to:

- readily reconfigure a house to address the needs of the residents, or to address this with the SDA provider in a timely way, or
- assist a person in identifying an alternative location and being in a position to continue to provide SIL supports to them in that new location if that is what the person wishes, or
- effectively work with the SDA provider and with existing residents to fill a vacancy when one arises, for example a person who has SIL in their plan but not SDA.

The Inquiry considers this to be of concern, given the obligations that are on SDA providers to under the SDA Module of the Practice Standards to work with other providers (such as SIL providers), address concerns about an SDA dwelling, manage potential conflicts involving participants (including responding to violence, abuse or exploitation), and address changes to a participant's circumstances or supports.

The NDIS Commission will consider a future compliance campaign targeting SDA providers and their obligations under the Practice Standards, particularly in regard to Tenancy Management.

Across all the providers, there wasn't an obvious connection in the nature of incidents or complaints for providers in this Inquiry and whether they provided only SIL, or SIL and SDA.

It was apparent that the residences that were included in the Inquiry involved a range of arrangements. Many were SDA, others were:

- private rental arrangements leased by the SIL provider
- leases of state or territory owned properties
- leases through a community housing provider
- property owned by the SIL provider.

There was no specific link between the rate of incidents and issues and the type of tenancy (or other) arrangement in place.

Some of the providers included in the Inquiry own a significant number of properties, and are considering in various ways redeveloping those, to provide more contemporary accommodation options to people with disability.

In all cases, the providers who were considering or acting on these plans gave information to the Inquiry about how they were engaging with the residents and their supporters about their accommodation preferences and associated services, and were also piloting new arrangements for some people so they could experience other supported accommodation options before they made a long-term decision. These plans were in keeping with the Practice Standards for:

- *Independence and Informed Choice:* Each participant is supported by the provider to make informed choices, exercise control and maximise their independence relating to the supports provided.
- *Access to supports:* Each participant accesses the most appropriate supports that meet their needs, goals and preferences.

In other examples observed by the Inquiry, SIL providers were delivering supports in larger residential settings that they did not own, and where there were no plans by the SDA provider to redevelop.

The interaction between SDA and SIL provision requires further detailed exploration. It has been suggested by some stakeholders that steps should be taken to mandate a separation between the provision of SIL and SDA. The Inquiry has observed that in some situations this separation can in fact exacerbate issues of participant safety, if the SDA provider is not closely connected to the NDIS participants and their other support providers, and attuned to issues that are arising in a house.

Further exploration is needed about how SIL and SDA providers interact, and how the Quality Indicators may be adjusted to make the obligations for SIL and SDA providers clearer about managing complex situations in group homes, whether the SIL provider and the SDA provider are the same, or different.

This may be a matter most appropriately referred to the NDIS Review given that it relates to broader considerations about home and living supports in the NDIS.

Larger supported accommodation settings

It was apparent from the reportable incidents and complaints examined for this Inquiry that group homes that are larger in scale (for example 10 or more people living together) are more isolated from the local community and have proportionately higher levels of reportable incidents and complaints than other smaller group homes.

Although not all participants received all of their supports from the SIL provider in these settings there, there was a higher proportion of NDIS participants living in these settings to whom the SIL provider delivered other supports and services.

While the Inquiry acknowledges that this is not the case for all residents, those whose accommodation is in larger support accommodation configurations appear to have more limited access to a broader range of providers to deliver their supports than in smaller settings. This appears to be because, over time, the SIL provider delivered these elements of support as part of the total package of supports for a person under previous funding arrangements. The Inquiry makes no judgment about this where there has been an active choice taken by the person around these arrangements.

Where the Inquiry observed the larger supported accommodation settings, each provider had arrangements in place to facilitate connections for the people with disability with advocates or other independent parties, particularly offering these connections to people who did not have an existing support network that they were regularly engaged with, such as family and friends. These were sometimes new initiatives.

These are important measures for these providers, so that people who need or would benefit from independent assistance are able to be supported with decisions independently from the provider who delivers their supports.

In setting up these connections, the providers must be prepared to respond and act on what people determine they want to change, including changes in how their accommodation supports are provided, or indeed if they wish to receive supported accommodation services from a provider other than them.

In all cases where larger settings were observed by the Inquiry, the Boards and Senior Leadership were aware of the institutional aspects of these supported accommodation arrangements and had also commenced plans for changes to those sites where they had the ability to do so, because they were also the owners of the property.

Where the provider did not own the property, in most cases it was owned by the state or territory government in which it was located.

Whether the provider owned the property or not, all were actively working with residents who live in the larger settings about any redevelopment plans, so their preferences were paramount in how these plans were formulated and implemented. Information was provided to the Inquiry about how providers were engaging with the residents about their accommodation preferences and associated services, and piloting new arrangements for some people so they could experience other supported accommodation options if they chose to, reserving the ability to return to their original accommodation should they prefer it.

Although the Inquiry did not explore the funding arrangements for people in these settings, it was informed that most people had not had any significant engagement regarding their accommodation preferences since they had entered the NDIS, and the current way of funding SIL made adjustments on the part of their current provider difficult to facilitate changes when a person chose to make one, without affecting the support arrangements of others, or creating viability issues for the provider in the operation of the facility.

The Inquiry was informed that the NDIA has been working with residents of group homes to assist them in considering alternative living arrangements if that is their choice. This is a key measure to make sure that people with disability have true choice and control over their supported accommodation arrangements. This is in all group home settings, not only larger facilities.

It should be a priority for each provider that operates larger residential arrangements to address the nature of these settings so the living arrangements for people with disability that they support aligns with the Practice Standards, and provisions set out in Article 19 of the Convention on the Rights of Persons with Disability (CRPD).[72] This should be done in close consultation with current residents and their supporters. The strategies that each of the providers with these arrangements had in place to work with residents on any changes was a priority by the relevant Boards, and the NDIS Commission will continue to engage with those providers on these measures. These providers will also engage with the NDIA to ensure that residents are able, within the parameters of their NDIS plans, to consider alternative accommodation options if that is their decision.

Funding arrangements for SIL and SDA

From discussions with various stakeholders throughout the Inquiry it was apparent that there are issues with how people with disability are able to work with their providers to consider and make changes to their living arrangements. These issues appear to be connected to how the current funding arrangements across SIL and SDA operate. There appear to be, at times, limited levers for providers to assist people to make changes to their supports where a person expresses a desire to explore a change, or to fill vacancies in houses in a way that is appropriately planned for with all residents.

These limitations might present an issue for some people with disability who are living in settings where there are issues with the compatibility between residents.

Sometimes it is the preference of a person to live in a different setting, including a more independent setting, if their funding in the NDIS plan allows for this.

There were examples given to the Inquiry about people who had been successful moving into independent settings, and a corresponding reduction in incidents affecting them and their former co-residents. However, there were also examples where, after living in a more independent arrangement over time, the corresponding reduction in support needs led to reconsideration of their SIL arrangements, making the more independent placement unsustainable within the funding available. The Inquiry directly raised one such situation with the NDIA where it was identified through a site visit that a person was potentially having to leave their independent living arrangement and return to a group arrangement because of a reassessment of their SIL 'roster of support'. It was anticipated that the disappointment of this move for the person would potentially be reflected in an increase in incidents related to them, and others. The risk was addressed by the NDIA.

It is not a finding of this Inquiry that the funding mechanisms for SIL and SDA is the cause of these limitations, but it does appear that this contributes to the ability of people with disability living in supported accommodation to have the same extent of individual choice and control over their NDIS supports as other NDIS participants.

The NDIS Commission will work with the NDIA to refer consideration of any impact on NDIS participant choice, control, quality and safety arising from SIL and SDA funding arrangements for exploration through the NDIS Review.

72 *Convention on the Rights of People with Disability:* Article 19 (Living independently and being included in the community). Article 19 recognises the right of all persons with disabilities to live in the community, with choices equal to others, and involves persons with disabilities having the opportunity to choose their place of residence (and where and with whom they live) on an equal basis with others, such that they are not obliged to live in a particular living arrangement

It was also apparent to the Inquiry that some people living in supported accommodation, and who had lived in their homes for an extended period of time, may not yet have had engagement about whether their arrangements were desirable to them for the longer term. This is evidenced by the complaints and incidents arising from issues of incompatibility and conflict within group homes settings over an extended period of time for some people. This was outlined in the previous section.

