Counting What Matters:

Quality, Safety and Safeguarding in the NDIS

Published 11 November 2026

59
providers

67,715
participants

66,746
workers

63.9M
hours of direct NDIS support

ability roundtable

dsc

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Ability Roundtable is Australia's leading disability sector benchmarking and analytics platform, helping providers turn data into better decisions, stronger services and improved outcomes for people with disability.

Established in 2013, Ability Roundtable currently represents more than 115 NDIS registered providers with approximately $9.5 billion in revenue, supporting over 100,000 NDIS participants. Ability Roundtable provides organisations with access to analytics that aren't available through traditional reporting systems, through their growing suite of benchmarking programs: including Quality & Safety, Financial & Workforce, Home & Living, Allied Health and Employment Supports. By transforming organisational data into meaningful benchmarks and insights, Ability Roundtable enables leaders to understand how their performance compares with peers, identify opportunities for improvement and make evidence-based decisions.

The Roundtable also fosters innovation and service improvement through communities of practice, giving participating organisations the opportunity to share innovations and service improvements. Collection of granular data enables powerful and nuanced analysis of service performance. Aggregate information is also used to develop White Papers to help influence government policymakers' decisions in their roles as market stewards.

Ability Roundtable is recognised for its commitment to disability sector data insights, sector collaboration and independent, objective and practical analysis. It translates complex data into meaningful actions for boards, executives, quality teams and operational leaders. By participating in Ability Roundtable, providers become part of a community committed to learning from one another, improving quality and safety and building a stronger disability sector for the future.

DSC is Australia's leading independent NDIS education and information provider, supporting the disability sector through practical training, analysis and resources. Every week, DSC provides NDIS news, policy analysis and practical guidance to more than 100,000 people across the sector, including service providers, participants, advocates and government stakeholders. Alongside our national conference, consulting services and extensive training library, DSC works to help the sector understand change, strengthen practice and improve outcomes for people with disability.

Executive Summary

The Quality and Safety Benchmarking program was developed by the sector. Benchmarking involves comparing an organisation's performance, practices and outcomes against peers and established standards to identify strengths, gaps and opportunities for improvement. Rather than ranking providers, it creates a trusted environment for sharing data and learning from one another about what works and the associated costs.

NDIS providers have invested heavily in quality and safeguarding systems, generating substantial data on complaints, incidents, restrictive practices and worker safety. Yet much of this data is collected for compliance rather than to understand why problems occur, whether practice is improving or how participants experience their supports. The sector has become better at measuring harm than understanding impact.

Ability Roundtable's Quality and Safety Benchmarking program seeks to address this gap, using shared evidence to drive improvements in quality, safety and participant outcomes. In 2025, the program brought together 59 providers supporting 67,715 participants and employing 66,746 workers who delivered 63.9 million hours of direct NDIS support. It examined indicators across compliance and reporting, quality of service, health & wellbeing and worker safety.

The results highlight several important findings:

01 **Providers are investing heavily in quality and safeguarding.** Participating providers invested $71.1 million and 540 full-time-equivalent (FTE) positions in quality, safeguarding, clinical and practice functions. There was a relationship between higher expenditure on quality, safeguarding and clinical staff and higher rates of reportable incidents.

02 **Providers already collect extensive safeguarding data.** The benchmarking examined complaints, reportable incidents and regulated and unauthorised restrictive practices (URPs). Median reportable incident rates declined year on year, but considerable variation remains between providers. It is not yet clear to what extent lower rates reflect safer supports or differences in reporting practices and culture.

03 **Active Support and Frontline Practice Leadership are not yet consistently embedded.** While most providers had started implementing these approaches, only 22% reported that Active Support was embedded and regularly reviewed, compared with 17% for Frontline Practice Leadership. Providers reported investing $5.8 million in recruiting, training and implementing these approaches.

04 **More mature Active Support was associated with fewer reportable incidents.** Providers in the early stages of implementing Active Support recorded a median of 10.2 reportable incidents per 100,000 support hours. This fell to 8.4 among providers reporting full implementation and 7.5 where Active Support was embedded and regularly reviewed.

05 **Rights-based practices and participant involvement were associated with better safeguarding outcomes.** More mature supported decision-making frameworks and documented tenancy rights were associated with lower rates of URPs. Lower reportable incident rates were also associated with documented tenancy rights, stronger shared-home governance, participant involvement in decision-making and advisory committees. These relationships warrant further investigation.

06 **Unauthorised restrictive practices remain a significant safeguarding concern.** Chemical restraint remained the most commonly reported URP and the median rate increased year on year, despite being a regulatory focus for the NDIS Commission. The high number of URPs arising from expired behaviour support plans also warrants closer examination on how they can be prevented.

07 **High rates of polypharmacy and low rates of medication reviews raise questions about health oversight.** The median provider primarily delivering Supported Independent Living (SIL) reported polypharmacy among 26% of participants. Some providers reported rates above 70%, while the median proportion of total participants recorded as having received a medication review was only 2.3%. These findings raise important questions about how medication use is monitored and reviewed.

08 **Providers need to make better use of health and safeguarding data to prevent harm.** The benchmarking collected data on unplanned hospital admissions, healthcare plans, pressure injuries and medication errors. However, many providers were not yet able to bring this information together to identify recurring events, contributing factors or whether preventative action was effective.

09 **Measuring positive outcomes is the next challenge for the sector.** Providers have developed substantial capability in collecting compliance, incident and safeguarding data, alongside investing a further $24.7 million in staff education, training and professional development. There is an opportunity to apply the same rigour to understanding whether supports are improving people's participation, independence, choice, wellbeing and quality of life.

The benchmarking results tell a much richer story than simply whether providers are compliant. They point to emerging relationships between governance maturity, practice quality, clinical oversight and participant outcomes, while also highlighting the major challenge facing the sector: providers are generally much better at measuring harm than measuring impact.

There is a real opportunity to make better use of existing data and address gaps in how quality and outcomes are measured. For boards and leaders, this can provide a clearer picture of where risks are emerging, where improvements are needed and which practices are delivering positive results.

Background

The NDIS Quality and Safeguarding Framework, established in 2016, is the underpinning policy framework for regulation and quality of NDIS services. It recognises that safeguarding requires more than responding to harm. It also depends on preventative and developmental approaches that strengthen the capability of participants, workers and providers to uphold rights, reduce risks and prevent harm. Yet the early years of NDIS regulation have largely focused providers' attention on compliance, reporting and audit requirements. While providers have invested heavily in meeting these obligations, less attention has been given to using the data to understand performance, improve practice and prevent harm.

Nearly a decade later, there is an opportunity to shift this focus. Incident, complaint and restrictive practice data can help providers identify patterns, understand risks and take preventative action. The NDIS Commission is already investing in analytics to identify systemic risks and respond earlier to serious non-compliance. Providers have an opportunity to do the same. Benchmarking allows providers to compare their results with similar organisations and help identify areas for further investigation and improvement.

The regulatory environment is also shifting toward greater emphasis on quality. The new Supported Independent Living (SIL) Practice Standards, which commenced 1 July 2026, focus on participant rights, supported decision-making, workforce capability and evidence-based practice. The broader NDIS Practice Standards review is also considering a more participant-centred and outcomes-focused approach.

At the same time, the *National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Act 2026* has strengthened the NDIS Commission's powers and introduced substantial penalties for serious contraventions, including significant failures to comply and systemic patterns of conduct. This reinforces the importance of identifying and addressing recurring problems before they lead to serious harm.

The cost of delivering quality supports is also receiving greater attention. The NDIA's Quality Supports Program and 2026-27 Annual Pricing Reviews are examining the costs of service delivery and registration, including workforce capability, supervision and operational overheads. Questions remain about whether existing pricing adequately recognises the investment required to implement and sustain evidence-informed practice. Benchmarking can contribute to this discussion by providing evidence of what providers are investing in quality and safeguarding.

Together, these developments strengthen the case for more systematic measurement of quality. Provider-led benchmarking can help organisations understand their performance, identify gaps and make more informed decisions about where to invest in improving practice and participant outcomes.

How the benchmarking was established

Beginning in May 2025, a six-month pilot was co-designed with 39 providers representing more than 60,000 participants, alongside sector experts and policymakers. The pilot demonstrated that sector-wide quality benchmarking was both feasible and valuable.

The framework was then refined through ongoing member consultation and structured around three pillars:

01

Quality and safeguarding - reporting and compliance:

Regulatory and safeguarding measures, including reportable incidents, complaints, restrictive practices and provider investment in quality and safeguarding staff.

02

Quality of service, health and wellbeing:

Indicators of good practice and participant outcomes, informed by research, sector consultation and lived experience. The pilot initially examined whether providers could collect these measures, creating a foundation for future quantitative benchmarking.

03

Worker safety:

Work health and safety measures including staff injury, hazards, workers compensation and investment in training and development.

In April 2026, the program was rolled out nationally, with 59 providers participating. This provided a stronger basis for comparing performance, identifying emerging trends and sharing learnings across the sector.

