

11 September 2026

Via submission portal: [Public consultation to help inform a possible 'commissioning' approach for part of the SIL market](#)

Catholic Health Australia Submission – Supported Independent Living (SIL) Commissioning Public Consultation 1

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views on the design of a possible commissioning approach for Supported Independent Living (SIL). CHA recognises the work of the Government and the Department of Health, Disability and Ageing in seeking to improve the quality, consistency and safety of supports for participants with the highest support needs, as informed by the 2023 Independent Review of the Scheme and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

CHA has been working with our members to consider the future of SIL, alongside our broader work on the sustainability, quality and regulation of the NDIS. We support the objective of ensuring that people receiving SIL have access to safe, high-quality supports that promote independence, choice, and genuine participation in community life.

The design of any commissioning approach will need to account for the circumstances in which SIL is delivered, including the complexity of participants' needs, workforce availability, differences between markets and the capacity of providers to sustain the standard of support required. Our members' experience in delivering disability, health, aged care and community services provides a practical perspective on these issues, including the points at which participants move between systems and where gaps in support can create risks for participants and providers alike.

CHA's view is that commissioning can provide an opportunity to strengthen quality and safeguarding in SIL, provided it is designed as a proportionate and sustainable intervention rather than a separate layer of compliance. The approach should preserve the choice and control that underpin the NDIS, recognise the different risks and circumstances across SIL participants and households, and support providers to develop and sustain the workforce, practice leadership and systems needed to deliver high-quality support. It should also recognise that provider viability and participant outcomes are closely connected, as requirements that cannot be sustainably delivered will ultimately affect the availability, continuity, and choice of supports.

CHA welcomes the opportunity to contribute to ongoing discussions and assist in the implementation of reforms that will build a more resilient, sustainable, and equitable disability system for all Australians. If you wish to discuss anything further, please contact Dominic Butler via mobile on 0402 772 571 or email at dominicb@cha.org.au.



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Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, disability, community, and aged care providers. Our members operate 80 hospitals in each Australian state and the ACT, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, in addition to extensive community and residential aged care. CHA members involved in disability service provision include St John of God Accord, and Villa Maria Catholic Homes.

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Question 1 (Participants): Which SIL participants could benefit most from additional government oversight of planning, delivering and monitoring of SIL supports?

Response 1:

Commissioning has the greatest potential value where the ordinary safeguards of the NDIS may be less effective. In most parts of the Scheme, a participant receiving poor support can raise concerns themselves, have a family member or other supporter raise concerns on their behalf, or exercise choice by moving to another provider. Where these mechanisms are limited or not practicable, additional oversight can provide an important safeguard.

CHA and our members do not consider that these circumstances should be defined through fixed participant categories. Support needs and living arrangements change over time, and categories such as continuous versus occasional support, or shared versus individual living arrangements, may both capture participants who do not require additional oversight and miss participants who do. Instead, commissioning should consider a broad spectrum of risk markers, which may overlap and compound with one another. We consider four broad categories of risk to be particularly relevant:

- **Participant vulnerability.** This includes circumstances that can limit a person's ability to identify, communicate or act on concerns about their support. Communication support needs, limited capacity for supported decision-making and self-advocacy, and weak or declining informal support networks can all reduce the safeguards available to a participant.
- **Support complexity.** The intensity, complexity and changing nature of a participant's support needs can increase the consequences of poor practice. This includes high-intensity or complex personal support, multiple health conditions and circumstances involving behaviours of concern or restrictive practices. For CHA members operating across health, disability and aged care, multiple health needs are particularly relevant where workers need to recognise deterioration and coordinate appropriately with health services.
- **Household and living environment.** Risk is not necessarily confined to the individual participant. In shared living arrangements, the combination of participants, their compatibility, cumulative support needs and staffing arrangements can create risks that may not be apparent from an individual assessment. The household should therefore be considered alongside the circumstances of each participant when determining whether additional oversight is warranted.
- **Market conditions.** The availability of alternative providers and workers is an important safeguard in a participant-driven system. In rural, regional and remote areas, thin markets can significantly limit practical choice and reduce the ability of participants to respond to poor quality by changing providers. Thin markets should therefore be treated as a risk marker in their own right, rather than simply as a service availability challenge.