However, judging from the number of complaints about the general quality of supported accommodation supports, and frustrations on the part of many people with issues not being resolved to address the quality of those supports, it is likely that some of these people might consider exploring accommodation options with other providers if they were supported do so.

Where people do choose to consider alternatives, exploring and testing such arrangements is mainly left to their current providers to facilitate, or goes through a person's support coordinator if they have one. If there is a deterioration in the relationship between a person and their provider, it would not be expected that a person would seek such assistance from their current provider to make such an important decision.

This is a complex part of the NDIS to navigate on an individual basis. The market is dominated by large providers, both for SIL and SDA, and there are complex arrangements for how funding arrangements work. It is likely to be a daunting, if not an almost impossible, task for people living in group homes and their supporters to navigate individually if they wish to explore new home and living arrangements.

A number of stakeholders also raised with the Inquiry their concerns as to whether many support coordinators would have the experience to navigate such a complex system, or indeed consider it their role to do so. It is appropriate given the complexity of this issue that there be some exploration of how better guidance and support might be provided to people with disability who wish to consider alternative home and living arrangements if it is their desire to do so.

The Inquiry is aware that the NDIA has commenced engagement with many people in this regard, to determine whether there is a preference to explore a change, or to affirm a current home and living arrangement.

Mainstream services are well connected to accommodation supports

From the outset of this Inquiry, many of the 7 providers identified that they faced challenges with the supports needed by an ageing population of residents, many with high and complex support needs requiring extensive or specialist health support.

The responsiveness of the health system to the needs of people with disability living in group homes, particularly those with intellectual disability, appears to have been not always positive, and there were ongoing issues with assumptions about how the general health needs of people with disability who live in supported accommodation should be met, with the assumption sometimes being that elements of this healthcare would be delivered as part of the NDIS supports a person receives.

Of particular concern to the providers were:

- the access to General Practitioners with knowledge and expertise of working with people with intellectual disability and who had different communication needs
- hospital discharge planning and support
- end-of-life support, including access to appropriate palliative care when required.

Routine access to health support prevents deterioration from any pre-existing or underlying health conditions, or overshadowing in diagnosis by support workers, which may result in people not getting access to the medical support that they need in a timely way. These matters have been shown to be contributing factors to otherwise avoidable deaths through the NDIS Commission's *Scoping Review on the causes and contributors to deaths of people with disability in Australia* undertaken in 2019.

The Australian Government Department of Health is also progressing implementation of the *National Roadmap for improving the Health of People with Intellectual Disability*[73] to address serious health inequities faced by people with intellectual disability. The objectives of the roadmap are to:

- improve support for people with intellectual disability, their families and carers
- develop better models of care for people with intellectual disability
- support health professionals to deliver quality care for people with intellectual disability
- improve the oral health of people with intellectual disability
- improve monitoring of the health of people with intellectual disability
- ensure that the needs of people with intellectual disability are considered and met in emergency plans and responses.

Successful implementation of many of the activities set out in the *Roadmap* will go a considerable way to addressing the issues raised by these providers and other stakeholders. The NDIS Commission is closely engaged with the Department of Health on the *Roadmap* implementation, and will provide information to providers as this work progresses.

NDIS providers would benefit from guidance on their obligations to support people with disability to access healthcare, and the types of plans and information that should be made available to support workers to assist in supporting a person to make a timely healthcare referral.

There are a number of complaints examined in this Inquiry that relate to people with disability not being supported to attend appointments, including healthcare. There are also many reportable incidents that relate to seizures, falls and other events that might point to a deterioration in a person's health and wellbeing, requiring a change in the healthcare supports they access.

It is sometimes difficult for NDIS providers and healthcare professionals to agree on what is a disability related support over a healthcare response, and which system is responsible for which element.

Fundamentally, a person with disability with high support and healthcare needs will require aspects of both to be delivered to them in an integrated way to have a good QoL and to be safe. There is an obligation on NDIS providers as established through the Practice Standards to support a person to access the supports they may need from other systems.

There is also a duty on the healthcare system to ensure that citizens with disability receive equitable access to the health services they need. Achieving improvements in this regard, for people with intellectual disability, is one of the objectives of the *Roadmap*.

The issue of the health interface places even greater emphasis on the need for effective medication management and record-keeping by registered NDIS providers, and for training and support staff on approaches to ensuring that people with disability are accessing health supports on a regular basis and have up-to-date health plans in place.

All providers that the Inquiry engaged with on these issues were considering or actively deploying different strategies to address them. This included making sure that each participant had an up-to-date health plan that was easily accessible to all staff supporting that person.

One provider had entered into an arrangement with the local health district to pilot a new virtual healthcare system. The purpose of this pilot is to resolve issues with limitations on the accessibility and responsiveness of primary healthcare for people with disability living in supported accommodation provided by them. This pilot will enable an access point to health supports on a day to day basis.

The provider will be developing procedures for staff on how to support residents to engage with this new service, and has commenced co-design with residents and their supporters on those protocols. They will also undertake a formal evaluation of the trial.

It would be beneficial for the NDIS Commission to provide guidance to providers and their workers on monitoring for health support needs and continue to promote good practice in this regard, building on the work already done by the NDIS Commission arising from the *Scoping review*.

73 **National Roadmap for Improving the Health of People with Intellectual Disability | Australian Government Department of Health and Aged Care**

Workforce capability

Chapter 5 on best practice in supported accommodation focused mainly on how the capability of the workforce could be improved by applying the recommended elements of the best practice framework to supporting people with intellectual disability in group homes. Those observations are not repeated here.

Worker attitude and culture

A significant proportion of the reportable incidents that were examined by this Inquiry related to the alleged abuse or neglect of a person with disability by a worker. As previously observed, many of these reports concern verbal abuse, rough handling, and a worker exerting undue influence over a person, for example denying a person something because they haven't done what a worker has asked, or withholding an aspect of their support because of their behaviour.

The NDIS Commission regularly works with providers and workers to address conduct of this nature, however the persistence of this conduct raises serious concerns about the culture and capability of the workforce in group home settings. This raises issues about the adequacy of the supervision of workers, the performance and disciplinary practices of providers, and how effectively some of the strategies to promote a preventative and quality focused practice in supported accommodation are being applied in frontline practice.

Although not the majority, there are apparent issues with the attitude and aptitude of some support workers which is unlikely to be addressed through training or routine supervision. The NDIS Commission will continue to apply its powers to address patterns of behaviour and conduct of workers. The 7 providers included in this Inquiry each have work in place to enhance their identification and response to such conduct, including improvements in their workforce management systems to address these types of issues. They all equally acknowledged that there is further work to be done to grow and develop the NDIS workforce and particularly retain, develop and attract people with the capabilities to work in supported accommodation settings where people have complex support needs.

The NDIS Commission will also continue to promote existing resources such as the NDIS Code of Conduct Worker Orientation Module – Quality Safety and You, which is mandatory for all workers delivering supports and services in the NDIS.

Supporting choice and control

A theme across the complaints examined in this Inquiry also suggested that the concept of choice and control for people living in shared accommodation may not be sufficiently well understood in practice by some support workers.

A high number of complaints and also reportable incidents appear to arise due to conflicting preferences between residents, which can result in participant-on-participant altercations arising from disagreements that are unable to be negotiated between residents.

Enabling choice and control for an individual where they live in a group setting can present complex issues where each of the residents has a different view or preference.

Specific guidance to assist workers in managing the complexity of individual choice and control, the choice of all individuals in a group setting where their preferences may sometimes not align, and situations where there is tension between residents, would be important in developing this understanding. The guidance should have a strong focus on rights, and individual or supported decision-making.

Workforce capability

A number of the providers who were the subject of this Inquiry reported limitations in their ability to attract workers with the requisite capabilities to roles, particularly with capabilities to support people with more complex needs and behaviours. They reported issues with not being able to secure experienced casual staff, and they also reported challenges with having time to properly induct workers about the needs of the people they are supporting before starting on shifts.

A theme across a number of the reportable incidents and complaints was the support workers' understanding of a person's behaviour support plan, and whether, for example, they were applying the plan to manage situations that might result in incidents.