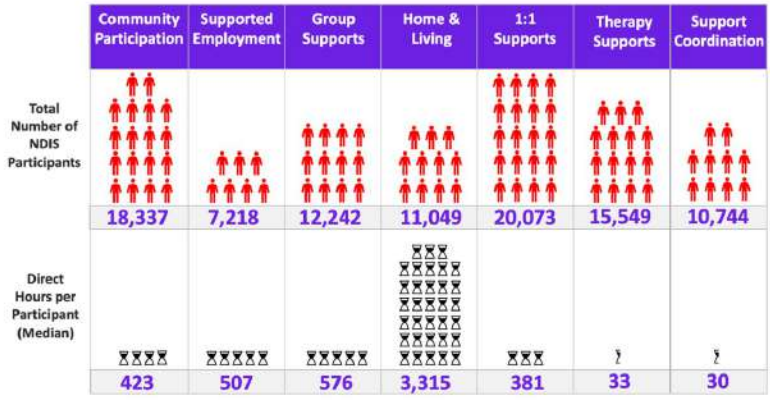
> **The Ability Roundtable Quality and Safeguards benchmarking data set has provided us with national insights into like organisations, something that hasn't been previously available. These insights have assisted us to have more meaningful conversations with all levels of our organisation about what could be done differently or better, and where we are performing well in the safeguarding space. The benchmarking offers a collegiate process to inform a national data set and inform change."**
>
> **Amelia Rowell**
> Group General Manager Practice Governance and Quality, CPL

Who participated in the benchmarking?

The benchmarking captured data for the 2025 calendar year and included 59 providers supporting 67,715 participants and employing 66,746 workers. Together, they delivered 63.9 million hours of direct NDIS support. Participating organisations varied considerably in size, with annual revenue ranging from around $5M in turnover to Australia's largest NDIS providers.

When looking at participants by service use, the largest proportion of participants received one-to-one support and community participation. Home and living accounted for the largest proportion of direct support hours.





Some metrics in this report compare CY24 and CY25 results. These comparisons are based on the full dataset for each year, rather than a matched cohort of providers that participated across both years.

Quality and Safeguarding - Reporting and Compliance

Reportable Incidents

Median rate of reportable incidents was 26% lower in the 2025 calendar year compared with 2024.

10.7
is the median number of reportable incidents per 100,000 direct support hours in 2024

7.9
is the median number of reportable incidents per 100,000 direct support hours in 2025

1.06
reportable incidents for every 10 participants (median provider)

The median provider recorded 1.06 reportable incidents for every 10 participants during 2025.

When adjusted for the amount of support delivered, the median number of reportable incidents was 7.9 per 100,000 direct support hours down from 10.7 in 2024.

However, incident rates varied considerably by service type and organisation size.

Differences by service type

Providers primarily delivering Supported Independent Living (SIL) recorded a median of 10.2 reportable incidents per 100,000 direct support hours. This is more than twice the median of 4.3 among providers delivering other service mixes.

Differences by organisation size

Larger organisations also recorded higher incident rates, with a median of 13.8 incidents per 100,000 direct support hours, compared with a median of 5.0 incidents in small organisations.

For this analysis, provider size was classified by annual revenue:

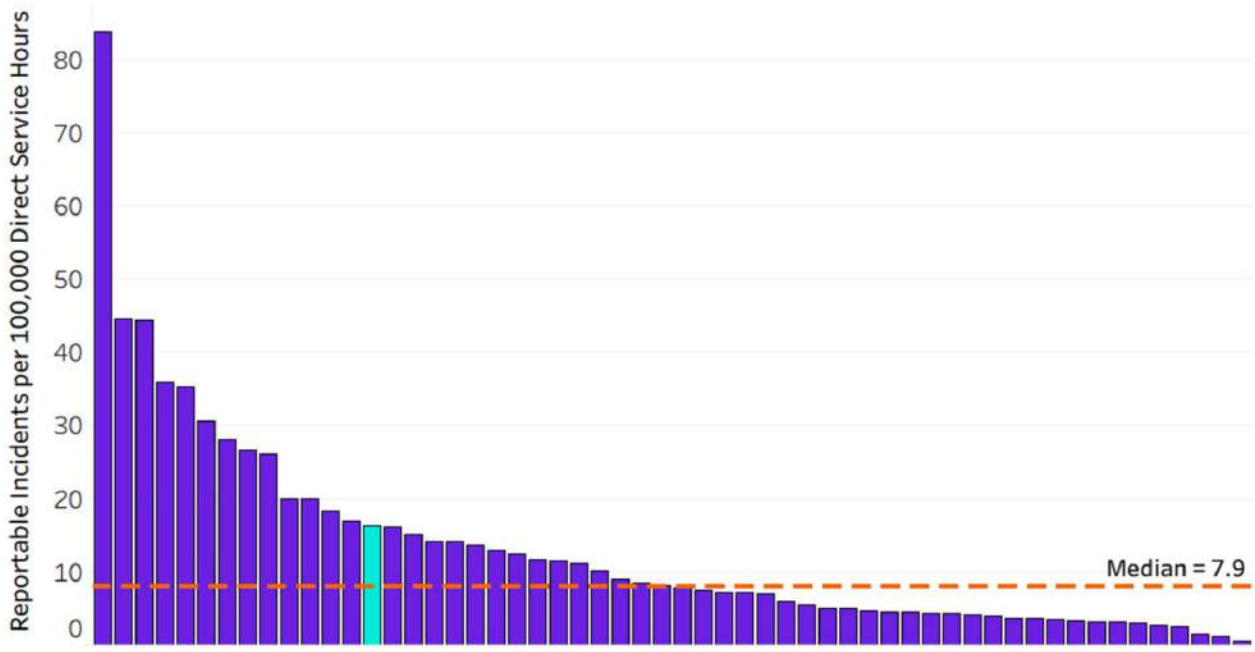
SMALL:
Less than $50 million

MEDIUM:
$50-100 million

LARGE:
$100 million +

These findings do not necessarily indicate that SIL services or larger organisations are less safe. Higher rates may reflect the greater complexity and intensity of support delivered in SIL, as well as the concentration of SIL and high-intensity services among larger providers. Differences in incident identification and reporting practices may also contribute, with more established reporting systems potentially capturing incidents that might otherwise go unreported.

Benchmarking organisations receive personalised reports to show where they sit in comparison to their peers.



When unauthorised restrictive practices (URPs), which account for the majority of reportable incidents, are excluded, the most common reportable incident was serious injury, followed by neglect, then abuse.

Regulated Restrictive Practices

5.1% The total proportion of participants subject to regulated restrictive practice

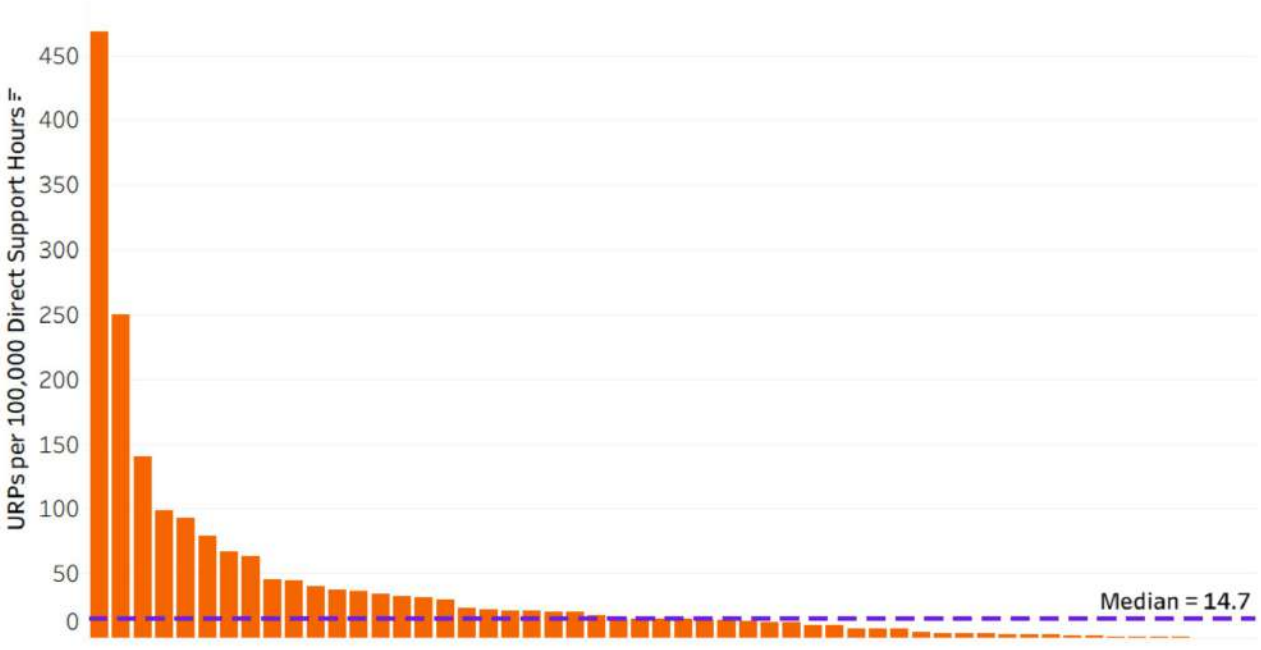
Higher in 2025
median number of URPs, compared to 2024