These categories should not be used to create rigid commissioning cohorts. Rather, they provide a framework for identifying where additional oversight may be most valuable. Risk factors may overlap and compound with one another, and their significance may change as a participant's support needs, health, relationships, and living arrangements or access to alternative providers change.

Risk should also be considered at both the participant and SIL household level. An assessment focused only on the individual participant may miss risks arising from the combination of participants in a home, including compatibility, cumulative complexity and the capability and consistency of the workforce supporting them.

CHA also considers that participant and household risk should be considered alongside provider capability. Workforce stability, practice leadership and organisational systems can materially affect the quality and safety of SIL, particularly in shared living environments. Providers commissioned to deliver supports to participants identified as higher risk should therefore have the capability to meet the standard of care expected under the commissioning approach.

This approach is consistent with CHA's broader position that regulatory and oversight requirements should be proportionate to the nature and risk of the supports being delivered, rather than applied uniformly across the NDIS. It would allow commissioning to target additional oversight where it is most needed while avoiding unnecessary restrictions on participant choice or provider participation.

Overall, CHA supports a SIL commissioning approach for participants and households where identified risk markers indicate that additional oversight is needed. This should be based on a broad spectrum of risk rather than fixed participant or service categories, with thin markets recognised as a risk marker in their own right.

Recommendation 1: Commissioning should be targeted at participants and SIL households displaying identified risk markers across a broad spectrum of risk, rather than fixed participant or service categories. Thin markets should be recognised as a risk marker in their own right.

Question 2 (Quality): What do high-quality SIL supports look like?

Response 2:

High-quality SIL is support in which the participant is engaged in their own life, rather than having it managed around them. Active Support, also referred to as Person-Centred Active Support, provides a strong foundation for this approach. It focuses on maximising each participant's engagement, choice and skill development in everyday activities, rather than staff simply completing tasks on their behalf.

However, adopting an Active Support model alone does not guarantee consistent practice. Practice leadership is critical to translating the model into what happens in people's homes. This requires frontline leaders to actively observe, coach, and model good practice, rather than managing staff primarily through rostering, compliance, and administrative processes. CHA considers that high-quality SIL should therefore be characterised by:

- **Active Support as the basis of everyday practice.** Routine activities such as cooking, cleaning, shopping and personal care should provide opportunities for participants to engage, develop skills and exercise choice, rather than simply being tasks completed by staff.
- **Effective practice leadership.** Team leaders and frontline managers should have the skills and time required to observe practice, coach staff and reinforce good practice. Practice leadership should be understood as a distinct capability within SIL, rather than assumed to follow from general management or compliance responsibilities.
- **Participant goals reflected in everyday support.** Goals should influence the way support is delivered in daily routines and activities, rather than being recorded in a plan without a clear connection to the participant's day-to-day experience.

- **Ongoing, observation-based measurement of practice quality.** Providers should be able to demonstrate how they observe and measure the quality of practice occurring in the home and use that information to improve staff practice. This should complement, rather than replace, existing quality and safeguarding requirements and should not depend on a particular proprietary measurement tool.
- **Accessible information for participants and families.** Participants and their families should have information they can use to understand the quality of support being offered and, where possible, compare providers.
- **Protection of individual choice and outcomes in shared settings.** Shared SIL should continue to support individual privacy, relationships, preferences, and goals. The fact that support is delivered to more than one participant should not result in individual needs or choices being subordinated to the requirements of the household.

These elements should be reflected in the requirements for commissioned providers. However, commissioning should focus on the capability and outcomes being demonstrated rather than prescribing a particular service model, measurement tool or organisational structure. CHA supports the development of consistent approaches to measuring practice quality across commissioned SIL, which could improve transparency and provide a stronger basis for continuous improvement across the sector.

Each of these elements carries a cost that any commissioning approach will need to recognise, namely that practice leadership requires funded time away from direct rostering. Observation-based quality measurement needs systems and the workforce to operate them. Whilst workforce continuity requires renumeration and supporting staff sufficiently to retain them.

The cost of delivering these capabilities should be recognised in commissioning and pricing arrangements. A provider cannot be expected to maintain workforce continuity, invest in practice leadership and undertake meaningful quality measurement if the price paid for commissioned SIL does not cover the reasonable cost of doing so. This is consistent with CHA's broader position that the funding of NDIS supports needs to account for the reasonable cost of delivering safe and high-quality supports.