A number of the providers advised the Inquiry that the funding in participant plans in a group setting does not allow for any induction or training of new staff (such as about a person's behaviour support plan) or for learning and development in general. Some providers told the Inquiry about teams they had established to develop the skills of their staff in particular practice domains, particularly clinical and behaviour support. They emphasised that the costs of establishing these teams was not met through the funding they receive from NDIS participants for SIL. The Inquiry noted this but it was not within the terms of the Inquiry to explore the funding for such measures in any detail. The Inquiry has informed the NDIA that this was raised.

One provider was addressing this issue by establishing a mobile team of staff with clinical expertise to translate the many different plans (health, mealtime, behaviour and so on) for NDIS participants into short guides that support workers are able to easily navigate quickly, as a summary to the complete plans.

The new NDIS Workforce Capability Framework sets out the behaviours and core capabilities to be demonstrated by providers and workers when delivering services, depending on their role. The Capability Framework is an important resource for NDIS providers in workforce planning and development, and therefore in shifting the culture and composition of the workforce. It is part of the regulatory framework to the extent that it promotes improvement in the attainment of progressively higher standards in how supports and services are provided, though providers are not currently obliged to apply it.

Amending NDIS Practice Standard guidelines to include that the NDIS Workforce Capability Framework be taken into account when assessing compliance with the Practice Standards should be considered as a way to promote its application in supported accommodation settings to start with, and potentially more broadly.

The NDIS Commission will also continue to develop information and practice guidance for workers, and in a format which enables easy engagement in the workplace. It will continue to target issues such as participant rights, what abuse and neglect is, how to support a person to make decisions and to assist them in carrying through those decisions to action, and in conflict management between the residents they support.

Feedback on worker conduct by people with disability

Most providers had ways of getting feedback from people with disability and their supporters about the quality of support they receive and about the conduct and capability of the workers who support them.

Without exception providers considered this to be a key mechanism to assist in developing the workforce capability within their organisations. This was most commonly observed at an organisation level, although in a couple of providers there was a well-structured engagement between residents and their supporters and the supervisor that managed multiple houses. This approach is strongly supported by the research on best practice at Chapter 5.

Valerie is 49 years old. She lives with 4 other people. She stays at home most days because she likes quiet places and "gets stressed" if there are lots of people around. At home she watches day time TV every day which she finds boring, or makes her art which she loves. Valerie draws intricate mandalas and other shapes that she meticulously colours. She gives her pictures to friends, family and anyone she meets who wears a uniform so "they will trust me". Trust is very important to Valerie. It makes her feel safe if she knows a person trusts her. She wants to go to the library because she also loves encyclopaedias and ancient Egypt. She doesn't know who can help her to go. Her support worker thinks it might be her support coordinator who should work this out for Valerie. Eventually we agree that the support worker will take Valerie to the library after they drop the other residents off at their day program.

Governance

The Inquiry paid particular attention to the governance within each of the providers. For governance to be effective it must be outcome oriented with a strong customer service focus. This is strongly supported by the best practice research, particularly the element of the best practice framework where senior leaders value direct staff practice (that is practice that is centred on the rights, choice control and QoL of people living in supported accommodation) and implement structures and processes to support and maintain it.

The NDIS Practice Standard for Governance and Operational Management requires that: *Each participant's support is overseen by robust governance and operational management systems relevant (proportionate) to the size and scale of the provider and the scope and complexity of supports delivered.*

The Governance and Operational Management standard includes the following indicator: *Opportunities are provided by the governing body for people with disability to contribute to the governance of the organisation and have input into the development of organisational policy and processes relevant to the provider of supports and the protection of participant rights.*[74]

People with disability receiving supports from a provider should also expect to have a voice in describing their experiences with the services and supports they receive. They should know how to raise issues and how those issues will be addressed by the provider. They should have confidence that when a provider identifies an issue that affects all the people they support, that the remedy for that issue will be addressed by the Board and senior management and the way that those issues are addressed will be applied at all levels of the organisation, including by individual support workers. The inquiry considered this in the context of how each provider used information from incidents and issues raised in complaints to brief the Board on risks and develop its strategies and plans for quality improvement.

Each of the 7 providers had appropriate governance arrangements in place reflecting their size and scale. Every one of the 7 providers had work underway to improve their governance arrangements so that there is a stronger focus on the people they support, and so that these arrangements would meet the expectation of the people receiving those supports. The work would also ensure that the key personnel of the organisation had the interests of the people they support at the centre of all their considerations regarding the operation of the organisation. Some providers were more advanced in this work than others.

One mechanism for improving the accountability of boards and senior management on quality improvement is to have an embedded and authentic presence of the people with disability at every level of their governance, and for that representation to reflect the diversity of the people they support. That presence must be understood by all staff to be influential in how the organisation establishes its strategy, how it undertakes it's forward planning, and monitors and evaluates performance. This is important for good governance in a market that is about providing a service that people rely upon in the most basic terms, but it is also critically important for promoting a people centric and action oriented culture.

A number of the providers in this Inquiry were well advanced in their plans to expand the role of people with disability at every level of their governance.

74 *NDIS (Quality Indicators) Guidelines 2018* Division 2 – Governance and Operational Management s11 (1)

In terms of the observations made through the Inquiry:

- All providers had:
  - some mechanism in place to escalate serious incidents and issues to the attention of senior management
  - Board briefings on serious incidents and issues and trends, with the sophistication of the trend analysis varying across the providers
  - a sub-committee of the Board focused on risk and customer safeguarding
  - a reasonably well-developed assurance or internal audit function.
- The providers with **more advanced** governance arrangements in place had:
  - customer representative committees as part of their formal governance
  - clear policies on when matters were to be escalated, the reason for the escalation and procedures setting out roles and responsibilities, and management responses
  - Key Performance Indicator based reporting to the Board, enabling issues and incidents to be benchmarked over time and including recommendations for action connected to learning and development and operational policy
  - forward plans to undertake checks and audits to identify systemic issues across the organisations' operations with a focus on higher risk supports
  - regular governance reviews, with the Board supporting adjustments where particular reporting, or particular committee's needs required adjustment.
- Providers representing **best practice** also had:
  - people with disability on their boards and sub-committees, including an active consumer representative committee directly advising the Board
  - thematic reporting to Boards on incidents and issues (in addition to reporting individual matters)
  - an outcome based governance culture, with systematic monitoring by Boards and senior management on implementation and impacts of practice changes arising from incident and issue data
  - collaborative relationships with other providers to share insights and expertise.

While there were examples that would be considered governance best practice, most models were in early stages of implementation. The NDIS Commission should monitor how the providers in the Inquiry are deploying these new systems and processes and applying them in a way that has a demonstrable positive impact on outcomes for the people who choose them to deliver their supports.

Understanding that the majority of providers that deliver supported accommodation are not of the scale of the providers in the Inquiry, there would be benefit in the NDIS Commission undertaking more work with providers across the NDIS market to promote best practice in governance arrangements.

The NDIS Commission will develop guidance and education to NDIS providers on best practice governance models that embed a person-centred culture that acts on issues and incidents affecting people with disability, and holds the organisation as a whole to account for quality and safety.

The NDIS Commission will develop these tools in co-design with providers that the NDIS Commission identifies as having well developed governance arrangements, for application across the NDIS. Importantly, the NDIS Commission will engage with people with disability to get their perspectives on how they could be best included on organisational governance arrangements.

The Inquiry was informed about mergers affecting some of the 7 providers, and most of the 7 providers had during the course of the period covered by the Inquiry expanded to take on supports and services that had previously been delivered by other organisations. Almost all of the 7 providers described the complexity with adjusting to the NDIS arrangements, coupled with expansion and amalgamating different organisational cultures.

A core function of the NDIS Commission is market oversight, including by monitoring changes in the NDIS market that may indicate emerging risk. Organisational growth does not in and of itself present a risk to the quality and safety of supports to NDIS participants, however systems processes and governance must be adjusted appropriately to take account of the changes in the organisation.

As a condition of registration, registered NDIS providers are obliged to notify the NDIS Commission of certain changes (including a change in the scale of the provider) and certain events (including a significant change in the organisation or governance arrangements of the provider).[75]

These obligations are designed to enable the NDIS Commission to assess the risk of the change or event, to monitor the provider's management of it, and to take any action that the NDIS Commission considers necessary to avoid any actual or potential risk to NDIS participants arising from the change or event.

