Limbs 4 Life
Empowering Amputees

Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into Independent Assessments 2021

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Making a real difference together

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Introduction and key issues

The Productivity Commission's 'Disability 2011 Care and Support Inquiry Report' advocated for a National Disability Insurance Scheme (NDIS) to address the fact that then ***"Current disability support arrangements are inequitable, underfunded, fragmented, and inefficient and give people with a disability little choice. They provide no certainty that people will be able to access appropriate supports when needed".***[1] This report heralded introduction of the landmark NDIS in order to harmonise disability supports across the nation and, in doing so, offer people with disability better options, dignity, opportunity to make decisions and be provided with choice and control in relation to the supports they need to live an ordinary life.

The community, social and economic benefits and outcomes that the NDIS has provided to tens of thousands of amputees has been extraordinary. Limbs 4 Life, and our community of amputees, fought hard to see the NDIS established, and we will continue to challenge any changes that we feel will fundamentally alter or negatively impact the individualised and personalised nature of the NDIS.

Despite claims that individual assessments will ensure that the NDIS is more 'consistent and fair', the introduction of standardised tools and a lack of opportunity to discuss a person's unique circumstances and aspirations to guide the selection of reasonable and necessary supports is shifting the NDIS away from its original individualised model intention.

Key issues:

- The introduction of mandatory independent assessments may bring a range of unintended consequences, inequities and risks and is at odds with some of the underpinning philosophies and guiding principles upon which the NDIS was founded and has been built.
- Mandating independent assessments, where a recent one is already accessible by the prospective or current participant is burdensome to both the individual and the scarce NDIS budget.
- As allied health practitioners are an already thin market, particularly in in rural and remote locations, it is unclear how contracted independent assessment organisations will meet supply demands for suitably qualified assessors while also ensuring quality assured and timely reports.
- Contracting eight organisations to form the Independent Assessment Panel creates a perceived and/or actual conflict of interest, perception that they are agents of the NDIA and may find that desires to retain contracts will influence how independent assessments are conducted.
- A minimum of twelve months of clinical experience for assessors, and one day of NDIA training, is insufficient to understand the complexities and nuances that limb loss brings seems grossly insufficient and/or suggests that the tools are not sophisticated enough to garner a complete and accurate picture of a prospective or current participants.

- Limiting an independent assessment to three or four hours, even if conducted over multiple sessions, may not be sufficient time to garner a complete picture of the person's functional capacity. Furthermore, it is unclear whether this will also be inclusive of time required for the assessor to prepare their report which will inevitably reduce time available to be spent with the person.
- The impact of disability is often, in itself, not fixed, so imposing a tight and standardised assessment approach is contradictory to the very nature of disability.
- Introducing an independent assessment approach whereby participants can only choose their assessor "where possible" is not only disempowering but challenges the 'choice and control' cornerstone upon which the NDIS has been built.
- While independent assessments have been proposed as a means of reducing inequity it is somewhat questionable whether it will actually achieve this given a lengthy Access Request Form provided by a health professional is still required and an opportunity to submit existing and costly clinical evidence is still allowed. People with disability will still incur costs, and the issue of the 'haves' and the 'have nots' will still exist.
- People who have recently acquired an amputation are less likely to understand the complexities of their disability and the impacts it may have on their lives. So, their ability to convey an accurate picture of functional impairments and needs during a short independent assessment, and with someone they have only just met, could negatively impact on whether they are eligible for the NDIS or the levels of funding they receive if accepted into the scheme.
- The NDIS is enabling amputees to access complex assistive technology (prosthetics), whereas their older peers, ineligible for the NDIS and receiving only basic state-based Artificial Limb Scheme funded prosthetics experience greater risk of falls, back and hip problems, unnecessary stress on their sound limb, poor mental health impacts, and reduced ability to engage in the community and economy.
- Artificial Limb Scheme budgets were under-funded prior to the NDIS, have been further stripped in recent years and struggling to meet the needs of a growing population of amputees over 65 years. This makes it questionable whether state-based health departments will cope if some amputees are denied access to the NDIS because of the introduction of independent assessments and referred back into state-based supports.
- It is of concern that a person's draft plan and budget will be developed prior to the Delegate even meeting with the NDIS participant to discuss their individualised needs and goals. By not engaging with a NDIS participant before determining a person's draft plan and budget puts the NDIS Participant Charter principle of 'Respectful' in question and counters the right to people with disability being involved in decisions that affect them, as required by the Convention on the Rights of Persons with Disabilities and the NDIS Act 2013.
- There is a risk that relying solely on an independent assessment, without gaining personal insights from individuals and their support network, will lead to even greater inconsistencies in plans and funding budgets and increased requests for internal reviews, Administrative Appeals Tribunal (AAT) appeals, and greater demands on already stretched advocacy bodies.
- It is of grave concern that the notion of goal setting and even the word 'goal' does not appear in either the 'Independent Assessment Panel - Statement of Work Request for Tender' and the