Commissioning should therefore set a clear quality expectation while ensuring that providers are funded to meet it. Raising the standard without recognising the cost of achieving that standard risks placing pressure on providers to reduce workforce investment, quality improvement activity or service capacity, ultimately undermining the outcomes commissioning is intended to achieve.

Recommendation 2: Commissioned SIL providers should be required to demonstrate practice leadership capability and use structured, observation-based measures of practice quality. The commissioning model should recognise additional cost of delivering SIL to this standard.

Question 3 (Safeguards): How should SIL supports **protect the safety, health, wellbeing and rights of participants?**

Response 3:

CHA believes that safeguarding in SIL requires more than a single mechanism or point of oversight. Commissioning should therefore establish a set of safeguards that operate at the participant, household, provider, and system levels, with the different elements working together rather than relying on any one single measure.

Risk should be assessed at the level of both the individual participant and the household. An individual assessment is important because participants living in the same home may have different support needs and risk profiles. At the same time, the composition of the household, compatibility between participants, the cumulative complexity of support needs and the capability and consistency of the workforce can create risks that may not be apparent when participants are considered individually.

Risk assessment should also be reviewed as circumstances change. Support needs, health, relationships and living arrangements can change over time, meaning that a point-in-time assessment may not provide an accurate picture of current risk. The use of restrictive practices should be treated as a risk indicator and any use should be subject to appropriate safeguards and plans to reduce and, where possible, eliminate their use over time.

Participants and the people supporting them should have accessible avenues to raise concerns, including an avenue independent on the provider concerned. Safeguarding depends not only on whether concerns can be raised, but on whether those concerns result in appropriate action. Independent advocacy should therefore be accessible to participants, including those who require communication support, and commissioning should provide confidence that concerns are considered and addressed.

Commissioning should also require providers to demonstrate respect for participant rights and decision-making in everyday practice. This includes demonstrating that decisions about routines, activities, staff, food, relationships and living arrangements are made by or with the participant, using supported decision-making where required. Worker screening, induction and ongoing training in rights-based practice should similarly be capable of being demonstrated through evidence of practice, rather than relying solely on organisational policies.

CHA considers that quality and safeguarding should also be supported by consistent and transparent reporting. There is currently variation in providers' capacity to demonstrate quality and safeguarding performance. Commissioning provides an opportunity to establish a consistent set of indicators across commissioned providers, including measures that provide an early indication of emerging risks rather than relying solely on reporting after an incident has occurred. This could include indicators such as the presence of practice leadership, trends in restrictive practices and the timeliness and resolution of complaints.

CHA would also bring a broader health and care system perspective to safeguarding. Many SIL participants interact with the disability, health and aged care systems, and risks can increase when responsibility moves between these systems. Hospital admission and discharge, management of acute and chronic health conditions, and the risk of inappropriate entry into residential aged care can all affect the safety and continuity of a participant's support. Commissioning should therefore support appropriate coordination with health and aged care services where this is necessary to maintain safe and effective support, rather than treating SIL as operating independently from the broader care system.

Finally, the effectiveness of any commissioning safeguards will depend on the capacity of the NDIS Quality and Safeguards Commission to monitor and act on them.

Commissioning is likely to create additional requirements for monitoring, reporting and enforcement. These requirements should be matched by appropriate regulatory capacity and resourcing. CHA has previously raised the importance of ensuring that the Commission has the capacity and funding required to undertake its existing and expanded responsibilities, and considers this an important consideration in the design of SIL commissioning.

Taken together, these measures would provide a more comprehensive approach to safeguarding than reliance on incident reporting or provider compliance alone. Commissioning should require providers to demonstrate how they identify and manage risk, support participant rights and decision-making, respond to concerns and monitor quality over time, while ensuring that the regulator has the capacity to oversee and enforce these requirements.

Recommendation 3: Commissioning should require providers to demonstrate a multi-level approach to safeguarding, including participant and household risk assessment, accessible avenues for raising and resolving concerns, rights-based decision-making, and transparent reporting of quality and safeguarding indicators. Commissioning should also be supported by sufficient regulatory capacity to monitor and enforce these requirements.

Question 4 (Innovation): How can innovation by SIL providers enhance the quality of SIL supports and outcomes for SIL participants?