The NDIS Commissioner is considering whether other mechanisms are required to assist her with the exercising of her market oversight function, to enable the NDIS Commission to be satisfied that when mergers occur, the entity is meeting its obligations under the NDIS Act. Any changes to the NDIS Commission's market oversight function would be subject to consideration of other market stewardship or oversight mechanisms identified through the NDIS review.

Quality and Risk management

The Practice Standards include obligations for registered NDIS providers to have systems that are proportionate to their size and scale for:

- *Quality Management:* Each participant benefits from a quality management system relevant and proportionate to the size and scale of the provider, which promotes continuous improvement of support delivery.
- *Risk Management:* Risks to participants, works and the provider are identified and managed.

The NDIS Commissioner's functions include: to build NDIS provider capability; to develop a culture of learning and innovation; to deliver high quality supports and services; to prevent incidents; and to respond to complaints.

The focus of the NDIS Commission's capacity building work with providers over its first years of operation has been on supporting providers to understand and meet their obligations, and taking compliance or enforcement action where providers or workers are not meeting their obligations, or to enhance their compliance. There has also been a strong focus on supporting NDIS providers that transitioned under the NDIS Commission's jurisdiction to complete a registration process which required them to be assessed against Practice Standards for the first time.

The NDIS Commission has also issued extensive guidance to NDIS providers and workers about key areas of practice that are important for providers to address to prevent harm and even death of people with disability. All of this material is relevant in the supported accommodation context, although it has been promoted across the whole of the disability sector. While some of this material has been focused on specific health or disability needs, the NDIS Commission has taken this focus because these areas present the highest specific risks to people with disability.

The material developed by the NDIS Commission includes practice guidance to build the capacity of direct support workers and providers in, for example:

- supporting people with **communication impairment**
- **mealtime management** and particularly understanding of, and providing supports and services safely to people with dysphagia
- addressing specific risks in relation to chemical restraints and the use of psychotropic medications
- extensive guidance on preventing COVID-19 infection risks, particularly in supported accommodation settings.

The NDIS Commission has also developed material to support providers in conducting **practice reviews of incidents**, including reviews of 'near misses' to prevent further incidents occurring, to equip workers to better manage incidents when they occur, and influence improvement across service delivery operations.

All providers of supported accommodation should ensure that they have reviewed and applied the guidance issued by the NDIS Commission on issues of particular risk to NDIS participants, including considering how the NDIS Commission's *Practice Review Guidance* could be applied in their organisation where they do not currently have a mechanism for those reviews.

75 Registration Rules, section 13 and 13A

Each of the 7 providers covered by this Inquiry had work underway:

- to review or audit complaints and incidents data to analyse trends and issues and feed that data into quality assurance and organisational risk management systems
- to upgrade incident management systems to better enable identification and reporting on systemic practice issues driving risk for NDIS participants, or issues at specific locations to guide specific operational responses, and to enable reporting to their boards and senior management on trends and treatments
- consolidating complaints management arrangements to give senior management and boards an organisation-wide view of issues being raised by the people with disability they support, their supporters, and third parties
- to develop or revise their internal assurance systems.

To have the desired impact on participant safety and wellbeing, the initiatives for quality improvement and risk management must be successfully embedded into the day-to-day practice of support workers, and developing the attitudes and aptitude of those workers through a risk based, regional or site-specific program. All providers in this Inquiry were attuned to these issues, and were aware of the complexity in adjusting the culture of their organisations to this focus, and how key effective governance was to this.

During the course of the Inquiry, a number of providers advised us that they had accelerated their work in these areas following consideration of some of the issues identified as the Inquiry progressed.

Preventing ongoing risks

It is apparent from examining the incidents and complaints included in this Inquiry, that incidents and issues reoccur, and the practice of support workers does not necessarily adjust over time to avoid incidents and issues repeating.

Some of the complaints to the NDIS Commission reflect a frustration on the part of some supporters of people with disability, and people with disability themselves, about the apparent failure of providers to address the underlying cause of an incident or issue, so that it continues to occur. Sometimes a person will make repeated complaints about a provider. It may not be until a central team with responsibility for overseeing the provider's complaint management system intervenes with local teams to resolve the complaint. This may be because local teams may not have understood the issue when it was raised with them, and required the support of the central team to define the issue and identify possible solutions.

It is apparent that there is further work needed by providers to develop a culture of learning that leads to the elimination or resolution of factors that drive incidents and issues that are within the ability of the provider to address.

The primary challenge for these large providers is the manner by which their current initiatives are embedded consistently and effectively across the frontline at such a scale. The elements of best practice that were set out in Chapter 5 of this Report provide a good basis for approaching the change necessary for this to occur.

Effective incident and complaint management and prevention

The Inquiry did not identify any issues with the incident management systems that each of the 7 providers had in place in terms of the requirements set out in the Incident Management Rules, or the Practice Standards on incident management which require that, "Each participant is safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, responded to, well managed and learned from".[76]

Similarly, the Inquiry did not identify any issues with the complaints management systems that the providers had in place, in terms of the requirements set out in the Complaints Rules.

Acknowledging, responding and managing incidents and issues

Most of the providers in the Inquiry are upgrading their incident management systems, policies and procedures, and deploying training of staff to reinforce the value of incident management for harm prevention and quality improvement.

Where improvements are being made, they are being applied across all supports and services delivered by each provider, not just supported accommodation. Most providers had a focus in this work on incidents and issues in supported accommodation however, which is appropriate given the proportion of incidents and issues that occur in these settings.

76 Registration Rules 2018 Schedule 1 Part 3 s16.

There was a consistent approach across all providers to oversight of incident management: each had a centralised team of some kind managing the organisation-wide incident management system, and responsible for maintaining and updating policies and procedures, training staff, providing advisory services to local management, and for monitoring compliance with the policy, and NDIS Commission reportable incident obligations.

These teams usually work through the various operational hierarchies to support teams with higher levels of incidents or recurring incidents, to identify the underlying issues, and to put in place strategies to improve outcomes for people with disability. They may also work with a local team on how to manage recurring incidents or complaints. They will also take a lead role in oversighting matters that involve alleged staff misconduct, undertaking or leading internal investigations and Police referrals. These teams are also usually the main contact point between the organisation and the NDIS Commission.

There was some variation within and across the 7 providers in terms of how long their systems for oversight of incidents had been in place, and therefore how well understood these systems were by frontline staff. In cases where providers had expanded significantly, most were still upskilling staff on consistent application of these systems.

The Inquiry found that providers that had systems which relied on staff members reporting factually – such as what happened, who did it happen to, and when did it happen – were generally more effective in their incident management practices than those who asked an immediate reporter to deduce motives or outcomes for the incident – such as why did the incident occur, or what went wrong.

Some of the providers were trialling new practices for incident management that placed management authority for incidents with local teams. This was to embed a culture of incident oversight and avoidance with local management and support staff. This was considered by some providers to be a way of resetting cultures that has previously seen incident reporting as a punitive mechanism, rather than a positive and preventative one.

It is important that in embedding such a preventative incident management focus that support workers do not take an overly risk averse stance in how they perform their roles, and that they do afford the people they support dignity of risk in handling reasonable tasks or activities that could involve a degree of risk that the person is aware of and willing to accept.

The Inquiry considers that placing the responsibility for incident oversight and management close to the people that are impacted by the incident is good practice, and the most effective means to develop the capability of support workers to manage and potentially avoid future incidents. It is important that providers consider carefully the change management approach that they take to embed such a change.

Not all incidents will be addressed through local adjustments to practice. Some incidents involve an impact on a person that does not relate to the actions of the provider, although they occur within the course of a support or service. For example the serious injury of a person with disability might relate to hospitalisation of the person resulting from a seizure.

It is important that in embedding incident management and prevention approaches at the local level, that these factors are acknowledged and procedures include mechanisms for staff to escalate factors that are outside their control or ability to directly manage.

Learning from incidents and complaints

Given the scale of the providers captured by the Inquiry, the NDIS Commission would expect that all had rigorous means of utilising incident data to enable the identification of systemic issues and drive improvement in the quality of supports they deliver, and that these systems would be commensurate with the size and setting of the providers.

