



NDIS Support Coordination and Connection Consultation

October 2026



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What is MS?

Multiple Sclerosis (MS) remains one of the most common causes of neurological disability in the young adult population (aged 18–40 years) with over 2.9 million people affected worldwide. More than 37,756 Australians live with MS and over 7.6 million Australians know someone or have a loved one with this potentially debilitating disease.

Three times as many women have MS than men. Symptoms vary between people and can come and go; they can include severe pain, walking difficulties, debilitating fatigue, partial blindness and thinking and memory problems. For some, MS is characterised by periods of relapse and remission, while for others it has a progressive pattern of disability. MS robs people of quality of life, primarily driven by the impact of MS on pain, independent living, mental health and relationships.

MS Australia is Australia's national multiple sclerosis (MS) not-for-profit organisation that empowers researchers to identify ways to treat, prevent and cure MS, seeks sustained and systemic policy change via advocacy, and acts as the national champion for Australia's community of people affected by MS.

MS Australia represents and collaborates with its state and territory MS Member Organisations, people with MS, their carers, families and friends and various national and international bodies to:

- Fund, coordinate, educate and advocate for MS research as part of the worldwide effort to solve MS
- Provide the latest evidence-based information and resources
- Help meet the needs of people affected by MS

George Pampacos
President

Rohan Greenland
Chief Executive Officer

NDIS Support Coordination and Connection

Executive Summary

MS Australia welcomes the opportunity to respond to the Department of Health, Disability and Ageing on the National Disability Insurance Scheme (NDIS) Support Coordination and Connection consultation.

MS Australia supports reform of Support Coordination and Connection (SCC) services that improves quality, safeguarding and consistency while preserving NDIS participant choice, continuity and access to specialist expertise. The future model should include generalist SCC and specialist SCC+ pathways, flexible funding that reflects participant complexity, strong workforce and safeguarding standards, and staged transition arrangements. NDIS participants with progressive neurological conditions, including MS, must be able to access specialist providers, trusted relationships and responsive supports as their needs change.

Lived Experience

This submission draws on the experiences and expertise of MS Australia's [Lived Experience Expert Panel](#) (LEEP) and state and territory [Member Organisations](#). LEEP members are people who live with MS or care for someone with MS and provide expert advice to inform MS Australia's advocacy. Our Member Organisations are registered NDIS providers delivering supports including support coordination, plan management, allied health, accommodation, respite, social support and in-home care. Some also support people with other neurological conditions, including stroke, Parkinson's disease, Huntington's disease, acquired brain injury and motor neurone disease.

MS Australia Recommendations

Service Provider Models & Approaches

- **Commissioning arrangements:** commissioning arrangements should follow a mixed model that includes lead providers delivering generalist SCC services across a region and specialist providers delivering specialised SCC and SCC+ service across a number of regions. The model should allow for participants to have a choice in provider regardless of where they live.
- **Lead organisations:** lead organisations should have demonstrated strong governance, safeguarding capability, workforce capability, efficient operational systems, the capacity to support participants across the allocated service area, a robust track recording in delivering support coordination and a focus on participant-centred services. They should be able to recognise when participants need specialist services and refer them accordingly.
- **Lead organisation model:** while a lead organisation model may improve participant safeguarding, service consistency and accountability, it carries significant risks and is likely to reduce participant choice and control, exclude specialist providers and increase administrative burn for subcontracted organisations.
- **Regional areas:** regional areas should align with existing and established government, health, disability and community areas and networks. Regional boundaries should not reduce participant choice and control or prevent access to specialist expertise.
- **Variable need:** SCC providers should manage variable need through a flexible, responsive model that recognises that support needs change over time and clear processes to deal with these changes and participants with complex needs accessing SCC+ services. This should be supported by funding certainty and services areas and participants numbers to sustain a viable service.

- **Funding & payment approaches:** funding and payment approaches that recognise the complexity of participant's support needs and funds the full cost of delivering support coordination services. It should also recognise the costs of staff training & supervision, workforce development, safeguarding, quality assurance and rural or remote service deliver.
- **Quality, workforce and safeguarding:** commissioned providers should meet consistent quality, workforce and safeguarding requirements that align with current requirements for registered NDIS providers, including strong complaints and incident management, conflict of interest controls, communication with participants, supervision, workforce capability and quality assurance systems.
- **Workforce retention:** the future SCC model should attract, build and retain workforce capability by providing certainty, appropriate funding and a clear professional development framework and resources with an emphasis on retaining the existing expertise in the support coordination workforce.
- **Local knowledge:** local knowledge and community connection should be defined as a provider's demonstrated understanding of the service systems, pathways, barriers and communities within the area they support. Specialist and SCC+ providers should have their specialist expertise assessed alongside local knowledge.
- **Regional, rural and remote areas:** that SCC services can support participants in regional, rural and remote areas through flexible service delivery models, commissioning specialist service providers and funding that recognises the increased costs of delivering in these areas.
- **Additional barriers & complex needs:** participants facing additional barriers or complex needs should have access to SCC+ services delivered by specialist providers with flexible funding to allow changes in service intensity and requirements.
- **Transition arrangements:** transition arrangements should be staged, participant-centred and transparent. There should be a minimum period of three months to transfer participants, funding to support transition, preserving trusted relationships where possible, additional support for participants with complex or higher risk circumstances and opportunities for experienced staff to move to commissioned provider.