Response 4:

Innovation in SIL should not be defined by the adoption of new technology. It should encompass approaches that improve a participant's engagement, independence, safety, or choice, whether through technology, workforce models, participant engagement approaches, rostering, or other changes to how supports are delivered.

The relevant test for commissioning should be whether an innovation produces an observable improvement for participants. Providers should be able to demonstrate what has changed because of an innovative approach, rather than simply demonstrate that a new product, program or process has been introduced. This also supports a more evidence-based approach to innovation, where approaches that demonstrate positive outcomes can be adopted more widely and those that do not can be reconsidered. Sharing relevant quality and outcome data across the sector would further support this process.

Technology and workforce

Technology can contribute to better SIL outcomes where it supports, rather than displaces, quality interactions between participants and workers. Applications that reduce administrative burden and free staff time for participant engagement, support communication for people with complex communication needs, improve communication with families, or give practice leaders greater visibility of staff practice may have value.

CHA also considers that technology should not replace human judgement in decisions about a participant's circumstances. In its submission on the NDIS Amendment Bill, CHA raised concerns about the use of automated systems for evaluative decisions, including the risk that standardised systems may not adequately account for circumstances that fall outside the patterns represented in the underlying data. The same principle applies within SIL. Technology should support professional and participant decision-making, with appropriate privacy protections where it operates within a person's home or living environment.

Innovation should also recognise workforce models that improve staffing consistency and continuity of relationships. In SIL, these factors can directly influence the quality and consistency of support. Commissioning should therefore assess whether an approach improves participant outcomes, rather than privileging technology or other forms innovation because they are new.

SIL alongside the wider home and living system

Innovation in SIL should also be considered in the context of the broader systems in which participants live and receive support. This includes supporting transitions from hospital, reducing inappropriate entry to residential aged care, and working effectively with Specialist Disability Accommodation and community housing providers.

Where these systems operate independently, participants can face gaps in support at points of transition. Commissioning should therefore support approaches that improve coordination across the disability, health, housing, and aged care systems where this contributes to better outcomes for participants.

Recommendation 4: Commissioning should recognise innovation based on its contribution to participant outcomes, rather than the adoption of technologies or models. Providers should be expected to demonstrate the outcomes of innovative approaches and share relevant evidence to support improvement across the sector.

Question 5 (Participant choice): How can effective participant choice and control be enhanced, including in regions with smaller populations?

Response 5:

Choice and control are two foundational principles for the NDIS. Any commissioning approach should therefore be assessed not only by its capacity to improve quality and safety, but also whether participants retain meaningful choice over the supports they receive. CHA considers these objectives compatible where commissioning establishes a quality threshold while preserving choice between suitable providers.

A key design risk is a commissioning model that allocates SIL to a single approved provider for a particular cohort or region. While this may provide greater certainty of supply, it could reduce the practical choices available to participants and limit the ability to change providers where an arrangement is not working.

A panel model

CHA recommends that commissioning operate through a panel of multiple approved providers rather than a single commissioned provider per cohort or region. Under this approach, commissioning would determine which providers meet the required quality and safety threshold, while participants retain the ability to choose the provider that best meets their circumstances and preferences.

Choice should extend beyond the selection of a provider. For a participant receiving SIL, it should include meaningful input into who they live with, who supports them and how their day is structured. Participants should also be able to change providers where an arrangement is not working, without losing access to commissioned SIL.

A panel model can also preserve an element of quality competition between providers. Providers would need to demonstrate their capacity to deliver high-quality supports while remaining responsive to participant preferences and outcomes. This is preferable to a model where commissioning decisions effectively determine a participant's provider in advance.

Regions with smaller populations

CHA recognises that a competitive panel may not be achievable in every location, particularly where population size and workforce availability limit the number of viable providers. Where this occurs, the Department should be transparent about the resulting trade-off between choice, quality and market sustainability.

Additional safeguards may be required where genuine provider choice is unavailable. These could include access to independent advocacy and a lower threshold for NDIA involvement where a participant is experiencing difficulties with their SIL arrangement. Thin and remote markets should not be treated as a lesser priority. Participants in these markets can have fewer alternatives when support is unsuitable, while providers may face higher costs in maintaining services and workforce capacity.

