

14 October 2026

Via submission portal: New Framework Planning and NDIS Supports Consultation

Catholic Health Australia Submission – New Framework Planning and NDIS Supports Consultation

Thank you for the opportunity to provide Catholic Health Australia's (CHA's) views on New Framework Planning and proposed amendments to the NDIS Supports Transitional Rules. CHA supports the Commonwealth Government's objective of establishing a fairer and more consistent approach to identifying and funding disability support needs, and securing the Scheme for people with permanent and significant disability so it is there for future generations, as well as for those who need it now.

Our engagement with NDIS reform is grounded in the dignity of the human person and the responsibility to enable people with disability to fully participate in community life. Moreover, we support reforms that promote responsible stewardship, ensuring that the Scheme's resources are used effectively while preserving the support on which people depend. Our members' experience across disability, health, aged care and community services informs this submission, alongside our earlier contributions to the reform process.

A planning framework that reduces repeated assessments and gives participants greater flexibility must recognise needs over time and draw on suitable existing evidence. Participants should be able to contribute, understand decisions and correct information before it determines their plan.

Our submission pays particular attention to translating assessed needs into sufficient funding, including shared staffing costs, safe delegated care and sustainable informal support. Members' reports of reduced community access among SIL participants reinforce the importance of funding participation alongside assistance at home.

Proposed changes to the supports rules also require clear guidance on eligibility, purchasing and the treatment of existing approvals across old and new framework plans. Alongside this, longer plans must remain responsive through timely variation and reassessment pathways, with interim assistance protecting continuity of care.

CHA welcomes further engagement to support a sustainable and equitable disability system. 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 not-for-profit group of health, community and aged care providers. Our members operate 88 hospitals in every state and the Australian Capital Territory, accounting for around 13 per cent of hospital-based healthcare in Australia. This includes about 30 per cent of private hospital beds and about 5 per cent of public hospital care through member hospitals St Vincent's, Calvary, Mater, St John of God, Cabrini and Mercy.

CHA members also operate approximately 12 per cent of Australia's residential aged care facilities and deliver around 20 per cent of in-home aged care, alongside community services. Twenty-five per cent of our members provide services in regional, rural and remote parts of the country. CHA members involved in disability service provision include St John of God Accord and Villa Maria Catholic Homes.

As not-for-profit providers, CHA members are a dedicated voice for the disadvantaged, advocating for an equitable, compassionate and secure health system that leaves no one behind.

Submission

Section 1 – Support needs assessment rules

Question 1: What parts of the support needs assessment process need more explanation?

CHA supports an assessment process that brings together the participant's account, existing evidence and targeted professional assessment where required. Further explanation is needed about how these sources will be considered together, particularly for people whose needs fluctuate, who have complex communication requirements or whose functioning depends on substantial support already being in place.

A guided conversation may provide valuable insight, but its findings must be understood in the context of the person's daily life. Achievements made possible through assistance, established routines or clinical oversight should not be interpreted as evidence that this support is unnecessary. Assessment must account for variation over time, the interaction between multiple impairments and the environmental barriers that affect participation.

The knowledge held by people who support a participant over time is relevant to this. In Supported Independent Living (SIL), established staff may recognise changes in behaviour, communication, health and daily functioning that are difficult to convey during a single assessment. The rules should therefore provide a formal pathway for this evidence, alongside input from support coordinators and treating professionals, with the participant's consent or appropriate authority. This should preserve the person's involvement in decisions, require disclosure of relevant provider interests and ensure that significant differences between sources are explained.

Assessment requirements should also be proportionate to what remains unclear. Suitable clinical reports, behaviour support plans and service records should be reused, with further evidence requested only to resolve an identified gap. Participants should be told why additional information is needed, how it will be obtained and who will meet the cost. Participants must be able to correct incomplete impairment information before it affects the assessment.

Greater clarity is also needed about the modified I-CAN instrument and targeted assessment scales. The Department should publish the modifications, rating definitions, validation findings and known limitations, including their application to people with complex or fluctuating needs and diverse cultural and communication requirements. Assessors need sufficient training, time and access to specialist expertise to apply these methods appropriately.

Finally, the disability-related health supports arrangements should distinguish direct nursing from high-intensity support delivered by trained disability workers under clinical delegation. This distinction affects workforce availability, continuity and cost. The rules should explain how the existing delegation model will operate and where the training, competency assessment, supervision and coordination required for safe delivery will be recognised.