‘Consultation paper: Access and Eligibility Policy with independent assessments’ documents. This is in contravention with the NDIS Act 2013, and the spirit of the NDIS model more broadly, wherein the pursuit of goals by participants filters throughout.

- It is stated that “independent assessment results themselves will not be directly reviewable by the AAT”. This is unacceptable as under the proposed arrangements participants will have little ‘right to appeal’ the outcome of an independent assessment, and with that denial of a fundamental human right afforded through the Universal Declaration of Human Rights.

About Limbs 4 Life

Limbs 4 Life’s mission is to provide information and support to amputees and their families while promoting an inclusive community. Our philosophy is to *empower amputees with knowledge and support to make a real difference, because no one should go through limb loss alone*.

Limbs 4 Life is the peak body for amputees in Australia, founded as an incorporated charity in 2004. Limbs 4 Life provides services to thousands of amputees and their care givers, who rely on its programs and support for assistance prior to or after a limb amputation. Limbs 4 Life is supported by over 200 trained Peer Support Volunteers and is governed by a board and operated by staff with a majority representation from those with the lived experience of amputation or close contact with someone who does.

Since its formation, Limbs 4 Life has greatly extended the supports available to amputees, their families, primary care givers and healthcare staff. Limbs 4 Life’s services include provision of:

- Best practice Peer Support Programs
- Evidence-based health literacy resources and wellbeing information
- Independent support and advocacy to assist people to navigate healthcare and disability systems and pathways
- Access to social and economic inclusion activities.

Limbs 4 Life advocates for amputees by initiating or taking part in research, providing recommendations to government, responding to submissions, and educating the community about amputation and limb loss.

Amputee population and limb loss impacts

Amputation and limb loss causes

The aetiology of surgical amputation of major limbs (upper and/or lower limbs) in Australia is varied and diverse, with the main causative factors including diabetes-related complications, vascular disease, trauma, cancer, and infections. Such limb loss can occur at any stage within an individual’s lifetime. In addition, members of the amputee community comprise those born with

congenital deficiencies of major limbs, which sees this cohort experience a lifetime of living with limb loss.

Annually, lower limb amputations alone account for almost 9,000 amputations across Australia[2] Notably, Australia has an appalling record when it comes to diabetic-related amputations with the rate of such limb loss increasing by 30 per cent in the past decade and resulting in our country having the second highest rate of such amputations in the developed world.[3] Of grave concern is the fact that major limb amputations are 38 times more likely in Indigenous Australians aged 25-49 years than in the general population.[4]

Amputation recovery and rehabilitation

The loss of a limb is considered a major health and disability event which can impact on a person's functionality, mobility, independence and mental health. Following an amputation and acquiring this physical disability, restoring functionality and daily living abilities, reducing dependency on others, increasing mobility and optimising a person's quality of life and satisfaction are key rehabilitation and disability adjustment goals.[5]

People who experience an amputation spend a period of time in acute hospital settings recovering from the surgery, after which, in most cases, they are transferred to sub-acute rehabilitation facilities to learn to adjust to the loss of a limb/s. Rehabilitation involves a multidisciplinary healthcare team to support new amputees to learn how to: ambulate safely; regain functionally, mobility and balance; use a wheelchair and/or other mobility aids (assistive technology); overcome fears; prepare for the fitting of a prosthesis (assistive technology); and, plan for socio-economic re-entrance into the community.