Chemical restraint
is the most commonly used URP

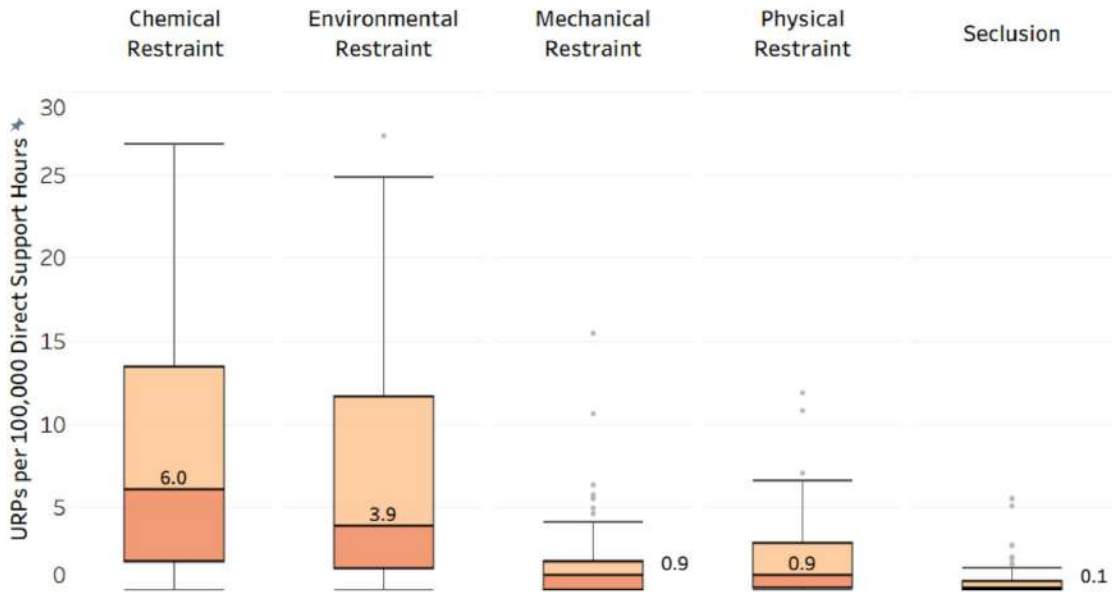
60%
of URPs are due to an expired behaviour support plan

Across the benchmarking group, 5.1% of all participants were subject to a regulated restrictive practice. However, rates varied considerably between providers, with a median of 3.8%. Medium-sized providers, with annual revenue between $50 million and $100 million, recorded the highest median at 11.1%.

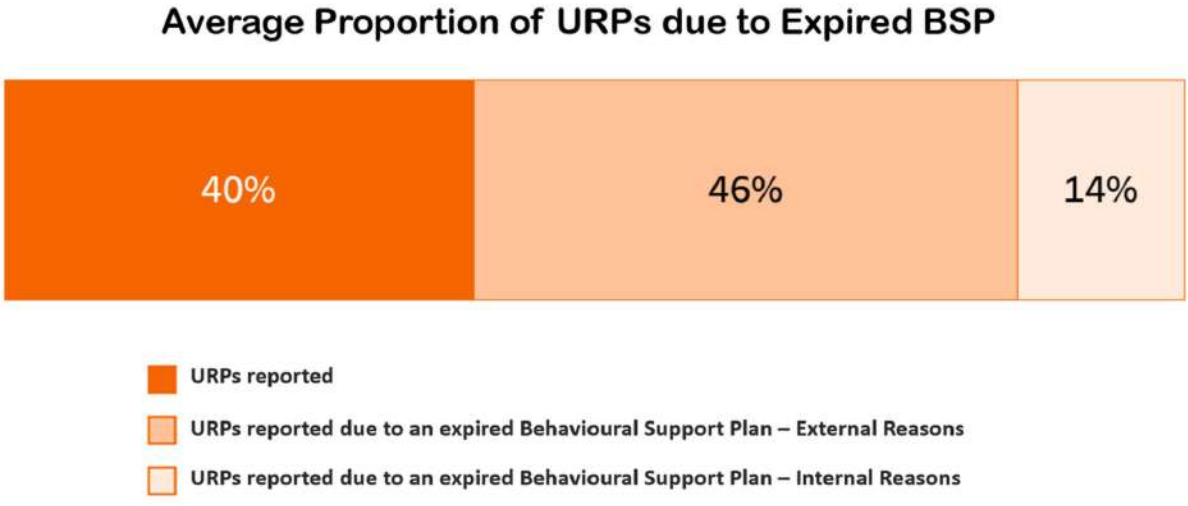
The median provider reported approximately 17 unauthorised restrictive practices (URPs) for every 100 participants in 2025. When adjusted for the amount of support delivered, the median was 14.7 URPs per 100,000 direct support hours, up from 13.1 in 2024. Large providers, with annual revenue above $100 million, recorded a higher median of 23.2 URPs per 100,000 direct support hours.



Chemical restraint was the most commonly reported URP, followed by environmental restraint. The median rate of unauthorised chemical restraint increased from 4.6 per 100,000 direct support hours in 2024 to 6.



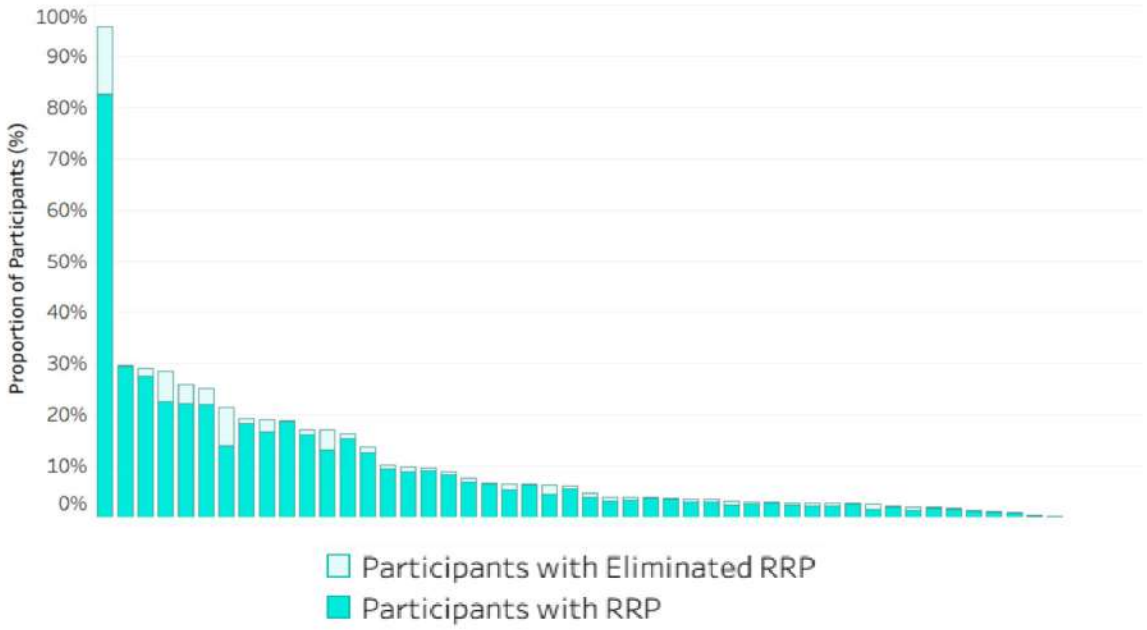
A significant proportion of URPs were associated with expired Behaviour Support Plans (BSPs). Around 60% of reported URPs were attributed to expired BSPs, with 46% attributed to external factors such as tribunal decisions, guardianship delays or delays in approval by a behaviour support practitioner. Only 14% were attributed to internal provider factors.



This may help explain why the number of URPs reported is relatively high compared with the proportion of participants subject to restrictive practices. For example, where medication is administered three times daily without the required authorisation, a provider may report 21 URPs per week for a single participant.

When URPs that would otherwise have been authorised under a current BSP are excluded, the median rate falls substantially, from 14.7 to 3.7 URPs per 100,000 direct support hours.

For the first time, the benchmarking also captured data on the elimination of restrictive practices through fade-out techniques. Approximately 0.8% of participants had at least one restrictive practice reported as eliminated, while 0.1% had a restrictive practice replaced by another restrictive practice.



High Intensity Funding

More than half of participants who reportedly meet the threshold for high intensity funding were not funded at that level.

14%

of participants met the high intensity eligibility criteria

6%

were funded at that level

The NDIA's 25-26 Pricing Arrangements define who can claim the higher intensity rate for support. It says higher-intensity prices may be claimed when a participant requires a support described in the High Intensity Daily Personal Activity (HIDPA) in Module 1 of the NDIS Practice Standards or meets the requirements for Intensive and Complex Behaviour Supports set out in the NDIS pricing arrangements.

Providers were asked to report how many participants they believed met the High Intensity Daily Personal Activities (HIDPA) criteria and how many were funded at the higher rate. Providers reported that a median of 14% of participants met the criteria, while only 6% were funded at the higher rate.

For providers who primarily deliver SIL, there was an average of 20.7% of participants who met the HIDPA criteria, but only an average of 8.8% were funded at that level.

Among providers with other service mixes, an average of 4% of participants were reported as meeting the criteria, yet only 1.7% were funded.