As supports that are provided in group homes are more complex and therefore present higher risks to the NDIS participants, it would be expected that providers would pivot these systems to focus on the specific issues that are observed in these settings.

Most of the 7 providers were investing in their data analytics capability to interrogate incident data, reporting through their senior management and to their Boards on incident rates across different support activities, regions/locations, and on the types of incidents and their cause, and the effectiveness of the incident response strategies.

Most providers had internal assurance arrangements that they deployed to assess incident responses, particularly in locations with higher incident rates. These localised or issue-specific responses were generally overseen by their Risk and Audit Committees (or equivalent).

A couple of the providers had a much more localised way of overseeing and monitoring incidents, particularly for locations with higher incident rates, using a more traditional case coordination approach.

Some providers are in the early stages of using incident data for more sophisticated predictive modelling purposes, applying this modelling to inform the prevention of adverse events through practice change on an organisational scale. The providers that are at this stage are actively sharing their approaches with other providers through sector networks.

There is great benefit in industry peaks and alliances working across their membership to assist providers of all types in applying these concepts and in sharing good practice examples and systems to develop the analytics capability of the sector.

Some but not all of the 7 providers were well connected to these networks, and indeed were sharing their approaches with peers. The Inquiry was informed of at least one project where providers were benchmarking their incident data to identify systemic issues at an industry level, and potential solutions.

Where they exist, these systems involve looking at both available incident data as well as the absence of incidents based on correlating factors such as participant characteristics and behaviour support needs, and other variations that might suggest a higher risk of adverse events occurring. Data inputs to these models include the use of restrictive practices, whether authorised or unauthorised, behavioural insights, medication requirements, and human resource data about the capability, skills and performance of staff.

Other providers have rudimentary systems of reporting to their Boards, focusing on volume and broad trend data only.

All providers had reflected on the provider focused hearings held by the Disability Royal Commission, and the importance of ensuring that the Board is aware and actively engaged in significant incidents affecting people with disability. They each had active means of drawing particular incidents to the attention of their Board, and for appraising the Board on the management of those incidents, and of activities to raise awareness more broadly in the organisation to avoid such incidents occurring in other locations.

A number of the 7 providers offered to work with the NDIS Commission to obtain insights into the types of incidents the NDIS Commission was observing across the system (not just their own), and to work with the NDIS Commission to develop guidance to assist other providers, particularly those of a smaller scale, with managing these matters.

The NDIS Commission will work with those providers that have developed more mature systems for the use of incident and complaints data, to develop guidance and education to other NDIS providers on the use of data and insights to actively inform the development of their practice, and to prevent incidents that can be avoided.

Insights into providers' strategies for improvement

Providers are audited as part of a registration application and a mid-term review, or compliance activities that the NDIS Commission might undertake from time to time, about the complaints and incident management systems that they have in place and whether these meet the requirements under the Rules and are suitability reflective of the size and scale of the provider. Those audits sometimes identify activities that a provider is undertaking to update its systems.

As these audits are currently focused on assessing compliance with the Practice Standards, they do not always collect information on broader strategies being undertaken by a provider to improve its quality and safeguarding systems.

The NDIS Commission, through the course of managing a complaint or assessing a provider's management of a reportable incident, might obtain information from a provider about what they are doing to identify systemic issues and drive improvements in quality, and to prevent incidents from happening again – not only for the impacted person, but more broadly. However, this occurs on an ad hoc basis, and is not a routine part of the regulatory response to a reportable incident or complaint.

The NDIS Commission has mechanisms to assess the systems that a provider has to manage incidents and complaints, to identify systemic issues and treat those issues, however it may be beneficial for the NDIS Commission to also capture the types of issues that a provider is observing and the actions they are taking to drive improvements that would address these.

This is not considered by the Inquiry to be a significant issue given the volumes of material that the NDIS Commission itself collects through the reportable incident function. However, there could be benefit in considering including in routine assessments of providers, for example in mid-term audits, an assessment of plans or strategies that a provider may have in place to collect and apply data about the key risks it is observing, or to understand the practice improvements being implemented arising from analysis of incidents and complaints.

This type of information will not necessarily be relevant for the NDIS Commission where the provider is a small provider, and where the effect of managing one particular incident is that the issue is addressed also for all people that the provider supports.

For larger providers however, this is information that should be accessible to the NDIS Commission to inform its assessment of risks to NDIS participants, specifically those living in supported accommodation, given the prevalence of issues that arise in these settings.

The way in which this is approached should not create an undue burden for providers and should be tailored to enable reporting similar to any existing reporting they might do within their organisation.

One way to achieve this is through the inclusion of an indicator in a relevant NDIS Practice Standard that requires assessment of the provider's approach to quality improvement. Another possible mechanism may be through a short annual statement given to the NDIS Commission by a provider. It would be important information for auditors, and the NDIS Commission's monitoring activities, and reduce potential for the NDIS Commission to ask for the same information multiple times as it deals with particular matters.

The ability of the NDIS Commission to implement such a mechanism, and to analyse the material that was collected, would likely require additional resources. Such a measure would also require consultation with providers about its form, to avoid any undue regulatory burden.

Challenges with examining NDIS Commission data

The NDIS Commission data systems are focused on its regulation of NDIS providers and the performance of its functions. The NDIS Commission's current systems enable for oversight of individual reportable incidents and the management and resolution of individual complaints, however they are not currently able to clearly identify the settings in which these matters occur, or make links across different reportable incidents and complaints to enable systemic analysis of trends or risks, among other things.

The NDIS Commission data systems do not always record the settings in which an incident or issue has occurred in a way that would readily enable analysis. The information about the setting that a reportable incident or complaint relates to is held in individual reportable incident records and is sometimes unclear, or incomplete.

Complaints are also not always able to be identified as relating to a supported accommodation setting, this is because some complaints might raise general issues about a provider rather than an issue specific to a location. Some complainants would also prefer not to identify a location so they can remain anonymous to a provider if that is their wish.

The way in which data is currently collected by the NDIS Commission presented 2 main challenges for this inquiry:

- Firstly, determining whether reportable incidents and complaints were in fact relevant to the Inquiry because they related to supported accommodation required a considerable level of manual review.
- Secondly, the analysis of reportable incidents and complaints to attempt to determine underlying factors had to be done manually through review of individual records, as well as through a site level profiling for a selection of sites for each provider.

The NDIS Commission holds outlet data as part of a registered NDIS provider's registration record, however there is currently no link between that information and individual reportable incidents or complaints. It is not always necessary for a link to be made, however where it can be made this would be useful to do so.

Where an NDIS participant is receiving SIL supports in a group home it would be useful for the NDIS Commission's systems to record that information. For example, the NDIS Commission could adjust the form that is required for the notification of a reportable incident to require the inclusion of the address and if that is a group home, or it could require a provider to 'attach' a reportable incident to an outlet that forms part of their registration record.

Improving the collection of reportable incident and complaint data to capture the setting in which the issue or incident occurred, and to identify and consistently assign a sub-category of incident or issue, and an outcome, would significantly enhance the ability of the NDIS Commission to better analyse and risk assess data across its functions.

This information could be meaningfully used in the NDIS Commission's compliance function (including targeting campaigns), its monitoring activities, and as an important input to the audit process that is part of the registration of an NDIS provider.

There has been some work undertaken by the NDIS Commission over time to link a complaint to an element in the NDIS Code of Conduct, or to a Practice Standard, as these things are well defined and are the basis for the NDIS Commission's regulation of providers. The NDIS Commission should work to refine this approach to the classification of matters so that it better assists with the NDIS Commission's education function, and helps to target compliance action or campaigns over time. It would also assist in targeting the focus of registration related audits which are also based on the Practice Standards.

Mechanisms should be developed to enable the routine collection of outlet or addresses information for reportable incidents and complaints so that matters that are associated with supported accommodation can be triaged quickly, and can be readily joined up with prior matters received by the NDIS Commission linked to the group home, or other matters that are on hand relating to the same residence.

There should also be mechanisms in place within the NDIS Commission to review specific trends at both a provider and a location level, similar to the approach undertaken by this Inquiry, so that trends in a location are identified and responded to as a whole, rather than an individual matter based approach. Data profiling should be in place to enable flagging of sites with a high number of incidents and issues, to enable engagement with the provider on how they are managing particularly incidents and issues for all residents.