With respect to lower limb amputations, it is estimated that recovery post-amputation occurs over a 12 to 18 month period and is inclusive of activity recovery, reintegration into society, and prosthetic management and training.[6] It is also during this period that amputees seek funding supports, particularly the NDIS, to facilitate independence, community engagement and socio-economic participation.

The development, modelling, reasons and justifications for the introduction of independent assessments into the NDIS

Like many other disability organisations, Limbs 4 Life is concerned that the original independent assessment trial was too small and brief to genuinely and meaningfully capture insights from a broad and diverse range of people living with various disabilities. And while a second pilot is currently taking place, and opportunities to submit feedback has now been afforded via the Consultation and this Joint Standing Committee review, it has been announced that the introduction of mandatory independent assessments, and associated legislative amendments, will be introduced in 2021 regardless of knowledge acquired and lessons learned. Limbs 4 Life trusts that all submissions and a thorough and transparent review of the pilot will influence whether or

not independent assessments will be introduced, rather than rolling out this process without a meaningful determination to do so drawn from broad community consultation.

Limbs 4 Life recognises that the upfront cost of sourcing evidence of a person's functional capacity can be a barrier to people accessing the NDIS. We also recognise, and have been privy to, unacceptable inconsistencies in NDIA access requests and plan funding amounts when two 'like' amputees are compared, receive very different plans and consequently very different outcomes. We acknowledge that the introduction of independent assessments has been proposed as a mechanism for eliminating or mitigating some of these barriers and unfairness.

However, it is Limbs 4 Life's view that the introduction of mandatory independent assessments will bring a range of unintended consequences, inequities and risks. Furthermore, the introduction of independent assessment is at odds with some of the underpinning philosophies and guiding principles upon which the NDIS was founded and has been built.

The human and financial resources needed to effectively implement independent assessments

While it may be well intentioned to introduce free independent assessments to incoming or current NDIS participants, it is unclear whether costs to the system have been fully captured or considered. To Limbs 4 Life's knowledge there is no report outlining costings, which should be made publicly available if such costs have already been captured and informed this policy shift.

Financial costs
Although outsourcing the independent assessments to the already contracted eight NDIS Independent Assessment Providers may appear to be financially efficient, it is unclear what this investment is and will be for the NDIS into the future. Furthermore, introducing mandatory assessments for persons who can provide a recent functional capacity assessment conducted by an AHPRA registered allied health professional seems unnecessary and a waste of tax-payers' money.

Human resources
As allied health practitioners are an already NDIS acknowledged thin market[7], particularly in rural and remote locations, it is unclear how contracted independent assessment organisations will meet supply demands for suitably qualified assessors. Furthermore, as appointments for independent assessments must be arranged within 10 days after the referral[8], makes the issue of access to a sufficient pool of assessors even more challenging and will likely create workload pressures that may impact on the quality of assessments and the need to meet desired targets and KPIs.

And whilst telehealth or phone-based independent assessments may be proposed to address geographic access limitations in rural and remote locations, inaccurate outcomes may be the

result. With respect to amputees, for example, how can an assessment of mobility and physical functionality really be appropriately measured via a video demonstration? And, what if the participant in question does not have access to a smartphone, computer, internet access or other necessary technology?