Recommendation 1: Establish a transparent assessment process that uses suitable existing evidence, provides formal pathways for participant-authorised professional and provider input, and explains assessment scales and delegated care arrangements.

Question 2: What questions and feedback do you have about the draft support needs assessment report template?

CHA supports including descriptions of support needs alongside assessment outcomes. The report should enable participants to understand how the evidence has been interpreted and how its conclusions will inform their plan. This requires a clear account of the person's circumstances, preferences and existing support arrangements, together with reasons for the assessed levels.

Participants should have an opportunity to review and respond to a draft before it is used to approve a plan. Scores should be accompanied by definitions, and any outstanding evidence requirements should be identified separately from a finding that support is unnecessary. Where information is disputed or incomplete, the report should explain how this will be resolved.

While the sample includes provider observations, the pathway for structured professional and service evidence needs to be clearer. Behaviour support assessment, for example, should consider an existing practitioner-prepared plan, implementation records and family observations together. The report should show how these sources inform the outcome and explain any departure from documented support requirements.

Shared living arrangements require similar attention. Recording a support ratio does not establish whether the combined funding will sustain the staffing needed across a household. Our members encounter circumstances in which a change in one resident's needs increases the staffing requirement beyond the combined funded arrangements. The report should identify when shared and individual support are required and provide sufficient information for the budget method to address these interactions, while protecting residents' privacy and choice.

Distinguishing between high-intensity support worker assistance and nursing is useful. However, recording that direct nursing is unnecessary must not imply that training, clinical delegation or ongoing oversight is unnecessary. These requirements should remain visible in the assessment and resulting funding.

The Circle of Support section should also capture the duration, reliability and sustainability of informal assistance, including the carer's willingness and capacity to continue. Frequency alone provides an incomplete basis for determining whether assistance can replace paid support.

Further, the assessed supports summary should reconcile all needs identified throughout the report with relevant funding categories. While the published sample illustrates several possible assessment outcomes, each participant's completed report must clearly connect their identified needs to the budget calculation, including reasons where an identified need does not result in funding.

Recommendation 2: Require assessment reports to connect evidence, assessed needs and funding categories, with defined rating scales, explicit consideration of shared and delegated support, and an opportunity to correct the draft.

Question 3: In what circumstances do you think a replacement assessment should be arranged? Are there additional circumstances that should be considered?

A replacement assessment should be available where the original assessment no longer provides a reliable basis for approving a plan. This may arise through a change in circumstances or through limitations in the initial assessment itself. The rules should recognise both, so that participants are not required to demonstrate deterioration before an inaccurate assessment can be addressed.

Relevant circumstances include:

- Changes in support needs, living arrangements or informal care between assessment and plan approval, including gradual or cumulative change.
- Assessment during an atypical period, such as acute illness, hospitalisation or crisis, which does not adequately reflect needs over time.
- Missing communication adjustments, an unsuitable assessment setting or the absence of a chosen support person where this affected participation.
- Omission or misinterpretation of relevant clinical evidence, provider records or a behaviour support plan.
- Incorrect impairment information, recording or scoring errors, or an incomplete targeted assessment.

Participants and nominees should be able to raise an evidenced concern with assistance from an advocate, support coordinator or provider. Where the discrepancy is apparent in existing records, another privately funded report should not be required simply to establish that an error has occurred.

Moreover, the response should be proportionate to the problem. For example, a factual correction or targeted assessment may be sufficient in some cases, while others will require a full replacement. Decisions should also explain why a pathway was chosen and provide an accessible opportunity for review.

Defined timeframes will also be necessary. Where an unresolved assessment places essential support or safety at risk, an urgent pathway and interim arrangements should prevent the participant from carrying the consequences of administrative delay.

Recommendation 3: Provide proportionate correction and replacement pathways for changed circumstances and assessment deficiencies, supported by accessible requests, reasoned decisions, defined timeframes and continuity of essential support.

Section 2 – Budget method rules

Question 4: What information would help participants understand how a budget is calculated?

Participants need to understand how their assessed needs translate into funding and whether that funding can purchase the support required in practice. Consistent assessment will have limited value if the resulting budget cannot meet those needs.

The methodology, assumptions and worked examples should therefore be published before the rules are finalised, with sufficient opportunity to examine their consequences. Participants should also be able to follow the calculation from assessment outcomes to support quantities, prices, adjustments and the final allocation. Explanations should identify any standard amounts or benchmarks, the evidence supporting them, how needs outside those settings will be addressed, and distinguish funding for the full plan from annual amounts and funding periods.