Safeguarding, Compliance and Clinical Practice Workforce

$71M
expenditure on quality and safeguarding

540
FTEs

$230,000
Small providers (median)

$762,000
Medium providers (median)

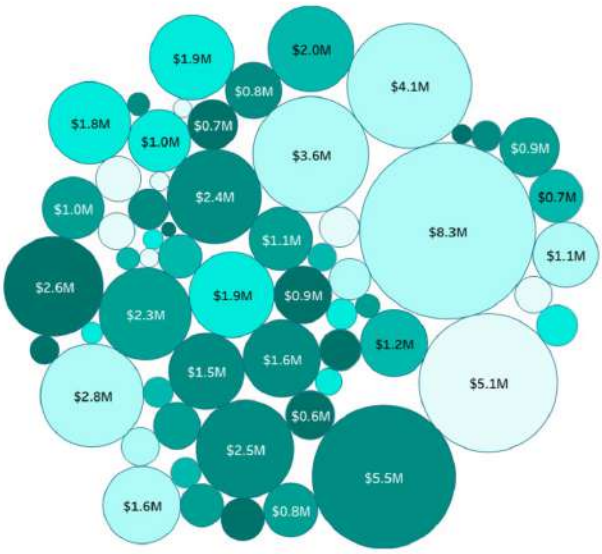
$2.17m
Large providers (median)

Providers reported the cost and size of their dedicated corporate or indirect teams with quality, safeguarding and clinical practice functions. This included:

- Quality, safeguarding, compliance, reporting, internal audit and investigation teams
- Audit and provider registration costs
- Clinical governance, nursing advisory and practice development teams
- Salaries, management costs, administrative overheads and workers compensation premiums associated with these functions

It excluded clinicians, therapists and other operational staff delivering direct services, even where compliance activities formed part of their usual role.

Across participating providers, these functions accounted for 540 FTE and $71.1 million in expenditure. The graph below provides a representation of the varying investment in quality, safeguarding and practice across participating members.



Investment in dedicated quality and practice teams

For every hour of support delivered, the median provider invested $1.04 in dedicated quality, safeguarding, compliance and clinical practice functions.

This was equivalent to a median of:

- 0.8 dedicated FTE for every 100,000 direct support hours
- $787 incurred cost per participant for every 100,000 direct support hours

For example:

> A provider delivering 500,000 hours of direct support each year would typically invest approximately $520,000 and employ around four dedicated quality, safeguarding or practice staff.

The median number of dedicated quality, safeguarding and clinical practice staff increased with organisation size:

SMALL PROVIDERS:	MEDIUM PROVIDERS:	LARGE PROVIDERS:
2 FTEs	**5.8 FTEs**	**17.4 FTEs**

There was considerable variation within each size group, particularly among large providers, with the range running from three to over 47 FTEs.

When staffing was normalised against the amount of support delivered, the differences were much smaller:

SMALL PROVIDERS:
0.8 FTE
per 100,000 support hours

MEDIUM PROVIDERS:
0.8 FTE
per 100,000 support hours

LARGE PROVIDERS:
1.0 FTE
per 100,000 support hours

This suggests larger providers have bigger teams primarily because they deliver more support, rather than because they employ substantially more quality and practice staff relative to their service volume.

Unsurprisingly, larger organisations spent more overall on dedicated quality, safeguarding and clinical practice functions:

SMALL PROVIDERS:
median of
$230,000

MEDIUM PROVIDERS:
median of
$762,000

LARGE PROVIDERS:
median of
$2.17m

After adjusting for the amount of support delivered, expenditure still increased with organisation size:

SMALL PROVIDERS:
83 cents
per support hour

MEDIUM PROVIDERS:
$1.02
per support hour

LARGE PROVIDERS:
$1.28
per support hour

> **"The Ability Roundtable Quality and Safety Benchmarking data has added real value to our understanding of quality and safeguarding pressures across the sector. The insights enable meaningful comparison and greater transparency around compliance effort and cost. It is a practical evidence base for informed decision-making and advocacy."**
>
> **Debra Benger**
> Chief Quality Safeguarding & Practice Officer, Scope Aust.

Quality of Service, Health and Wellbeing

The benchmarking examined practice elements and inclusive practices, looking at how effectively organisations embed rights-based and person-centred approaches in everyday support.

The framework explores areas such as:

Person-centred practice,
including Active Support and Frontline Practice Leadership.

Choice and control,
including how people with disability participate in decisions about their lives and supports.

Community inclusion and participation,
including opportunities for meaningful relationships and social connection.

Rights-based practice,
including respect for participants' dignity, autonomy and human rights.

Supported decision-making,
promoting independence and self-determination.

Positive behaviour support,
including proactive and evidence-informed approaches.

Cultural responsiveness and inclusion,
recognising and respecting participant diversity.

Inclusive governance,
including representation of people with disability on boards.

Together, these indicators help providers understand the organisational practices that influence service quality and explore how they relate to safeguarding outcomes.

Active Support and Frontline Practice Leadership

46%

of providers reported fully implementing or embedding and reviewing Active Support

37%

reported fully implementing or embedding and reviewing Frontline Practice Leadership

This correlated with lower reportable incidents.

As part of its Own Motion Inquiry into supported accommodation, the NDIS Commission commissioned La Trobe University's Living with Disability Research Centre to review the evidence about best practice. This work produced a literature review identifying the organisational and frontline practices associated with better quality support in supported accommodation. A central element of best practice in supporting people with intellectual disability in shared living is Active Support, which enables people to engage in meaningful activities and relationships. Frontline Practice Leadership supports its consistent implementation by focusing staff on participants' quality of life, organising staff effectively, observing and coaching practice and providing regular supervision and team meetings.

Drawing on this commissioned research and its detailed examination of provider incidents, the NDIS Commission's Own Motion Inquiry found a compelling case for mandating key elements of the review, particularly Active Support and Frontline Practice Leadership. The benchmarking therefore examined how widely providers had implemented these approaches, how deeply they were embedded in everyday service delivery and whether greater practice maturity was associated with differences in incidents and other safeguarding measures.

Providers were asked to assess the implementation of key inclusive practices using the following classifications:

Not in place

The practice element has not been introduced or implemented within your organisation

In development or early implementation

The practice element is being developed, piloted, or is in the early stages of rollout across your organisation.

Fully implemented

The practice element has been implemented across relevant areas of your organisation but is not scheduled for regular review or assessment.

Embedded and regularly reviewed

the practice element is fully integrated into everyday operations and is subject to regular monitoring, review and continuous improvement.

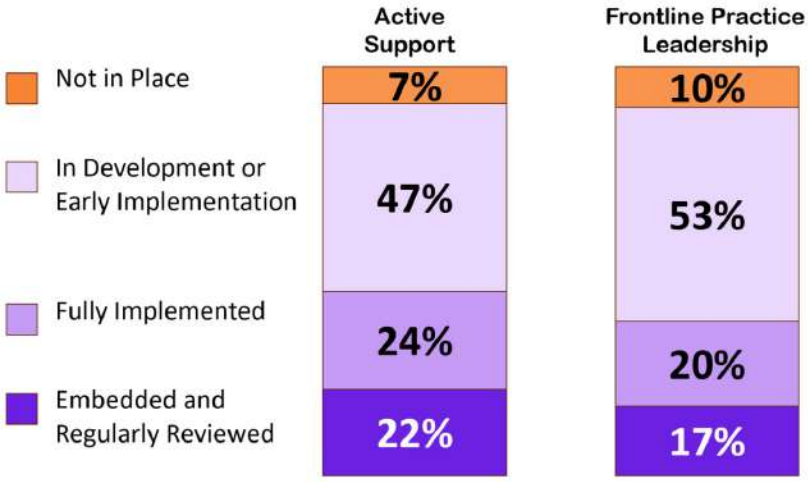
Most participating providers reported that they had begun implementing Active Support and Frontline Practice Leadership, although maturity varied considerably.

Active Support

- 7% had not introduced it
- 47% were developing or beginning implementation
- 24% had fully implemented it
- 22% had embedded it and regularly reviewed its effectiveness

Frontline Practice Leadership

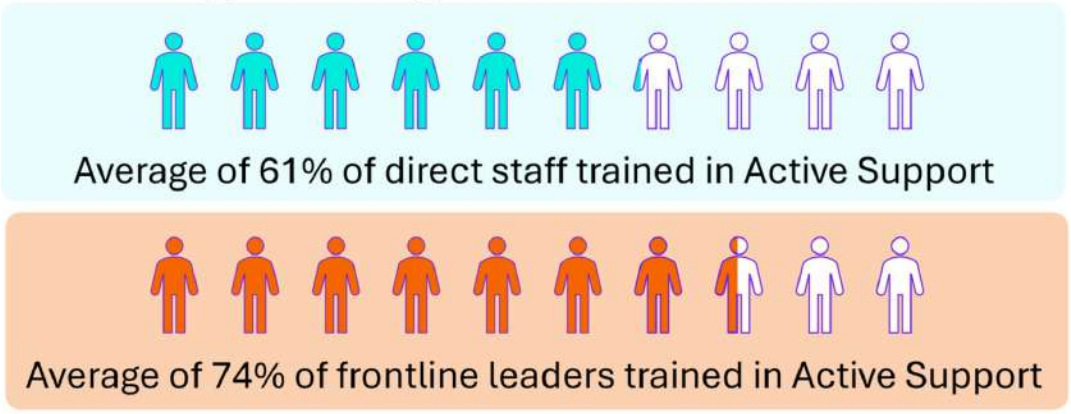
- 10% had not introduced it
- 53% were developing or beginning implementation
- 20% had fully implemented it
- 17% had embedded it and regularly reviewed its effectiveness



Overall, 46% of providers reported fully implementing or embedding Active Support, compared with 37% for Frontline Practice Leadership. The findings suggest that these approaches are widely recognised across the participating providers, but many organisations are still working to translate them into consistent, sustained everyday practice.