The independence, qualifications, training, expertise and quality assurance of assessors

Independence
Limbs 4 Life is concerned that independence of the already contracted NDIS Independent Assessment Providers creates a perceived and/or actual conflict of interest. If the NDIA is directly contracting organisations to provide independent assessments, it is concerning that contract continuation (initially for three years with an NDIA option to extend it for two more years)[9], impacted by timeliness and other pressures, would influence how assessments are conducted. Furthermore, as contracted bodies of the NDIA this is in conflict with the independent assessment system proposed in the Tune Review which stated that a new approach requires "assessors providing truly independent functional capacity assessments, so they are not perceived agents of the NDIA".[10]

Qualifications, training and experience
While employed assessors will be required to "have a minimum of 12 months full time clinical experience (post General Registration) working within their respective field and appropriate level of clinical supervision"[11], Limbs 4 Life has concerns that this is an insufficient period to understand the complexities that amputation brings and needs to be understood in order to conduct an accurate independent assessment.

For example, has the assessor worked in acute or sub-acute hospital settings, do they have experience in the rehabilitation model of care and, for that matter, is there sound experience understanding the complexities of the disability? It is possible that an assessor could have had only minimal clinical placement/contact hours during their University studies (and potentially less so due to restrictions on hands-on placement hours as a result of Covid-19 restrictions in 2020/2021), or have only worked privately with little if any clinical experience working with or understanding the unique needs of a person with disability? The system is therefore relying solely on the effectiveness of the assessment tool to illustrate the true functional capacity of that individual, which may be marred if the assessor has little to no experience working directly with disability.

In the training requirements of the 'Independent Assessor Statement of Work', the NDIA advises that training packages will be made available to the supplier, who in turn will train personnel who will be involved in the provision of services via a 'train-the-trainer' method. The training will include content provided by the publishers of the Functional Capacity Assessment Tools to be used by assessors, management of the administrative processes associated with supply of services, and provision of assessment services to different cultural groups.[12]

It is very concerning that "The NDIA expects that the likely time commitment for the provision of the NDIA training will be up to ***one day*** per Assessor prior to the commencement of Assessment Services. It is anticipated that training will be conducted through a web portal".[13]

Given the complexity and nuances of amputation, and the level of professional experience required to understand an amputee's individual assistive technology and support needs, this minimal level of training for assessors seems grossly insufficient and/or the tools being not sophisticated enough to garner a complete and accurate picture of a prospective or current participant's needs.

The implications of independent assessments for access to and eligibility for the NDIS

It is Limbs 4 Life's view that the Independent Assessment approach, through utilisation of a standardised assessment tool and use of an assessor that a person has just met, does not take account of the heterogeneity of amputees, and people with disability more broadly. It puts some amputees at risk of being denied access and returning to a pre-NDIS time where basic prosthetics and other assistive technology, which led to poor socio-economic participation and unnecessary hospitalisations, were only available through poorly funded state-based schemes offering consumers little to none choice and control.

Assessment time limitations

Limbs 4 Life has some concerns that limiting an independent assessment to three or four hours, even if conducted over multiple sessions, may not be sufficient time to garner a complete picture of the person's functional capacity. This could be due to a range of factors, such as: the state of the person on the day of the assessment; cultural or language barriers; lack of insight into their disability; poor confidence; inability to fully disclose intimate personal details; multiple disabilities; and, lack of a support person or advocate to attend the appointment.

Furthermore, it is unclear whether this three to four hour period will also be inclusive of time required for the assessor to prepare their report which will necessarily reduce time allowed to be spent with the person.

These factors, coupled with such time constraints, could impact on the independent assessor gaining a complete picture of the person's capacity and needs which in turn could lead to a person not gaining access to the NDIS, or removed from the scheme if already a NDIS participant. The impact of disability is often, in itself, not fixed, so imposing a tight and standardised assessment approach is contradictory to the very nature of disability.

Trusted relationships

Limbs 4 Life recognises that the introduction of independent assessments is designed to assist in removing the barriers that sourcing and personally funding costly assessments impose on some members of the community. This is a good way forward.