Participants and the SCC service

- **Existing model:** the new SCC service model should retain the existing established relationships that participants have with experienced support coordinators and a focus on building participants understanding of the NDIS, developing confidence in decision-making and supporting greater independence where appropriate.
- **Improvements:** the new SCC service should improve the training and expertise of SCC workers, improve quality & safeguarding and introduce a consistent minimum standard of service that also incorporated access to specialist knowledge and expertise. Improvements should ensure that current high-quality support coordinators and providers continue as part of the system
- **Face to face vs virtual:** the SCC model should support flexible delivery arrangements with an emphasis on participant preferences and individual needs.
- **Participant groups:** SCC should be available to participants who need support to navigate the NDIS, mainstream services and community supports, including people with limited informal supports, complex or fluctuating needs, cognitive impairment, rural or remote access barriers, or social and cultural barriers. SCC+ should be available to participants with progressive neurological conditions, complex physical disability, significant cognitive or intellectual impairment, multiple interacting support needs, safeguarding risks, unstable housing or significant cross-system coordination needs.

- **SCC Workers:** SCC workers should have strong disability sector knowledge, communication and listening skills, integrity, adaptability, local service knowledge, appropriate training, and access to specialist disability expertise to support safe, high-quality and person-centred service coordination.
- **Safety:** participants should feel safe using SCC services through clear service expectations, transparent complaint and escalation pathways, mandatory safeguarding training, conflict of interest controls, trusted worker relationships, accessible information about rights, and assurance that raising concerns will not affect their access to support.
- **Other considerations:** future SCC service design should be driven by the needs and input of NDIS participants with genuine co-design. The future model should also explicitly recognise the role of specialist providers in supporting participants who need specialised and targeted support coordination services.

Service Provider Models and Approaches:

What commissioning arrangements would best balance participant outcomes, quality, sustainability and choice and control?

The proposed lead-provider model may strengthen oversight, safeguarding and consistency. However, it also carries the risk of reducing participant choice and access to specialist providers, particularly where only a small number of organisations are commissioned within a region. To address the needs of all participants, MS Australia and our Member Organisations support a mixed model as follows:

- **Lead providers** commissioned for a region to deliver generalist SCC services. This could include several lead providers in each region to give participants choice and control and the option to change providers if they are unsatisfied.
- **Specialist providers** commissioned to deliver specialised SCC and SCC+ services across a number of regions. There are already a range of NDIS providers who deliver specialised services to specified disease groups/cohorts and who have the skillset and knowledge to continue doing this. We believe that people living with MS and other neurological conditions benefit from support coordination provided by specialised providers who understand the needs of this cohort.,

Commissioning should require providers to meet clear quality, safeguarding and outcome expectations, including measures focused on independence, wellbeing and quality of life. Funding arrangements should be flexible enough to recognise progressive and fluctuating needs, support workforce sustainability and enable regional providers to maintain viable services.

Participants most likely to benefit from SCC include those with limited informal supports, complex or changing needs, cognitive impairment, and those needing help to navigate the NDIS, mainstream services and community supports. SCC+ should be available for people with progressive neurological conditions, complex physical disability, significant cognitive or intellectual impairment, behaviour support needs, unstable housing, increased safeguarding risks, or significant cross-system coordination needs. People with MS and other neurological conditions may require higher levels of support as their needs fluctuate or increase over time.

Any lead-provider arrangement should include explicit safeguards so that participants can change provider, access specialist services where required and are not locked into a generalist model that cannot meet their needs. Commissioning should therefore be assessed against all objectives of the proposed model, including whether it improves quality and accountability without reducing meaningful choice, control or specialist support.

MS Australia recommends commissioning arrangements should follow a mixed model that includes lead providers delivering generalist SCC services across a region and specialist providers delivering specialised SCC and SCC+ service across a number of regions. The model should allow for

participants to have a choice in provider regardless of where they live.

What provider types would be best placed to be a lead organisation?

Lead organisations should demonstrate strong governance, safeguarding capability, workforce capability, efficient operational systems and the capacity to support participants across the allocated service area. They should have a demonstrated understanding of the disability sector, experience delivering participant-centred services and the ability to deliver high-quality services at scale. They should have a strong, robust track record of delivering support coordination.

Importantly, lead organisations should also demonstrate the capacity to work collaboratively across the broader disability sector, including with specialist providers, mainstream services and other disability providers.