Design risks

Two design features require particular attention. The first is allocating commissioned SIL to a single provider within a cohort or region, which could unnecessarily constrain participant choice. The second is setting panel entry requirements that are so narrow or resource-intensive that they exclude smaller, community-based or culturally specific providers that may be well suited to certain participants.

Commissioning should therefore establish a clear quality and safety threshold without creating unnecessary barriers for capable providers. This would allow participants to benefit from stronger oversight while retaining meaningful choice over who provides their support.

Recommendation 5: Commissioning should operate through a panel of multiple approved providers that meet defined quality and safety requirements rather than allocating commissioned SIL to a single provider for a particular cohort or region. Participants should retain choice over their provider and living arrangements, with additional safeguards where competitive choice is not available.

Question 6 ([Provider sustainability](#)): What's needed to ensure that SIL providers are sustainable?

Response 6:

Provider sustainability is an essential component of a viable SIL market. A commissioning approach as described in this consultation can establish stronger expectations for quality and safeguarding, but those expectations need to be achievable within the funding available to providers. Provider viability should therefore be assessed alongside workforce, governance, practice, and organisational capability, with a focus on whether providers can sustain high-quality SIL over time.

Provider capability and sustainability

Commissioning should assess a provider's capacity to deliver quality SIL through a range of indicators, including workforce stability and continuity, organisational governance, systems for monitoring quality and outcomes, financial and operational maturity, and demonstrated practice leadership capability.

Workforce stability is particularly relevant in SIL. Continuity of relationships and familiarity with participants can support better outcomes, while high reliance on casual or agency workers can make it more difficult to maintain consistent practice. Providers should therefore be able to demonstrate how they recruit, train, retain and support a workforce capable of delivering the required standard of SIL.

Practice capability should also form part of any assessment of provider suitability. As outlined in the response to Question 2, high-quality SIL depends on more than policies and compliance systems. Providers need the capability to observe practice, support workers to improve and measure whether their approach is producing better outcomes for participants.

This should not require every provider to adopt identical organisational structures or processes. It should instead establish a clear quality threshold and allow providers to demonstrate how they meet it. This is consistent with CHA's broader position that NDIS regulation should be proportionate to risk and provider type, rather than imposing the same requirements irrespective of the nature of the supports being delivered.

Funding the required standard

The standard required through commissioning must also be reflected in the price paid for commissioned supports. Providers cannot be expected to maintain workforce continuity, practice leadership, quality measurement, training, governance and safeguarding systems without those costs being recognised in funding.

This is particularly relevant where commissioning is intended to address participants with higher levels of risk or complexity. A higher quality requirement without corresponding funding would create pressure on providers to reduce workforce investment, limit the supports they can sustainably offer, or withdraw from the market. That would ultimately reduce the availability and choice that commissioning is intended to protect.

CHA has consistently argued in the NDIS context that funding settings need to reflect the reasonable cost of delivering supports to the required quality and regulatory standard. This is not an argument for funding providers irrespective of performance. Rather, commissioning should establish the standard providers are expected to meet, assess whether they can demonstrate that capability, and ensure the price provides a viable basis for delivering it.

Quality rather than price

Commissioning should avoid creating a procurement model in which providers are primarily competing on price. Where the objective is to improve quality and sustainability, the selection of providers should give appropriate weight to demonstrated outcomes, workforce capability, practice leadership, governance and participant experience.

The panel model proposed in Question 5 provides a basis for doing this while preserving participant choice. Providers can be assessed against a defined quality threshold, while participants retain the ability to choose between providers that meet that threshold.

The Government's existing Quality Supports Program also provides an opportunity to build the evidence base for these settings. The SIL pilot is intended to provide information relevant to quality, value for money and future pricing reform. Commissioning should draw on this evidence when establishing funding and provider requirements, rather than setting expectations independently of the actual cost of delivering quality SIL.

Ultimately, commissioning will only improve SIL if providers are able to sustain the practices it requires. Quality, participant choice and provider viability should therefore be treated as connected elements of the commissioning model rather than competing objectives.

Recommendation 6: Commissioning should assess provider sustainability through demonstrated workforce, governance, practice and quality capability, and commissioned SIL should be funded at a level that reflects the reasonable cost of delivering the required standard of support. Commissioning should reward quality and capability rather than create incentives for providers to compete primarily on price.