It may be possible to make changes within existing NDIS Commission systems that would go some way to addressing some of the issues observed through this Inquiry, however considerable investment will be needed to address everything outlined here.

The NDIS Commission is developing a Data and Digital Strategy to mature the NDIS Commission's systems and data analytic functions. This will take some time, and significant additional resourcing to implement.

It is important that the observations made in this Inquiry are incorporated into the NDIS Commission's current program of work for improvements to those systems.

The NDIS Commission should consider, to the extent possible within existing resources, adjustments to its data collection practices to better identify supported accommodation settings. Significant investment in systems and data analytics capabilities will be required to better enable the NDIS Commission to identify the trends and issues that arise from reportable incidents and complaints and to inform compliance campaigns, and monitoring of providers through mechanisms such as the audit function.

As part of the NDIS Commission's future state arrangements, and subject to available resources, there should be consideration given to how reportable incident and complaints staff enhance their monitoring and response to system level risk, as well as how the information collected through these functions is better connected to registration and compliance activity.

Appendices

APPENDIX A: Terms of Reference

The NDIS Quality and Safeguards NDIS Commission (NDIS Commission) is established under the *National Disability Insurance Scheme Act 2013 (the NDIS Act)*. The functions and powers of the NDIS Commission and the NDIS Commissioner are set out in Chapter 6A and Part 3A of Chapter 4 of the NDIS Act.
The NDIS Commission's functions and powers reflect the relevant provisions of the NDIS Quality and Safeguarding Framework, which was agreed to by all Australian governments.

The NDIS Commission commenced operating on 1 July 2018 and its jurisdiction has been established progressively across Australia since that date as follows:

- from 1 July 2018, New South Wales and South Australia only
- from 1 July 2019, all other Australian states and territories, excluding Western Australia; a
- from 1 December 2020, full national coverage.

Inquiry into aspects of supported accommodation

Now that the NDIS Commission is operating nationally and has gathered substantial information in the performance of its functions, the acting NDIS Commissioner has determined to authorise an inquiry in relation to a series of Reportable Incidents and a series of Complaints that have occurred in connection with the provision of supports or services by a number of specified registered NDIS providers.

The acting NDIS Commissioner's purpose in authorising this inquiry is to enable the NDIS Commission to identify:

- from Reportable Incidents and Complaints it has received:
  - the issues and incidents that are occurring in supported accommodation;
  - any trends in those issues and incidents; and
  - the underlying factors that are causing or contributing to those issues and incidents;
- models of best practice in supported accommodation that could help to eliminate or address those issues and incidents; and
- how best to promote the continuous improvement amongst NDIS providers of supported accommodation and the delivery of higher standards of supports and services in supported accommodation.

The inquiry is to be conducted under the following provisions of the NDIS rules:

- Section 27 of the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018, which is made for the purposes of section 73Z of the NDIS Act; and
- Section 29 of the National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018, which is made for the purposes of section 73X of the NDIS Act.[77]

The Reportable Incidents and the Complaints that are the subject of this inquiry have occurred in connection with the provision of supported accommodation. The inquiry will examine the experiences of participants living in supported accommodation through examining Reportable Incidents and Complaints relating to supported accommodation.

For the purposes of this inquiry, 'supported accommodation' means support that is often referred to in the NDIS as 'supported independent living', as well as 'specialist disability accommodation'. The focus here is on the provision of supported accommodation that involves congregate living, which is a form of accommodation sometimes referred to as 'group homes'.

Supported accommodation is a support setting of particular interest to the NDIS Commission because people living in supported accommodation can have a relatively heightened exposure to risks of violence, abuse, neglect and exploitation due to a number of factors, including the following:

- many residents have an intellectual disability;
- many residents have high physical support needs, and/or dependence on others for most aspects of their daily living needs;
- participants who display what are termed 'behaviours of concern' or 'challenging behaviours' commonly reside in supported accommodation;
- residents may have fewer connections to family, community and a range of informal safeguards; and
- residents may have considerable difficulty in making complaints, including because of a number of the factors listed above.

77 As a matter law there will be 2 inquiries: one under section 27 of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* and a second under section 29 of the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018*. However, for ease of reference and because the inquiries are to be conducted concurrently, these terms of reference refer to them jointly as the one inquiry.

Selection of providers

The inquiry will focus on Reportable Incidents and Complaints that involve a small number of NDIS providers that are large providers of supported accommodation.

Particular providers have been selected based on a number of factors:

- the NDIS Commission has received notifications of Reportable Incidents and received Complaints related to supported accommodation provided by the provider;
- the provider has a significant market share in respect of supported accommodation, either nationally or in a specific jurisdiction; and
- the provider delivers supported accommodation across a wide geographic area including in regional and metropolitan locations.

Reportable Incidents and Complaints the subject of the inquiry

The inquiry will focus on Reportable Incidents and Complaints that have occurred in connection with the supported accommodation services provided by the following registered NDIS providers:

- Aruma
- Endeavour Foundation
- Life Without Barriers
- Lifestyle Solutions
- Minda
- Scope
- The Disability Trust

Structure of the inquiry

The NDIS Commission is engaging the Inquiry Lead to conduct the detailed examination of the Reportable Incidents and the Complaints on the acting NDIS Commissioner's behalf and also to identify any available models for the delivery of supported accommodation that demonstrate best practice.

A significant component of the inquiry will involve an examination of the Reportable Incidents and the Complaints that are the subject of the inquiry.

At the end of the inquiry, the acting[78] NDIS Commissioner intends to prepare and publish a report setting out the acting NDIS Commissioner's findings in relation to the inquiry.

The terms of reference for the examination of the Reportable Incidents and the Complaints are set out below.

Terms of reference for the detailed examination of reportable incidents and complaints

The Inquiry Lead is to examine:

- Reportable Incidents notified to the NDIS Commission by the provider who provides the supported accommodation where an impacted person is an NDIS participant residing in the supported accommodation[79] ('the Reportable Incidents'); and
- Complaints made to the NDIS Commission by or on behalf of one or more NDIS participants residing in the supported accommodation arising out of or in connection with the provision of supports or services by the provider of the supported accommodation ('the Complaints').

The Inquiry Lead is to identify:

- the issues and incidents that are the subject of the Reportable Incidents and Complaints;
- any trends or patterns in those issues and incidents, whether in relation to the provider concerned or across one or more of the providers selected for the inquiry;
- to the extent possible, the underlying factors (or 'root causes') that are causing or contributing to those issues and incidents; and
- any differences in the matters identified under paragraphs 2(a), (b) or (c) between different supported accommodation premises operated by a provider and any apparent reasons for those differences.

78 If during the course of the inquiry a person is appointed Commissioner under section 181L of the NDIS Act references in these terms of reference to the acting Commissioner should be read, where relevant and appropriate, to the appointed Commissioner.

79 The Inquiry Lead may examine the number and nature of reportable incidents notified solely as unauthorised uses of restrictive practices, and the length of time for which such uses are notified as reportable incidents without being brought within the reporting requirements under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, but the Inquiry Lead is not expected to examine in detail reportable incidents that according to the notification relate solely to the use of a restrictive practice.

The Inquiry Lead is to identify whether and to what extent the Reportable Incidents and the Complaints:

- raise issues of possible non-compliance with the NDIS Practice Standards, or would have raised issues of possible non-compliance with the NDIS Practice Standards if the relevant NDIS provider had ceased to be a transitioned provider[80] at the time the Reportable Incidents or the circumstances the subject of the Complaints occurred;
- raise issues of possible non-compliance with the NDIS Code of Conduct; and
- raise issues of possible breaches of any other conditions of the provider's registration, or would have raised issues of possible breaches of the conditions of the provider's registration if the provider had ceased to be a transitioned provider[81] at the time the Reportable Incidents or the circumstances the subject of the Complaints occurred.

The Inquiry Lead is to consider:

- the adequacy of the provider's management of the Reportable Incidents under both its own incident management system (as required by section 73Y of the NDIS Act and Part 2 of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018)* and as a reportable incident (under section 73Z of the NDIS Act and Part 3 of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018*); and
- whether any of the Complaints had been the subject of prior complaints to the provider and, if so, the adequacy of the provider's handling of them under the provider's complaints system (as required by section 73W of the NDIS Act and Part 2 of the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018)*.
- The Inquiry Lead is to identify, through an examination of local and international resources, models of best practice for the delivery of supported accommodation that might be appropriate for consideration by the NDIS Commission in its capacity building work with providers and in to the context of development of any future amendments to relevant practice standards and quality indicators.