Further, shared living requires an explicit method for calculating and apportioning support costs. Individual assessment must remain central to this, whilst recognising that the staffing needed to support one resident can affect the household arrangement. A method that calculates the justified shared staffing requirement and apportions costs according to individual needs could operate within in-home and Community Supports. It should separately recognise individual assistance, avoid double counting and preserve choice over where and with whom people live. Worked examples should address different support ratios, overnight arrangements, changing needs and temporary vacancies where the staffing required for remaining residents does not fall in proportion to occupancy.

Community participation also needs to be considered in this methodology. Attachment 4 proposes a default community supports amount, but participants differ in the assistance required to leave home, travel, communicate and participate safely. The Department should explain the basis of the default and how additional funding will be determined where assessed needs exceed it.

Our members have reported reduced community access and increased isolation among SIL participants despite protections for in-home support. These experiences reinforce the importance of assessing adequacy across the person's daily life. Preserving assistance at home must be accompanied by sufficient support to sustain relationships and participation outside it. On transition, reduced service use following an earlier funding reduction should not be interpreted as evidence of reduced need.

CHA remains concerned about the proposed informal supports offset. Family involvement is a social good, and funding arrangements should sustain the relationships that support participants. Any offset must be grounded in evidence about the assistance available, its duration and reliability, the carer's circumstances and willingness, and whether it can safely replace paid support.

Regular contact alone does not establish this, and the Department should therefore publish the evidence underpinning the methodology, assess its distributional effects and make individual adjustments open to scrutiny and review.

Budgets must also recognise the work required to deliver complex support safely. Training, competency assessment, clinical delegation and ongoing supervision are integral to high-intensity care. Similarly, behaviour support requires resources for implementation as well as specialist plan development. The method should be tested against these delivery costs, including regional workforce and access constraints.

Where another service system is assumed to meet a need, the calculation should identify the equivalent support available and who is responsible for resolving any gap. Automated calculations must be transparent and correctable, while evaluative judgements about support needs and budget adequacy remain accountable to human decision-makers. Any AI use should be subject to appropriate privacy, consent and oversight arrangements.

Recommendation 4: Publish and test a transparent budget methodology that addresses shared living, individual participation needs, informal care and the full cost of safe delivery, with explainable adjustments and accountable decisions.

Question 5: What questions and feedback do you have about the draft participant plan template?

The distinction between flexible, restricted flexible and stated funding provides a useful foundation for explaining how a plan can be used. Participants also need to understand how those allocations were determined and what they can purchase. A plain-language explanation should connect the assessed needs to the budget, identify the period covered by each figure and explain any conditions before participants enter service agreements.

The shared living example illustrates the need for greater visibility of the underlying calculation. The plan identifies a restricted in-home and Community Supports allocation, but does not show how shared staffing costs have been apportioned. Participants should receive an explanation of their own contribution to shared support and the individual assistance funded alongside it. With appropriate authority, providers should have enough information to assess whether the agreed arrangement can be delivered, without requiring disclosure of housemates' personal plans.

The treatment of informal assistance should also be explicit. The example describes regular family support without showing whether an offset has been applied. Each adjustment should be separately identified, with its amount, evidentiary basis and calculation. This would enable participants and families to question an assumption before it becomes embedded in-service arrangements.

Funding restrictions should have a clear purpose and scope. The ability to supplement restricted funding from an unrestricted allocation may provide flexibility, but the initial budget must remain sufficient to meet the assessed needs. Participants should not have to surrender funding intended for other support because essential in-home assistance has been underfunded.

Finally, the plan should explain the available correction, review, variation and reassessment pathways, with assistance to understand and implement it. Funding periods must accommodate predictable expenditure and urgent changes, while checks on totals, dates and allocations should occur before the plan is issued.

Recommendation 5: Include an accessible budget explanation in each plan, showing shared support calculations and offsets, the scope of funding restrictions and practical pathways for implementation, correction and review.

Section 3 – Plan variation and reassessment rules

Question 6: What feedback and questions do you have about plan variations and reassessments?

Longer plans can provide stability and reduce the burden of repeated reassessment where they suit a participant's circumstances. However, a plan lasting up to five years must remain responsive throughout that period. Its duration should reflect the person's preferences, the expected course of their condition and the stability of their support arrangements.