61% of direct staff and 74% of frontline leaders have been trained in Active Support. This may indicate some providers are reasonably prepared for the new SIL NDIS Practice Standards introduced in July 2026, which require staff to be trained and assessed as competent in delivering these types of evidence-based supports.

Active Support Training - Direct Staff and Frontline Leaders



Greater maturity in Active Support correlated with fewer reportable incidents:

IN DEVELOPMENT OR EARLY IMPLEMENTATION:
10.2
reportable incidents per 100,000 support hours

FULLY IMPLEMENTED:
8.4
reportable incidents per 100,000 support hours

EMBEDDED AND REGULARLY REVIEWED:
7.5
reportable incidents per 100,000 support hours

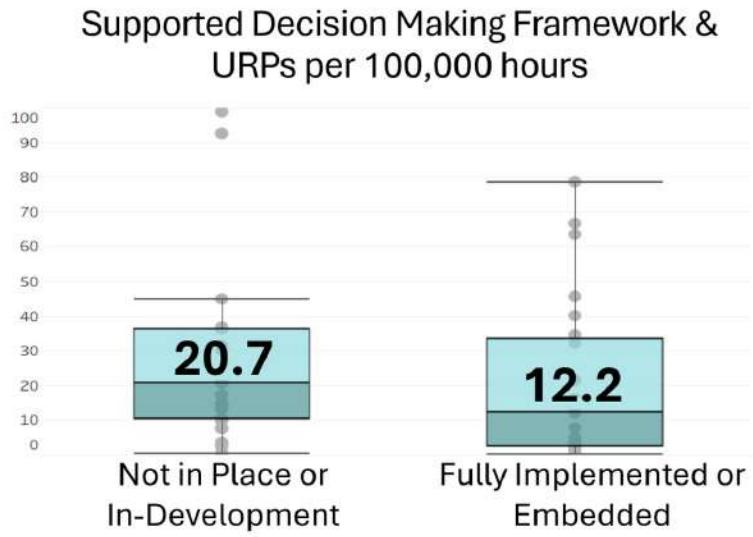
Providers reporting embedded Active Support had a median incident rate approximately 26% lower than those in the early stages of implementation.

Practice Elements

Providers with more mature governance and practice frameworks were associated with fewer reportable incidents and URPs.

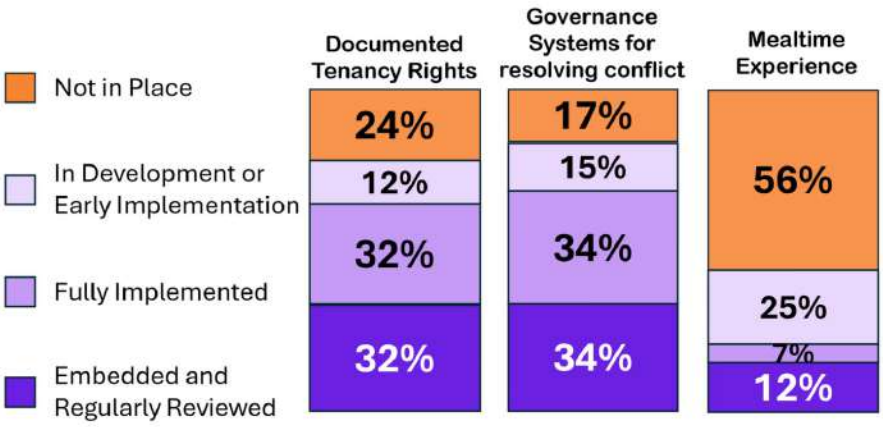
One of the strongest findings from the benchmarking is the relationship between established good practice elements and lower recorded rates of reportable incidents and unauthorised restrictive practices. While these results do not establish causation, several statistically significant associations emerged across different areas of practice.

More mature supported decision-making practices and organisational practice frameworks were associated with lower rates of unauthorised restrictive practices. A practice framework translates an organisation's purpose, values, evidence, participant rights and regulatory obligations into clear expectations for how people are supported in practice.



Documented tenancy rights were associated with lower rates of both unauthorised restrictive practices and reportable incidents. Providers also recorded lower reportable incident rates where they had more established systems for resolving conflict between participants living in shared homes, greater participant involvement in decision-making and established Client Advisory Committees.

Not all areas of practice were as well developed. More than half of providers reported having no system to measure satisfaction with mealtime support.



Together, these findings highlight the importance of looking beyond compliance measures to understand how rights-based practice and participant involvement relate to safeguarding outcomes. They also identify areas where providers have opportunities to strengthen their approach.

Inclusive Practices

62%
of organisations have a board member with disability

13%
is the median proportion of board members living with disability

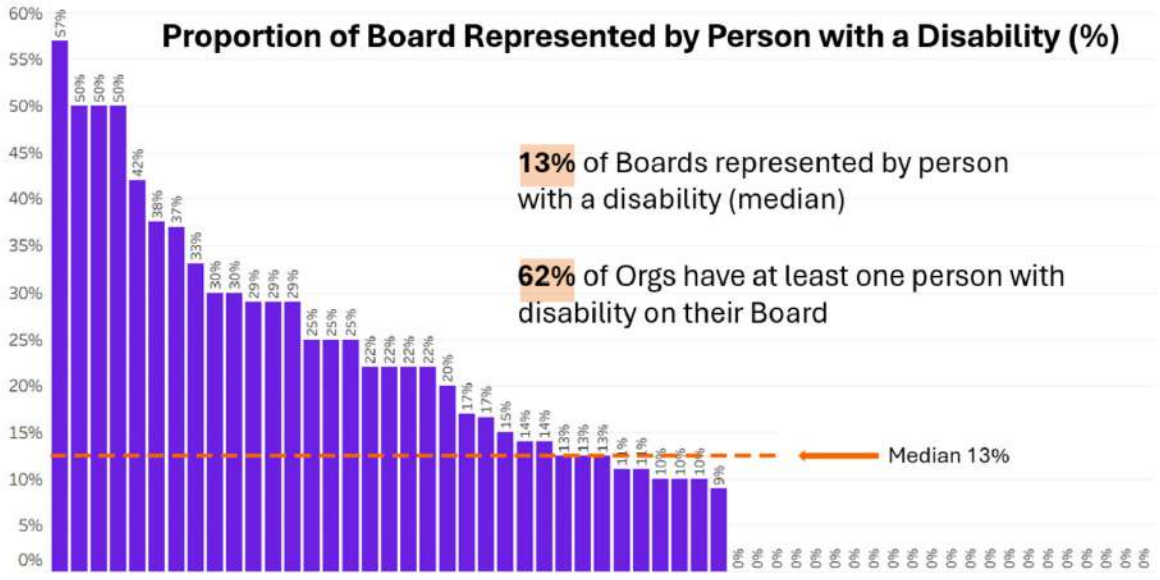
62%
have a Client Advisory Committee fully implemented or embedded and regularly reviewed, which was correlated with lower median reportable incident rates.

12%
make audit results accessible

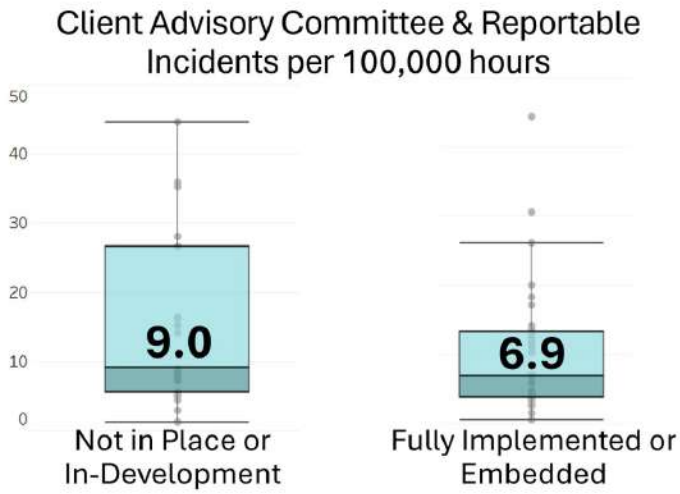
75%
have a satisfaction survey

Three-quarters of providers reported having a participant satisfaction survey in place, with most others developing or beginning to implement one.

Participant representation was evident at board level, with 62% of organisations having at least one board member with disability. However, people with disability only made up 13% of total board membership (median).



62% had a Client Advisory Committee fully implemented or embedded and regularly reviewed. Providers with fully implemented or embedded committees recorded a median of 6.9 reportable incidents per 100,000 support hours, compared with 9 among providers without a committee or still developing one. This relationship was statistically significant, although it doesn't show causation.