Conduct of the detailed examination of reportable incidents and complaints

The Inquiry Lead will be assisted in the conduct of the detailed examination of the Reportable Incidents and the Complaints by staff of the NDIS Commission and by any additional contracted resources required and agreed between the Inquiry Lead and the acting NDIS Commissioner.

The NDIS Commission will identify the Reportable Incidents and the Complaints referred to in paragraph 1 of the terms of reference and provide the Inquiry Lead with access to the NDIS Commission's records in relation to them, including any relevant compliance or investigation records.

The Inquiry Lead will review the documents associated with the Reportable Incidents and the Complaints and will determine what, if any, additional information is required for the detailed examination of the reportable incidents and complaints. This may include requesting discussions with: people with disability who are referenced in the relevant reportable incident and complaint; disability support workers or other staff of the provider; family members; advocates and/or guardians.

The NDIS Commission will work with the Inquiry Lead to identify the need for any exercise of the NDIS Commission's information gathering powers under the NDIS Act.

The detailed examination of the Reportable Incidents and the Complaints is to be conducted in a manner that avoids prejudice to any pending or current criminal or civil proceedings and any risk of actual or perceived interference with the conduct of the Royal NDIS Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, or any inquiry of the Joint Standing Committee on the National Disability Insurance Scheme.

Any disclosure of information for the purposes of or in the course of the detailed examination is to occur only in accordance with the provisions of the NDIS Act.

80 Under Division 2 of Part 6 of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018*.

81 Under Division 2 of Part 6 of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018*.

In conducting the detailed examination of the Reportable Incidents and the Complaints the Inquiry Lead is to take account of the objects of the NDIS Act and the general principles guiding actions under the NDIS Act, as set out in sections 3 and 4 of the NDIS Act respectively.

Reporting

By 31 March 2022[82], the Inquiry Lead is to provide to the acting NDIS Commissioner:

- For each provider listed above, a separate detailed report in relation to the reportable incidents and complaints that relate to the provider. These reports will necessarily include considerable amounts of 'protected NDIS Commission information' within the meaning of the NDIS Act and, as a consequence, will be subject to the restrictions on disclosure set out in the NDIS Act.
- A single report summarising the Inquiry Lead's findings[83] in respect of the matters in paragraphs 1 to 4 of the terms of reference and outlining the models of best practice for the delivery of supported accommodation identified under paragraph 5 of the terms of reference.

The Inquiry Lead is welcome to include in the separate detailed reports or the single report (as the Inquiry Lead considers appropriate) any observations or suggestions the Inquiry Lead wishes to make about the NDIS Commission's processes or systems or the legislation and rules governing the NDIS Commission's relevant functions.

If the Inquiry Lead identifies any issues or concerns during the conduct of the detailed examination of the reportable incidents and the complaints that the Inquiry Lead considers require the urgent attention of the NDIS Commission in advance of the submission of the Inquiry Lead's reports, the Inquiry Lead is to raise these matters in writing with the acting NDIS Commissioner.

The acting NDIS Commissioner intends to prepare and publish a report setting out the acting NDIS Commissioner's findings in relation to the inquiry. The publication will be subject to the requirements of the NDIS Act in relation to protected NDIS Commission information and any redactions necessary to avoid prejudice to any criminal, regulatory or civil proceedings or to protect the privacy of any individual.

The acting NDIS Commissioner intends that the Inquiry Lead's single report summarising the Inquiry Lead's key findings and outlining what the Inquiry Lead considers to be the models of best practice will form a substantial part of the acting NDIS Commissioner's report.

The NDIS Commission will cognisant of the demands of any other processes that might be underway that impact on the providers that are engaged in this inquiry, and will be open to adjust the timeframes for the provision of a final report by the Inquiry Lead to avoid any interference with those processes, including processes that might be initiated by the Royal NDIS Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

82 The original Terms of Reference were adjusted in July 2022 so that the Inquiry was to be concluded in Quarter 2 of 2022–3.

83 These findings are separate from any findings of the acting Commissioner in relation to the inquiry

APPENDIX B: Undertaking the Inquiry

The former NDIS Commissioner, Mr Graeme Head AO, contemplated in evidence to the Disability Royal Commission the circumstances in which the NDIS Commissioner's inquiry powers could be used. Mr Head confirmed in May 2021 his intention to establish an Own Motion Inquiry. He had determined that the Inquiry should focus on supported accommodation because the NDIS Commission was observing a range of issues through complaints, and reportable incidents, and in feedback from people with disability, advocates, and stakeholders representing both people with disability and industry, that related to the experience of people with disability in those settings.

Initiating the Inquiry

Mr Head AO established the draft terms of reference, and determined the providers that would be the focus of the inquiry in May 2021. He issued draft terms of reference for consultation with those providers in June 2021.

2 of the 7 providers gave feedback on the Terms of Reference. These related to procedural aspects rather that the Terms per se (such as information gathering, affording procedural fairness, and managing the competing demands of the Inquiry any that might arise from the Disability Royal Commission). The Terms of Reference were amended to account for these matters.

The Inquiry was subsequently initiated by the then Acting NDIS Commissioner, Ms Samantha Taylor in August 2021. Ms Taylor appointed **Mr Arthur Rogers** as Lead Inquirer and he commenced work in September 2021. Mr Rogers was supported in his activities by officers of the NDIS Commission.

Mr Rogers was due to report to the Acting NDIS Commissioner, or the new NDIS Commissioner if by then appointed, in March 2022. Mr Rogers worked on the Inquiry from September to February 2022. Due to unavoidable personal issues Mr Rogers requested an extension to the timeframe for his report to June 2022. This was agreed, however Mr Rogers formally resigned in May 2022.

Ms Rose Webb was engaged by the NDIS Commission in February 2022 to advise on areas of regulatory design and practice as part of the Inquiry. Ms Webb has spent her career working in Australian and international regulators including the Australian Competition and Consumer NDIS Commission (ACCC), the Australian Securities and Investments NDIS Commission (ASIC) and most recently led the Better Regulation Office within the NSW Government.

The NDIS Commissioner Ms Tracy Mackey commenced her term on 10 January 2022. Ms Mackey determined that Ms Taylor should progress the Inquiry together with Ms Webb. She appointed Ms Taylor to a new role as Strategic Advisor in July 2022.

Ms Taylor commenced work on the Inquiry in August 2022.

How the inquiry has been undertaken

The following activities were undertaken against each of the components of the Terms of Reference.

Part 1: Establishing the Inquiry parameters: Identification and examination of the reportable incidents and complaints

- extraction of all reportable incidents and complaints received from and in relation to the subject providers from the NDIS Commission's Operating System (COS). Data was initially extricated from 1 July 2018 and until 22 February 2022, and then expanded to take in matters received up to 30 September 2022;
- analysis of data holdings to determine those relevant to supported accommodation and linking these matters to specific premises, through data matching within the NDIS Commission systems and data held by the NDIA;
- identification of those premises for which relatively higher numbers of complaint and incident data was available – because they enabled the most reliable insights into the issues occurring within those premise comparative to those with low numbers of complaints and/or incidents;
- engagement between the Inquiry Lead and the teams of the NDIS Commission leading compliance and investigation activities to identify any issues that required consideration in undertaking the Inquiry, being limited to matters relating to supported accommodation.