The distinction between small and significant change requires further explanation. For people with degenerative, episodic or fluctuating conditions, needs may increase gradually or through repeated episodes without presenting as a single sustained decline. A series of smaller changes should be considered cumulatively, with access to additional support before the existing arrangement becomes unsafe or a crisis develops.

Relevant changes extend beyond impairment. Loss of informal care, a provider withdrawing, changed household composition or staffing requirements, and emerging clinical needs can alter the support required to sustain an otherwise stable living arrangement. Variation and reassessment pathways should be capable of responding to these circumstances.

An inadequate budget may also arise from an error in the original assessment or calculation. Participants should have a practical route to address this even where their underlying needs have not changed. The guidance should distinguish correction and review from processes intended to respond to changed circumstances.

Published timeframes should cover acknowledgement, decision and implementation, with urgency determined by the consequences of delay. Participants should have a named contact, be able to track progress and reuse suitable evidence. Interim funding must be available where essential assistance is at risk.

The commitment to maintain current plans until new framework plans are approved is welcome. Operational guidance should explain how continuity will be maintained through payment systems, funding periods and service agreements. Providers should not be left to carry unfunded essential support while administrative processes are completed.

Recommendation 6: Design variation and reassessment pathways around cumulative needs and changing support arrangements, with proportionate evidence requirements, defined response times and interim funding where essential support is at risk.

Section 4 – NDIS Supports Transitional Rules

Question 7: What feedback do you have about changes to NDIS supports for old and new framework planning?

Clearer purchasing rules and access to eligible supports through ordinary retailers can improve choice and reduce administrative burden. Participants and providers need to understand how the revised supports lists relate to assessment categories and funding restrictions, including how the changes will apply to existing old framework plans.

Exclusions should account for the disability-related function of an item. Proposed exclusions of electronic noise-cancelling headphones, fencing and gates may affect people who use these products for sensory regulation, safety or access. The Department should explain the basis of these exclusions and how an assessed need will be met where an ordinary product performs the required function. Appropriate authorisation and safeguards remain necessary where restrictive practices are involved.

Clarification of animal-assisted therapy should similarly consider the evidence for the intervention, the qualified professional's role and the participant's functional goals. Guidance should enable consistent decisions about clinically appropriate therapy.

CHA welcomes recognition of worker training within disability-related health supports, and frontline implementation of intensive and complex behaviour support within In-home and Community Supports. Further guidance should explain how these provisions operate alongside specialist Behaviour Support and clinical services, so participants and providers can identify where each component of care is funded.

For delegated health support, this should distinguish direct clinical care from assistance delivered by appropriately trained disability workers, including how competency assessment, delegation, coordination and ongoing supervision are recognised. Behaviour support guidance should likewise distinguish specialist assessment, plan development and monitoring from daily implementation, with sufficient funding to carry out the plan safely.

Transport arrangements also require explanation. Worked examples should distinguish Private Vehicle Transport from transport included within another support category, showing how journeys to activities and appointments are funded, including assistance during travel. This would help avoid gaps or double counting as existing arrangements move into the revised categories.

Coordination remains important for people navigating disability, health and aged care services, including younger people seeking alternatives to residential aged care. Any redesign should preserve effective assistance and participant choice, with changes evaluated against continuity, service access and crisis prevention.

Finally, changes affecting old and new framework plans need clear commencement and transition arrangements. Participants and providers should receive advance notice of affected supports, the treatment of existing approvals and the process for obtaining alternatives. Established arrangements should continue until an appropriate funded alternative is available.

Recommendation 7: Implement clearer supports rules with guidance on disability-related eligibility, the funding of specialist and frontline support, and transport arrangements. Provide advance advice and continuity protections for existing approvals and services across old and new framework plans.

Question 8: What impacts do you think will be experienced as a result of removing replacement supports? What items or services will no longer be available?

Removing replacement supports would reduce participants' ability to use an ordinary product or service instead of a funded NDIS support, even where it meets their disability-related needs safely and at equal or lower cost. Participants could lose effective arrangements, face additional out-of-pocket costs or need to purchase more expensive disability-specific alternatives.

Standard commercially available household items are the clearest category affected. Where these have been approved through the replacement pathway and are not otherwise eligible under the revised supports lists, participants would lose the means of obtaining approval for them. This could particularly affect people who use household products to carry out daily tasks with less paid assistance.