However, preventing amputees from drawing upon AHPRA registered health providers of their choice, who have the experience to conduct independent assessments, and with whom they have built trusted relationships, denies individuals of choice and control. Instead, introducing an independent assessment approach whereby participants can only choose their assessor "where possible" is not only disempowering but challenges the 'choice and control' cornerstone upon which the NDIS has been built. Indeed, it is seemingly in contravention with section 3(1)(e) of the NDIS Act 2013 which states it is striving towards a goal to "enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports".[14]

Inequities

While independent assessments have been proposed as a means of reducing inequity it is somewhat questionable whether it will actually achieve this. Prospective NDIS participants will still be required, during the pre-access stage, to provide information from a health professional that evidences they do live with a significant and permanent disability. In addition, clinical-based evidence reports is sought with regards to any treatment options that have been considered and/or administered.[15] Limbs 4 Life also notes that the new Access Request Form is significantly longer than the one used previously and provides an option to identify and submit from an array of clinical evidence reports already conducted, stating that "Providing copies of existing assessments helps the applicant to get a quick and accurate eligibility decision and reduces delays for the person when they have to provide more information".[16]

So, all aforementioned factors considered, the introduction of independent assessments will not remove the financial barriers that paying for a health practitioner's time to complete the Access Request Form places on the individual. And, it still enables those with the means to participate in functional tests prior to gaining entry to, or remain within, the scheme. So, suggesting that the costs and lengthy wait times for appointments, as well as creating a more level playing field between those with and without the financial means to pay for tests, as reasons for introducing independent assessments is somewhat baseless. People with disability will still incur costs, and the issue of the 'haves' and the 'have nots' will still exist.

Understanding amputee functional capacity activity levels

It is critically important to realise that people who have recently acquired an amputation are less likely to understand the complexities of their disability or are yet to adjust to living with a disability and the impacts it may have on their lives and those around them. So, their ability to convey an accurate picture of functional impairments and needs during a short independent assessment, and with someone they have only just met, could negatively impact on whether they are accepted into, and eligible for, the NDIS. Adjusting to the trauma of limb loss takes time to process. Determining what a person can and can no longer do is not pre-conceived or determined overnight. Physical and mental recovery comes first and that process cannot be escalated.

It is therefore important to recognise that an amputee 6 - 8 months post the loss of a limb/s is often more conversant with their disability, has experienced significant positive adjustments and learned skills through ongoing treatment and the re-training process provided by allied health professionals. However, it is at this stage that many amputees become situationally aware of what

they can and can't do, and thus recognise they are now in need of more complex assistive technology and other supports to facilitate socio-economic participation.

Traditionally a new lower limb amputee will begin their journey at a K1 or K2 activity level and within a six-month time frame increase their activity level to a K3 or possibly K4 (Appendix 1 describes each K level classification). As such prosthetics prescribed at the six-month (or earlier) mark will not be sufficient to sustain their increasing activity level for the following two to three years. This begs the question as to whether an assessment will be flexible enough to determine if they are eligible for the NDIS soon after their amputation, in the first instance, and if accepted will it recognise that many both upper and lower limb amputees will require funding for more complex assistive technology and supports as they adjust to their new disability?

Prosthetics and a risk of returning to state-based funding for those under 65 years

It is widely reported that the paramount goal for a person with limb loss is to access a prosthesis that aids in replacing what is missing in a functional effective manner.[17] Indeed, the role of prosthetics and advances in this technology over recent decades provide amputees with a wide range of options that can improve function, assist in preventing further health complications and enable an optimal quality of life.[18]

The type of prosthesis that a person utilises is contingent on the individual; taking account of the cause of amputation, location of the missing limb/s, any other health considerations, and their desired goals.[19] Consequently, prosthetic limbs must be custom made by qualified prosthetists, who work to manufacture, fit and maintain a device that best meets the individualised mobility and functional needs of their participant.