Part 2: Identification of issues incidents, trends, patters and underlying factors

- analysis of the reportable incident and complaint data focusing on the locations with significant volumes of complaints and reportable incidents;
- development of site profiles detailing and categorising all reportable incidents and complaints for each of the 7 providers and at the sites with the greatest numbers of reportable incident and complaint;
- detailed analysis of a selected number of premises for each provider that exemplified particular issues observed through the analysis;
- a series of interviews with the CEOs and key staff of each of the providers on various matters informed by review of the NDIS Commission's data and the information and documents supplied by the providers;
- a series of selected site visits including meetings with NDIS participants, their support workers and in some instances family members;
- a series of interviews with national bodies representing the interests of people with disability including through the NDIS Commission's disability sector and industry consultative committees exploring:
  - the features and characteristics of better practice and quality, and poorer practice and quality in supported accommodation, including examples of where practice improvement has occurred and what happened to improve the service quality;
  - the features and characteristics of providers constructively handling feedback and/ or complaints from participants, families or advocates that improves the way that supported accommodation was provided.
- recent inquiries and reviews into matters associated with supported accommodation in the NDIS were reviewed to determine whether the issues and themes identified through those reviews was borne out through the NDIS Commission's examination ;
- work underway by the NDIA on home and living policy and design was also considered;
- broad trends evident from the reportable incidents and complaints were documented and areas for consideration in adjusting the NDIS Commission's approach to regulation of supported accommodation were formulated.

Part 3: Reviewing provider policies and procedures for management of incidents and complaints

- information and documents were requested from the providers relating to their complaints management systems, incident management systems, and in some instances risk management arrangements, including policies, procedures and plans for adjustment and improvement to those policies and procedures;
- analysis of each organisation's polices, practices and other material relevant to the terms of the Inquiry had been undertaken.

Part 4: Best Practice in Supported Accommodation

It was determined that this component of the inquiry would delivered through a literature review, and be outsourced to a body that was expert in the models of best practice and supported accommodation for people with disability, and was an institution with history of high quality research work of this nature and on this subject.

The NDIS Commission engaged the Living with Disability Research Centre at La Trobe University to deliver this element of the Inquiry, with the project to be led by Professor Christine Bigby an acknowledged expert on support accommodation nationally.

Professor Bigby submitted the final draft of the Literature Review in October 2022.

To supplement this research, advocacy organisations representing the interests of people with intellectual disability were engaged to undertake targeted consultation with people with disability and their supports about their experience with supported accommodation, or other supports provided through the NDIS to assist them in living independently.

APPENDIX C: Consultation with people with disability

To inform the Inquiry the NDIS Commission commissioned targeted consultation with people with intellectual disability to gather their opinions about what constitutes good quality in supported accommodation, as well as their experience with how NDIS providers respond to their complaints and incidents that affect them, and what they suggest could be done to improve the quality of these supports based on their experience and aspirations. The views of people with intellectual disability were specifically sought as they are the predominant group living in supported accommodation.

The NDIS Commission engaged the Council for Intellectual Disability (NSW), the South Australian Council on Intellectual Disability (SACID) and VALID each of whom have established networks for engagement and consultation with people with intellectual disability. The organisations were asked to work together to establish the most appropriate approach for consultation through their networks, and to develop a series of questions that they would each use as the basis for consultation.

The questions they developed were:

- What is the best thing about your life?
- What is the best thing about your home?
- What are the things you need help with in your home?
- What is something you do not like or something you would change in your home?
- Who supports you to make decisions about where you live?
- How much choice do you have with the things that happen at home?
- If you are not happy with where you are living or the supports you are getting, who can you go to for help?
- If you could choose a dream home – what would it look like?
- Which right is the most important to you about your home?

The reports of these consultations are available in full on the NDIS Commission's website: **Own Motion Inquiry into Aspects of Supported Accommodation in the NDIS | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)**.

APPENDIX D: Best Practice Literature Review

The literature review led Professor Christine Bigby at The Living with Disability Research Centre at La Trobe University titled 'Evidence about Best Practice in Supported Accommodation Services: What Needs to be in Place?' is available via the NDIS Commission website: **Own Motion Inquiry into Aspects of Supported Accommodation in the NDIS | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)** and through the Living with Disability Research Centre at La Trobe University at: **Evidence about Best Practice in Supported Accommodation Services: What Needs to be in Place? (latrobe.edu.au)**.

APPENDIX E: Stakeholder Engagement

People with Disability

People with disability living in supported accommodation in Queensland, Victoria, New South Wales and South Australia (more than 50 people living across 14 residences).

NDIS providers

- Aruma
- Endeavour Fountain
- Life without Barriers
- Lifestyle Solutions
- Minda Inc
- Scope
- The Disability Trust

Sector & Industry Representatives: Individual meetings

- Inclusion Australia
- National Disability Services
- People with Disability Australia
- SDA Alliance
- Summer Foundation

NDIS Commissioner Consultative Committees

NDIS Commission Disability Sector Consultative Committee membership:

- Australian Autism Alliance
- Australian Federation of Disability Organisations
- Children and Young People with Disability Australia
- Consumers' Federation Australia
- Deaf Australia
- Disability Advocacy Network Australia
- First Peoples Disability Network
- Inclusion Australia
- National Ethnic Disability Alliance
- People with Disability Australia
- Women with Disabilities Australia
- Young People in Nursing Homes National Alliance

NDIS Commission Industry Consultative Committee membership:

- Ability First Australia
- Alliance 20
- Allied Health Professionals Australia
- Assistive Technology Suppliers Australia
- Australian Community Industry Alliance
- Mental Health Coordinating Council
- National Aboriginal and Community Controlled Health Organisation
- National Disability Services
- Reimagine Australia
- SDA Alliance

APPENDIX F: Data used for this Inquiry

NDIS Commission Data

Reportable incidents and complaints data within the NDIS Commission's Commission Operating System (COS) was extracted for the period 1 July 2018 to 30 September 2022. The extract was by provider and impacted person, and contained the incident summary; description; date of notification; the NDIS Commission status of the matter, and other fields to enable the unique identification of the incident notification and complaint for the purposes of the Inquiry.

Reportable incidents that related to the category of 'unauthorised restrictive practice' handled separately.

Reportable incidents and complaints with the status of 'draft' or were excluded from the dataset.

NDIA Data

The NDIA provided the NDIS Commission with:

- a summary of NDIS participant data (demographic and participation data) for all NDIS participants with SIL in their NDIS plans, and for the NDIS Participants associated with each of the 7 providers covered by the Inquiry;
- a summary of billing data for SIL supports, including for the 7 providers covered by the Inquiry;
- information about the supported accommodation market, and
- supported accommodation locations.

Sources of Supported Accommodation Locations

A list of supported accommodation locations were sourced from the NDIA. This list was based on the addresses of NDIS participants where there had been a least one SIL or SDA transaction against their NDIS Plan processed through the NDIA's payment system during the period 1 July 2018 to 30 June 2021.

These locations were reconciled with lists of supported accommodation sites meeting the terms of the Inquiry (group homes) provided by the 7 subject providers in September 2022. Other locations were sourced from outlet information under the providers' registration records in COS, or from locations specified in reportable incidents and complaints records.

Where complaints were identified as being related to supported accommodation but could not be attributed to a specific location these were retained in the dataset.

To ensure that the matters considered in the Inquiry related to supported accommodation, NDIS Commission data was then matched as follows:

Reportable incidents records were matched against the location sources:

- *Incident address* was matched against the location sources in the first instance;
- *Outlet address* was matched against the sources next;
- *Participant address* was then matched against the sources.

Complaints were matched against the location sources:

- *Outlet address* was matched against the sources in the first instance;
- *Participant address* was matched against the sources next;
- *Complaint Address* – some addresses were identified from free text fields in complaints and then matched against sources.

Data notes

Multiple Reports – There may be reportable incidents notifications relating to the same incident or complaints that also relate to a reportable incident. Each of these matters had a specific ID in the Commission's system.

Data Quality – Incidents or complaints may not have complete information where the matter is recent, or the information is not known to the person making the report e.g. address or participant information. Therefore a small number of reportable incidents and complaints about supported accommodation cannot always be identified as being about those types of supports. This will affect only a small number of matters.

Participant Movements – in some cases a participant may have moved to a different address during the period that the Inquiry covers. This means they may have reportable incidents about them, or have made complaints about more than one address, or more than one of the providers over the period that the Inquiry covers.

Offsite Matters – Some reportable incidents or complaints may have affected an NDIS participant from a supported accommodation setting but happened in another location e.g. during transport or while in hospital. These have been retained.

Multi-service locations – Some reportable incidents may have been made from a supported accommodation setting but are not about the supported accommodation supports for example an incident in a day program may be reported by the SIL provider as a third party notification.

Dates – Complaints and reportable incidents months are based on the date of notification to the NDIS Commission which may not be the same as the date that the incident occurred.

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