Tablets, smartphones, smartwatches and accessibility or communication applications are proposed to remain available as stated supports, subject to eligibility requirements. Their inclusion may simplify access, but participants need confirmation that existing disability-related uses will qualify. CHA members have not identified further specific items or services at this stage.

Before removing the pathway, the Department should identify which existing approvals would no longer be available and assess the consequences for participants. A means of approving safe, cost-effective alternatives should remain where the revised lists do not accommodate an assessed need.

Recommendation 8: Map existing replacement approvals against the revised supports lists before removing the pathway, resolve identified gaps and protect continuity while participants obtain appropriate alternatives.

Section 5 – General questions

Question 9: What information was most useful?

Presenting the assessment and budget policy settings category by category helped explain how the proposed funding arrangements would operate. Alongside this, the draft report and plan templates made the process more tangible, particularly for shared living and complex support. A complete worked example connecting these resources would help participants and providers follow how evidence informs assessment, funding and the final plan.

Question 10: What questions do you still have?

Further detail is needed on how the framework will operate for people whose support depends on shared staffing, clinical delegation and sustained assistance from others. Outstanding questions include:

- How will existing clinical, behaviour support and provider evidence be submitted and reconciled with assessment outcomes?
- What validation supports the modified I-CAN instrument, targeted assessment levels and resulting budgets across different participant cohorts?
- How will shared staffing costs, changes in household needs and temporary vacancies be addressed?
- How will funding above the proposed default community supports amount be determined?
- Where will the training, competency assessment and clinical oversight required for delegated care be funded?
- What evidence will underpin informal support and aged care offsets, and how will participants challenge their application?
- What response times and interim arrangements will apply to corrections, replacement assessments, variations and reassessments?

Resolving these questions will allow participants, assessors and providers to prepare with greater certainty. Before transition begins, a published implementation plan should establish how the rules, workforce and payment systems will be tested and coordinated with other NDIS reforms. Evaluation should then examine whether budgets purchase the required services and sustain participation and continuity, alongside assessment consistency and administrative efficiency.

Question 11: What would help people with disability better understand the NDIS new framework planning rules?

A complete worked example would help participants follow the process from assessment through to using their plan, with explanations of decisions and the options available when something is incorrect or needs change. Examples involving shared living, fluctuating needs, delegated health support and informal care offsets would address circumstances that are difficult to explain through general guidance alone. Showing how household staffing costs are calculated and apportioned, for instance, would make the implications for an individual resident easier to understand.

Participants should also have opportunities to discuss their own report and plan with someone who understands the process, accompanied by a trusted person where preferred. Testing these explanations with people who have complex communication needs or limited informal support would help establish whether the guidance works for those facing greater barriers to navigating the Scheme.

Question 12: What communication formats would make the information more accessible?

Accessibility will depend on both the formats available and the assistance people receive to use them. Plain-language and Easy Read materials, Auslan, captioned video, audio, translated resources and accessible digital documents should be accompanied by telephone and face-to-face explanations, with interpreters and communication support where required.

Trusted services can help this information reach participants who may otherwise miss it, particularly where language, geographic isolation or limited digital access creates additional barriers. Disability advocates, providers, support coordinators and Aboriginal community-controlled organisations should be equipped to assist, with directly distributed guidance and practical briefings helping staff explain the changes accurately and consistently.

Question 13: What should we focus on in future communication products?

Future communication should follow the decisions participants will encounter: preparing evidence, checking impairment information, understanding assessment outcomes and funding calculations, using their plan, and seeking changes or review. Particular attention should be given to shared living, delegated health support, informal care offsets and community participation, including how funding responds when the assumptions underlying a plan no longer hold.

Clear transition advice is also needed to distinguish changes affecting old framework plans from those introduced through new framework planning, and to explain their interaction with health, aged care and other disability reforms. Publishing updated worked examples alongside the exposure drafts would allow participants and providers to examine the actual calculations and operational requirements before commencement. Guidance should subsequently evolve in response to recurring questions, implementation experience and participant feedback.

Recommendation 9: Publish complete worked examples connecting assessment, budget calculation and the final plan, including shared living costs, delegated health support and informal care offsets, with explanations of how participants can query decisions.

Recommendation 10: Provide accessible information and supported explanations through trusted services, alongside directly distributed guidance and practical briefings for providers and others assisting participants.

Recommendation 11: Publish an implementation plan addressing outstanding policy questions, system and workforce readiness, and coordination with other reforms. Allow sufficient time to examine the final rules and calculations before commencement, with ongoing evaluation informing updated guidance.