Amputees utilising prosthetics are users of some of the most complex assistive technology available. Considerable engineering and biomechanical advancements in recent years have led to the manufacture of sophisticated feet, knee and arm units which utilise dynamic response, microprocessor, bioelectric technology. Such products include the dynamic responsive feet, computerised microprocessor-controlled knees and myoelectric arms, to name a few. The benefits to users of advanced prosthetics are better controllability, improved balance, fall reduction, reduced osteoarthritis incidence, reduction in shoulder and back problems, and decreased physical and mental energy consumption.[20] [21] Furthermore, recent trends in such assistive technology point to a more seamless integration of the capabilities of the user and the assistive technology they use, and lead to transformative mobility and participation capacity benefits.[22] As these products cost considerably more than the very basic technology developed in the 1950s - 1970s, the introduction of the NDIS has enabled amputee participants to trial and request these products as reasonable, necessary and fit-for-purpose devices which deliver impactful psycho-social-economic outcomes.

Conversely, amputees' ineligible for the NDIS receive prosthetic funding through their state-based Artificial Limb Scheme only fund the provision of basic prosthetics (at K2 activity level); some of which are driven by passive technology developed in the 1950/60s. Such products include the solid ankle cushion heel (SACH) foot, body-powered 'split-hook' hand and mechanical friction/pneumatic knee units, which require an exhaustive amount of energy and mental

concentration to use. For a lower-limb amputee who needs to be on their feet for lengthy periods, such as those in the workforce or engaging in regular community activities, wearing a basic prosthetic foot or knee, which provide minimal stability and support, can have long-term negative physical, body-biodynamical, mental, social and economic impacts.[23] A person is at a greater risk of falls, back and hip problems, unnecessary stress on their sound limb, poor mental health, and reduced ability to engage in the community if wearing a basic prosthesis that does not meet their individualised needs and lifestyle. For example, it is not uncommon for prosthetic feet – such as the SACH foot - to snap if too much force is put through the toe load, leaving the user at risk and unable to ambulate at all. Similarly, the impact of using an upper body-powered prosthesis on a regular/daily basis may lead to long-term shoulder, neck and back problems.

It is notable that in recent years microprocessor knees have been added to the prosthetic component list for above-knee amputees in the United Kingdom and New Zealand government healthcare systems. The primary reasons for this policy shift and associated expenditure is because these prostheses are shown to reduce safety risks, minimise fall risk, reduce hospital admission and rehabilitation costs, and increase users' socio-economic outcomes; representing a sound investment designed to reduce downstream amputee health and disability-related government costs in those countries.[24] [25]

Artificial Limb Scheme (ALS) budgets have been stripped in recent years, with funding re-directed from the state-based health department as a contribution to the NDIS. Already there is barely sufficient funding in ALS budgets to meet the needs of a growing population of amputees over 65 years and ineligible for the NDIS. If the introduction of independent assessments resulted in more amputees under 65 years denied access to the NDIS just how will ALS and state health departments cope with even more increasing demand for assistive technology, let alone resulting hospitalisations due to accidents and illnesses related to the provision of inappropriate and basic prosthetics?

The implications of independent assessments for NDIS planning, including decisions related to funding reasonable and necessary supports

Despite claims that individual assessments will ensure that the NDIS is more 'consistent and fair', the introduction of standardised tools and a lack of opportunity to discuss a person's unique circumstances and aspirations to guide the selection of reasonable and necessary supports is shifting the NDIS away from its original individualised model intention.

Personal insights

It is critically important to realise that people who have recently acquired an amputation are less likely to understand the complexities of their disability or are yet to adjust to living with a disability and the impacts it may have on their lives and those around them. So, their ability to convey an accurate picture of functional impairments and needs during a short assessment, and with

someone they have only just met, could negatively impact on their individual assessment and the resulting plan and funding budget.