Only 12% of providers made their audit results accessible to participants.



Polypharmacy

23%
is the median proportion of participants subject to polypharmacy

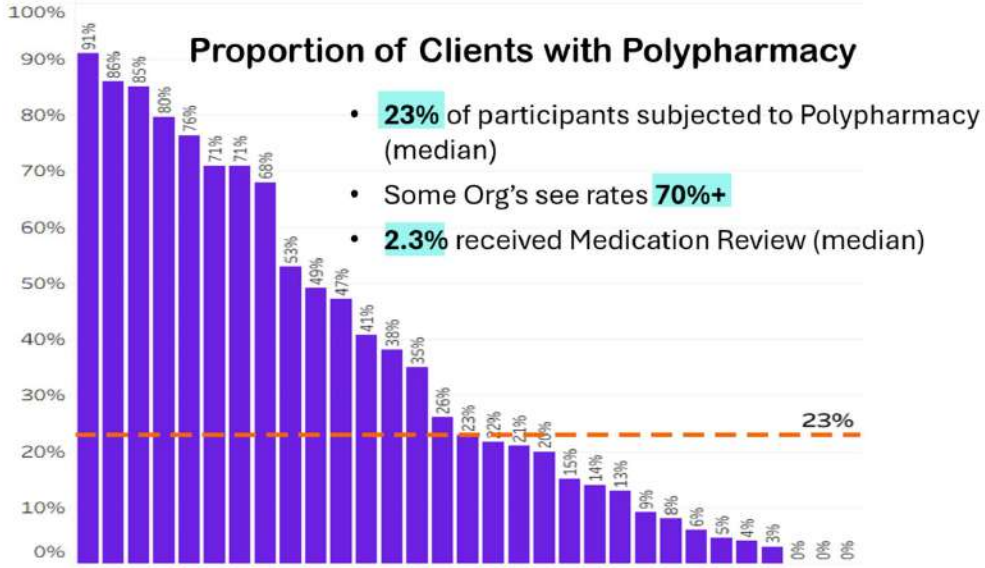
26%
is the median proportion of participants in SIL subject to polypharmacy

2.3%
is the median proportion who received a medication review recorded by the provider in the past 12 months

Polypharmacy is the concurrent use of multiple medications (often defined as five or more medications) to treat one condition or multiple concurrent conditions. It includes the use of all prescription medicines, over-the-counter medicines and complementary medicines.

Polypharmacy use is significantly higher in people with disability. This is partly because people with a disability are more likely to have multiple health conditions, such as epilepsy, diabetes, stroke, heart problems, high blood pressure and arthritis compared to the general population.

The NDIS Quality and Safeguards Commission issued a practice alert on polypharmacy in 2020. It recommended that participants who take multiple medications should have their medicines regularly reviewed to reduce the risk of adverse effects. A medical practitioner or pharmacist should review medications every 3 to 6 months and participants taking five or more medicines (or two or more antipsychotics) should be referred for a Home Medicines Review (HMR) with a pharmacist.



Providers reported a median of 23% of participants experiencing polypharmacy, with higher rates among organisations primarily delivering Supported Independent Living (SIL). Some providers reported rates as high as 70–90%.

Despite these high rates and the NDIS Commission's practice alert recommending regular medication reviews, the median proportion of participants reported as having received a medication review in the past 12 months was just 2.3%. This figure covers all participants in the benchmarking sample, not only those experiencing polypharmacy. It also only captures medication reviews recorded by providers, so the actual rate of medication review may be higher.

Client Health Related Indicators

For organisations that primarily deliver SIL:

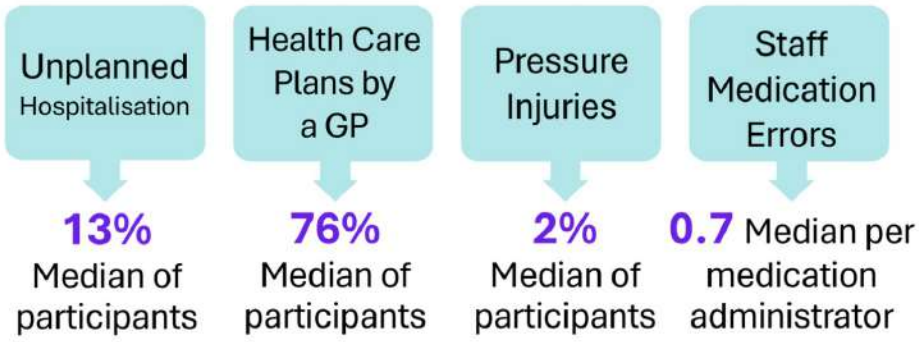
13%
is the median of participants in SIL who had at least one unplanned hospital visit.

Less than 1
staff-related medication error per medication administrator in 2025

76%
of all participants in SIL had a healthcare plan

Research has found that people using disability services in Australia have a mortality rate of 4.7 times the general population. An AIHW study conducted between 2013-2018 found the rate of potentially avoidable deaths was 3.6 times as high for service users compared with the general population.

Among providers primarily delivering Supported Independent Living (SIL), the median proportion of participants who had at least one unplanned hospital admission or presentation was 13%. The median proportion of participants with a healthcare plan authorised by a GP was 76%, while 2% experienced at least one pressure injury. Providers also reported a median of 0.7 staff-related medication errors per medication administrator during the reporting period.



These figures provide a starting point, but they also raise questions about how well providers can bring health information together and use it to guide practice. An organisation may record individual hospital admissions, medication errors or pressure injuries without being able to identify repeated events, contributing factors or trends across services. Strengthening this capability would help providers understand where health risks are concentrated, take preventative action and assess whether changes in practice are improving health outcomes.

Worker Safety

Worker safety is a critical component of quality service delivery. A safe, supported and capable workforce is better positioned to provide consistent, person-centred support, maintain positive relationships with participants and respond effectively to risks and incidents. For disability service providers, workforce safety and client quality are intrinsically linked. When workers feel safe, supported and well-trained, organisations typically experience lower turnover, increased engagement and reduced risk of service disruptions. Conversely, high rates of injury, violence, burnout or workforce instability can affect service quality, participant outcomes and organisational sustainability.

The benchmarking program includes a range of workforce safety indicators that enable organisations to understand their safety performance, compare results with peers, and identify opportunities for improvement. The data interrogates workplace injury rates, workers compensation claims and training compliance. Benchmarking these measures in the same program enables organisations to identify opportunities to strengthen both employee wellbeing and client outcomes.

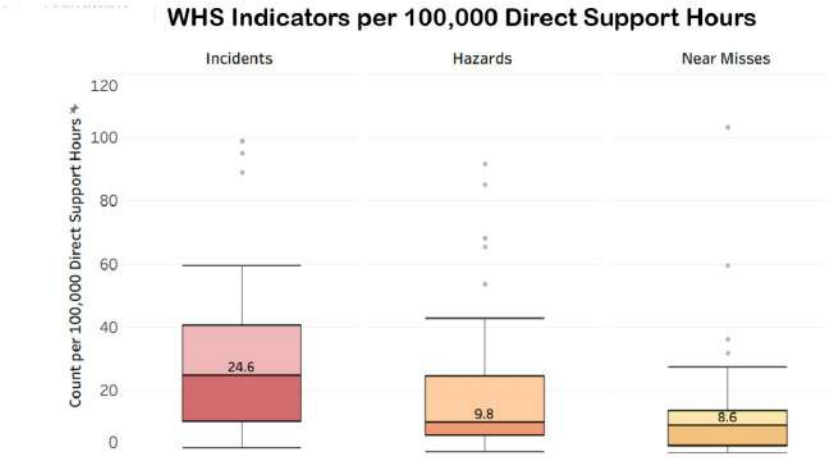
Work Health and Safety Incidents

25.3
WHS incidents for every 100 participants

Occupational violence
the most frequent incident type

97%
of injured workers return to work

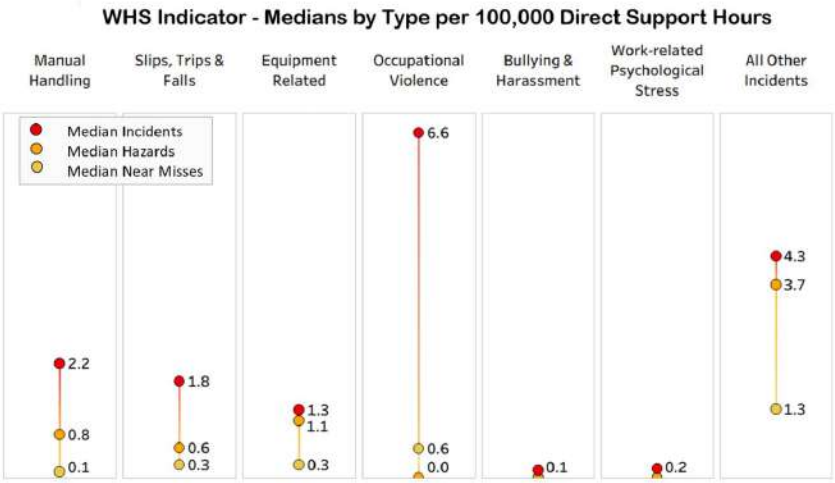
Work health and safety (WHS) incidents varied considerably across participating providers. The median provider recorded 24.6 WHS incidents per 100,000 direct support hours or approximately 25 incidents for every 100 participants. There was no clear relationship between incident rates and organisation size, though medium-sized providers did report the highest.