As noted earlier, an amputee 6 - 8 months post amputation is often more conversant with their disability, have experienced significant positive adjustments, shifted into a higher K activity level, and learned skills through ongoing treatment and training from allied health professionals. But it is also during this period that some amputees run the risk of developing mental health impacts as a direct result of their newly acquired disability, and therefore in need of early intervention and/or ongoing psycho-social supports. Thus, it is at this stage that many recognise they are now in need of more advanced reasonable and necessary assistive technology or other supports to facilitate socio-economic participation.

So, will a formulaic independent assessment tool applied to amputees still adjusting to their new disability or already a NDIS participant result in some amputees being denied access to assistive technology and/or other supports or removed from the system altogether because, although still living with a permanent and significant disability, they are perceived to have 'improved'?

Delegates and knowledge

It is of concern that a person's draft plan and budget will be developed prior to the Delegate even meeting with the NDIS participant to discuss their individualised needs and goals. By not engaging with a NDIS participant before determining a person's draft plan and budget puts the NDIS Participant Charter principle of 'Respectful', which states that the NDIS "will recognise your individual experience and acknowledge you are an expert in your own life"[26], into question. It also counters the right to people with disability being involved in decisions that affect them, as required by the Convention on the Rights of Persons with Disabilities and the NDIS Act 2013. For if a person has not had an opportunity to meet with a Delegate in advance of the plan and budget drafting, then is their lived experience, expertise and capacity to contribute to decisions that affect them really being considered?

It is acknowledged that Delegates cannot be expected to deeply understand all disabilities, but a lack of understanding by NDIA Delegates will likely lead to development of a poor plan and budget that does not reflect a participant's individual circumstances. There is a risk that relying solely on an independent assessment, without gaining personal insights from individuals and their support network, and by a Delegate without the relevant allied health background to review the outcomes of assessments, will lead to even greater inconsistencies in plans and funding budgets. It is likely to also increase requests for internal reviews and Administrative Appeals Tribunal (AAT) appeals, which will not only impact on individuals but also the advocacy bodies already experiencing high demand, many of whom are no longer being funded.

Goals and goal setting

It is of grave concern that the notion of goal setting and even the word 'goal' does not appear in either the 'Independent Assessment Panel - Statement of Work Request for Tender' and the 'Consultation paper: Access and Eligibility Policy with independent assessments' documents. Until now, goal setting has been a fundamental driver of plan development and reviews when meeting

with a LAC or NDIA planner and greatly assists in creating plans which meet NDIS participants' individual aspirations.

Yet, an ability to meet with a Delegate prior to plan development and even the notion of goal setting within the independent assessment approach now appears absent. This is in contravention with the NDIS Act 2013, and the spirit of the NDIS model more broadly, wherein pursuit of goals by participants filters throughout.[27]

Opportunities to review or challenge the outcomes of independent assessments

It is stated that "independent assessment results themselves will not be directly reviewable by the AAT".[28] Under the new approach, the independent assessment results will not be reviewable by the AAT as it is not a decision of the NDIA and disagreeing with a result, unless the assessment was not conducted in accordance with how the tool was supposed to be used, is not sufficient to fund another assessment.

As the plan and budget will seemingly be largely pre-determined by the outcome of the independent assessment report, if the resulting plan and funding does not reasonably meet a person's support needs, it is difficult to see that an internal review will yield a different result. And with the Administrative Appeals Tribunal (AAT) excluded from reviewing independent assessments there will be little scope for the AAT to change a decision.

This is deeply concerning as under the proposed arrangements participants will have little 'right to appeal' the outcome of an independent assessment, and with that denial of a fundamental human right afforded through the Universal Declaration of Human Rights[29].

Appendix 1: K Levels Classification

K0	Functional Level 0	The patient does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
K1	Functional Level 1	The patient has the ability or potential to use a prosthesis for transfer or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
K2	Functional Level 2	The patient has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
K3	Functional Level 3	The patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilisation beyond simple locomotion.
K4	Functional Level 4	The patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

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Australian Physiotherapists in Amputee Rehabilitation (AustPAR)
http://www.austpar.com/portals/gait/html/KClass.html

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