Occupational violence was the largest identified incident category, with a median of 6.6 incidents per 100,000 support hours. This was followed by manual handling, slips, trips and falls and equipment-related incidents. Bullying, harassment and psychological stress made up just 0.3 of the incidents combined per 100,000 hours.

Providers reported considerably more incidents than hazards or near misses. For every 100,000 support hours, the median provider recorded 24.6 incidents, compared with 9.8 hazards and 8.6 near misses. This may indicate that providers have stronger systems for recording events after harm occurs than for identifying and reporting early warning signs. However, differences in definitions, reporting systems and reporting culture may also contribute.

Incident and hazard rates were lower than in the previous benchmarking period, while near-miss reporting increased.

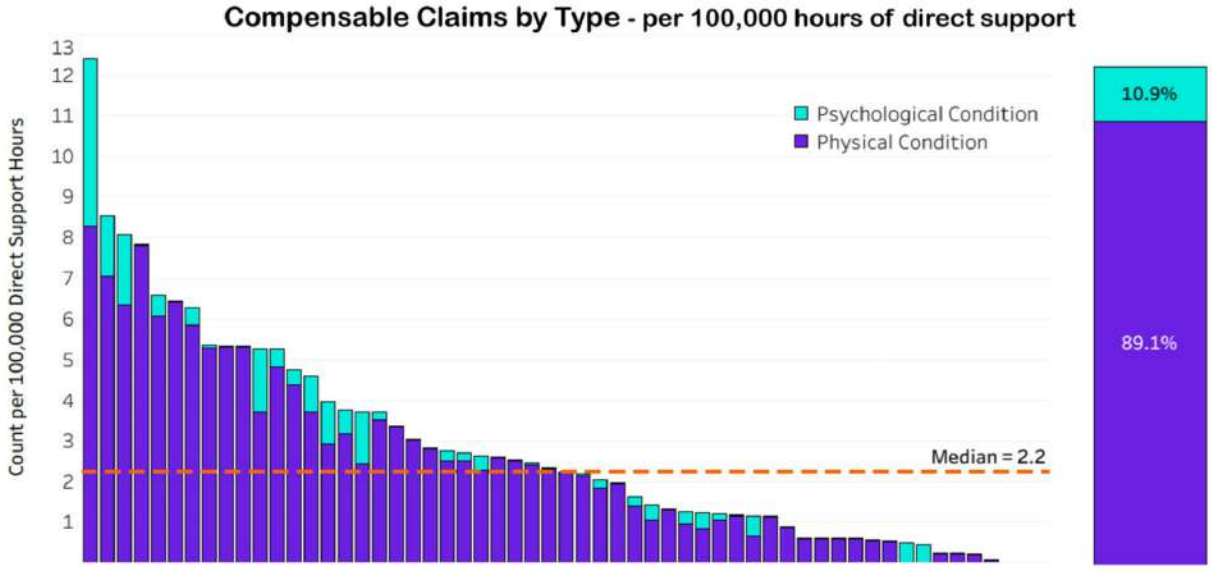


Workers Compensation Claims

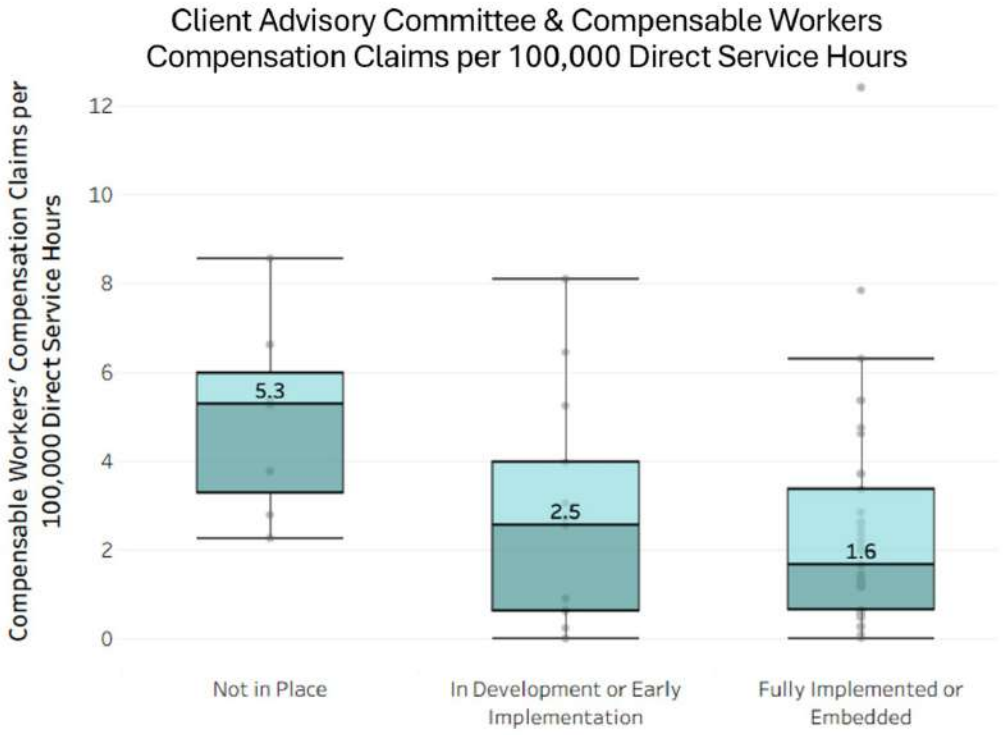
The median rate of workers compensation claims received fell from 3.1 per 100,000 direct support hours in 2024 to 2.5 in 2025. Compensable claims remained relatively stable, with a median of 2.2 per 100,000 direct support hours in 2025.



Nearly ninety percent (89.1%) of compensable claims related to physical injuries or conditions, with the remaining attributed to psychological harm. Though in some organisations psychological claims accounted for a comparatively high proportion.



Unsurprisingly, higher rates of reportable incidents and complaints correlate with higher compensable workers' compensation claims. However, Ability Roundtable also interrogated whether any practices correlated with lower workers compensation claim rates. Organisations which had fully implemented or embedded a Client Advisory Committee into the decision making of their organisation, had a statistically significant relationship with lower compensable workers' compensation claims.

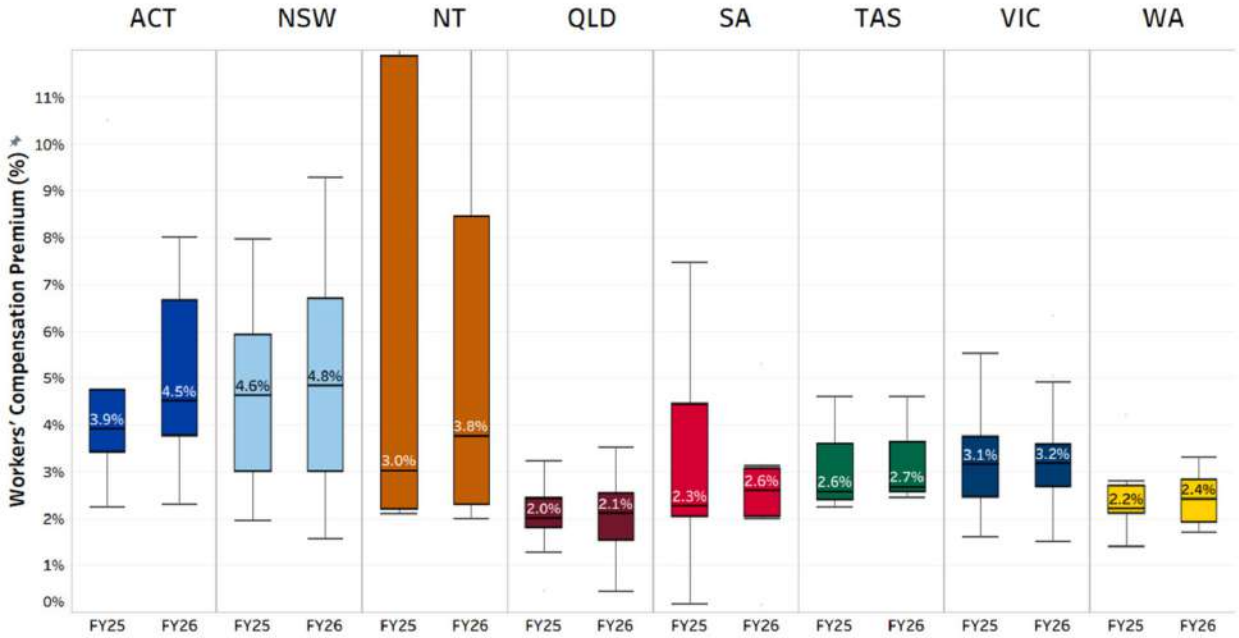


Workers Compensation Premiums

The NDIS Disability Support Worker Cost Model is the NDIA's pricing model used to estimate the reasonable costs of employing disability support workers and, in turn, inform the price limits for many NDIS supports. Historically this model calculated a workers compensation allowance of 2% of direct costs. This is now incorporated into operational overheads, making it less transparent how much funding is allocated to workers compensation.

Benchmarking data shows that median workers compensation premiums exceeded the historical 2% allowance in almost every jurisdiction and increased between 2024–25 and 2025–26. NSW recorded the highest median premium at 4.8%, followed closely by the ACT. Some providers in the Northern Territory also reported particularly high premiums.

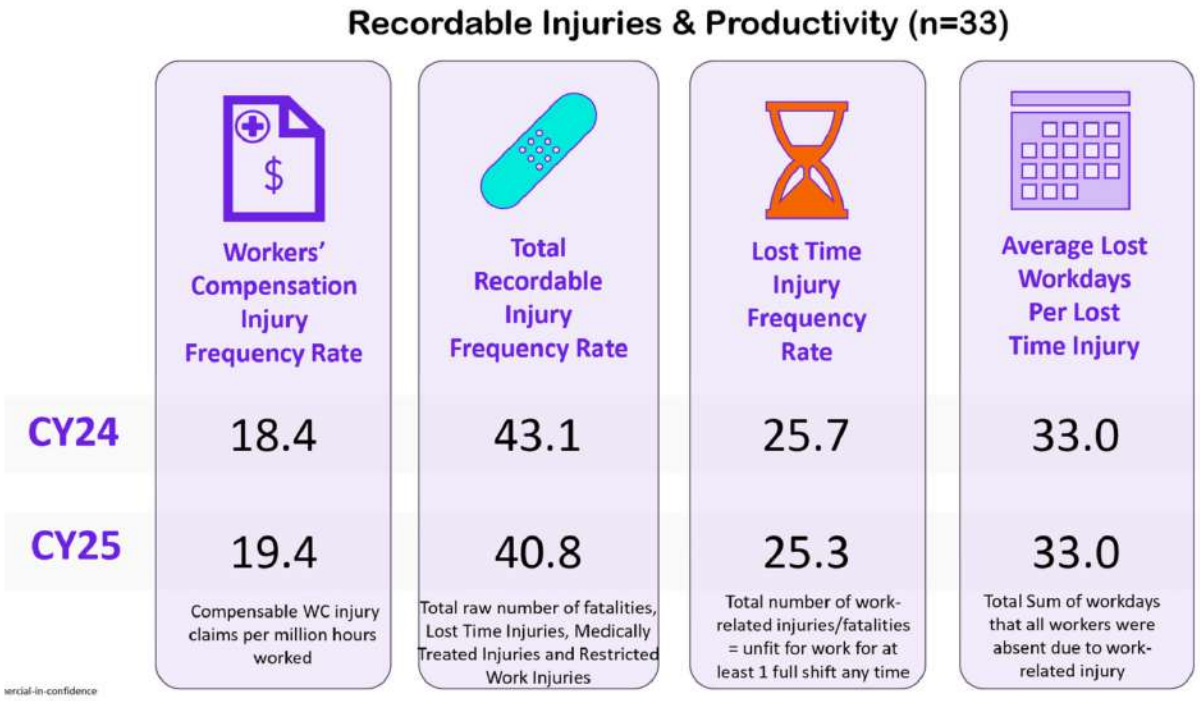
These findings raise questions about whether current NDIS pricing adequately reflects the workers compensation costs faced by disability providers, particularly in higher-cost jurisdictions.



Recordable Injuries and Productivity

The benchmark tracks key workplace injury and productivity indicators to help organisations understand workforce safety performance and the operational impact of workplace injuries. Results from the 33 organisations that reported in both 2024 and 2025 show a mixed but generally stable performance profile:

- **Workers' compensation injury frequency rate** increased from **18.4 to 19.4** compensable workers' compensation claims per million hours worked.
- **Total recordable injury frequency rate (TRIFR)** decreased from **43.1 to 40.8**, indicating fewer overall recordable workplace injuries per million hours worked.
- **Lost time injury frequency rate (LTIFR)** decreased slightly from **25.7 to 25.3**, suggesting a modest reduction in injuries that prevented workers from performing at least one full shift.
- **Average lost workdays per lost time injury** remained stable at **33 days**, indicating that while injury frequency improved, the severity and recovery duration of injuries did not materially change.



Recordable injury and productivity metrics provide important insight into the health, safety and resilience of the workforce. They help organisations move beyond simple incident counts and understand both the frequency and impact of workplace injuries.

Return to Work Outcomes

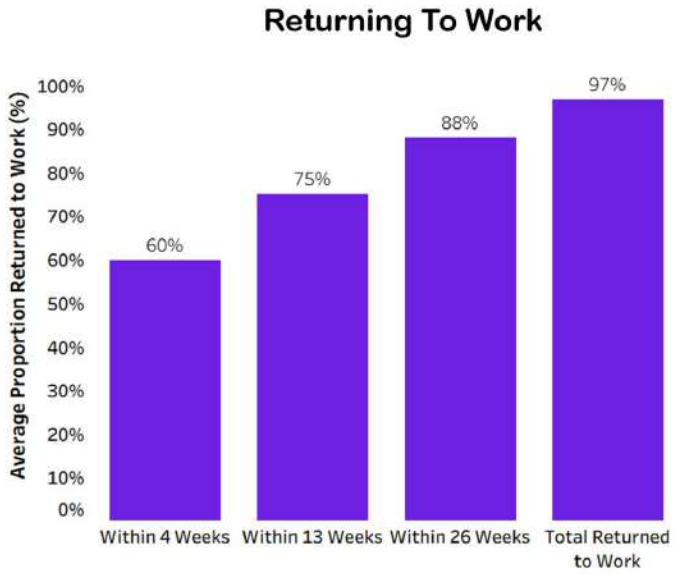
The benchmark also measures how effectively organisations support injured workers to safely return to work following a workplace injury. Return-to-work performance is an important indicator of workforce wellbeing, recovery support practices and organisational capability. The benchmark results demonstrate strong return-to-work outcomes across participating organisations:

60%
of injured workers returned to work within **4 weeks**

75%
returned to work within **13 weeks**

88%
returned to work within **26 weeks**

97%
of injured workers ultimately returned to work



While some workplace injuries result in extended absences, 97% of injured workers ultimately returned to work. Return-to-work outcomes complement injury frequency and severity measures by providing insight into recovery and workforce participation following an injury.

Training Programs

$24.7M
spent on staff to deliver training

$1,114
Median per direct FTE

$632
Median per direct head count

$5.8M
spent on Active Support and Frontline Practice Leadership

Providers reported their expenditure on staff wages associated with delivering education, training and professional development to their teams. This excluded the costs of training materials, resources and other training delivery expenses such as learning management systems and venue hire. It also excluded wages to pay staff who attended or participated in the training as a learner. The group expenditure totalled $24.7 million over 12 months. The median expenditure was $1,114 per direct support FTE or $632 per direct support (headcount).

Providers also reported investing $5.8 million in recruiting, training and implementing Active Support and Frontline Practice Leadership in 2025.

Workers consistently received training in safety and compliance. Induction, infection control, manual handling, first aid and safeguarding training were offered by more than 90% of providers and were generally mandatory.

Training on how support is delivered was less consistently provided but was still available in most organisations for select staff.





Conclusion

Ability Roundtable's Quality and Safety Benchmarking program provides one of the most comprehensive insights to date into the quality and safeguarding performance of registered NDIS providers. It offers a clearer picture of what providers are investing in, how consistently evidence-informed practices are being implemented and where opportunities for improvement exist.

One of the most significant findings is that greater expenditure on quality and safeguarding systems was not, on its own, associated with lower reportable incident rates. By contrast, providers with more mature Active Support, rights-based practices and participant involvement generally recorded lower rates of reportable incidents and unauthorised restrictive practices. There were also promising relationships between inclusive governance and worker safety. While these findings do not establish cause and effect, they highlight the importance of understanding how good practice is embedded and sustained.

The benchmarking also identifies areas requiring sustained sector-wide attention. High rates of polypharmacy, low reported rates of medication reviews and the continued prevalence of chemical restraint raise important questions about health oversight and safeguarding. The high number of unauthorised restrictive practices, particularly those arising from expired behaviour support plans, also warrants closer examination of the factors contributing to these events and the responsibilities of providers and other parts of the system in preventing them.

The sector also has an opportunity to become as sophisticated at measuring positive outcomes as it has become at measuring harm. Providers have developed substantial capability in compliance, incident reporting and safeguarding. The next step is to measure, with the same rigour, whether supports are improving people's participation, independence, choice, wellbeing and quality of life.

Benchmarking has an important role to play in both identifying persistent risks and understanding what contributes to better outcomes. By comparing performance, sharing evidence and learning from each other, providers can identify where improvements are needed and which approaches show promise. As expectations around quality measurement evolve, this evidence will become increasingly valuable in informing regulation, pricing and investment in quality supports.

The program has established an important foundation, but its value will grow as more providers participate and contribute data. All registered NDIS providers should consider getting involved. The opportunity is not simply to demonstrate quality, but to build a stronger evidence base for improving it across the sector.

ability roundtable

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