For participants requiring SCC+, lead organisations should be able to identify when specialist expertise is required and have established pathways to engage or refer participants to organisations with condition-specific capability.

MS Australia recommends that lead organisations should have demonstrated strong governance, safeguarding capability, workforce capability, efficient operational systems, the capacity to support participants across the allocated service area, a robust track recording in delivering support coordination and a focus on participant-centred services. They should be able to recognise when participants need specialist services and refer them accordingly.

What are the advantages and disadvantages of the lead organisation model?

A lead organisation model could strengthen participant safeguarding, service consistency and accountability by improving oversight, quality assurance and regional coordination. It may also support more consistent service delivery across regions and help ensure participants can access support regardless of location. For government, commissioning a smaller number of larger lead providers may create efficiencies and enable closer monitoring of provider performance, service quality and participant outcomes. For lead organisations, the model may also provide greater scale, sustainability and more predictable funding.

However, the model also carries significant risks if not carefully designed. Participant choice and control may be reduced if people have limited ability to change providers or access alternative supports when dissatisfied with service quality. Specialist expertise may also become less accessible if referral pathways are not clear or if participants' specific needs are not identified. These risks are particularly relevant for people with progressive neurological conditions and other complex disabilities, where specialist knowledge can be critical to achieving positive outcomes.

There is also a risk that specialist providers could be excluded or reduced to subcontracted roles under larger generalist organisations. This may increase administrative overheads, create unnecessary red tape and distance decision-making from the realities of service delivery. Experience from other commissioned models shows that umbrella or head contract arrangements can sometimes impose additional reporting or compliance requirements that duplicate existing safeguards and divert resources away from participant support.

The success of a lead organisation model will therefore depend on its ability to preserve genuine participant choice, maintain access to specialist SCC+ capability and avoid unnecessary administrative burden. Any model should include clear safeguards for choice and control, transparent SCC+ eligibility and referral pathways, formal arrangements for access to specialist providers, and accountability mechanisms that focus on participant outcomes rather than compliance alone. A lead organisation model may offer advantages in consistency and oversight, but it must not come at the expense of local flexibility, innovation, specialist expertise or meaningful choice for participants.

MS Australia recommends that while a lead organisation model may improve participant safeguarding, service consistency and accountability, it carries significant risks and is likely to reduce participant choice and control, exclude specialist providers and increase administrative burn for subcontracted organisations.

What would be appropriate regional areas to use for SCC service areas?

Appropriate SCC service areas should align with existing service systems and community pathways, such as local government areas, public health networks, health service catchments and established disability and community service networks. Providers should have strong local knowledge, including an understanding of referral pathways, workforce availability, service gaps and connections with local health, rehabilitation, disability and community services.

However, regional boundaries should not be so rigid that they reduce participant choice or prevent access to specialist expertise. As outlined in our answers above, people who need specialist SCC services should be able to access them regardless of where they live. Therefore, commissioning should allow cross-region servicing where specialist capability is required.

MS Australia recommends that regional areas should align with existing and established government, health, disability and community areas and networks. Regional boundaries should not reduce participant choice and control or prevent access to specialist expertise.

How might SCC providers manage variable participant need?

SCC providers should manage variable participant need through a flexible, responsive model that recognises that support needs can change significantly over time. This is particularly important for people with progressive neurological conditions, where episodic changes, disease progression, functional decline, health complexity, informal support availability and risk of hospitalisation or service breakdown can all affect the level of coordination required.

Providers need the expertise and capability to identify changes in participant circumstances early and respond without delay. This should include clear review triggers, documented decision-making and defined escalation timeframes so that support can be adjusted quickly when needs increase. Participants should be able to move between SCC and SCC+ without unnecessary administrative barriers or any interruption to essential supports while eligibility, funding or referral decisions are being resolved.

The SCC+ model will be particularly important for participants experiencing periods of increased complexity, risk or cross-system coordination needs. Timely referral and escalation pathways to SCC+ should be built into the model, supported by clear criteria and specialist capability.

Funding and commissioning arrangements must also support providers to manage fluctuating need sustainably. Providers require a level of certainty about funding, service areas and expected participant numbers so they can build and maintain an appropriately skilled workforce. Commissioning areas should be large enough to sustain viable services and should recognise the different requirements of SCC and SCC+.

MS Australia recommends that SCC providers should manage variable need through a flexible, responsive model that recognises that support needs change over time and clear processes to deal with these changes and participants with complex needs accessing SCC+ services. This should be supported by funding certainty and services areas and participants numbers to sustain a viable service.

Which payment and funding approaches would best support participant outcomes, workforce sustainability and innovation?

Funding approaches should recognise the complexity of participants' support needs and enable providers to deliver safe, high-quality and sustainable SCC and SCC+ services. A key limitation of the current model is that funding does not always reflect the actual level of coordination required, resulting in unfunded work, financial pressure on providers and increased risk for participants when necessary supports cannot be delivered.

Funding should be linked to the level and complexity of support required, rather than applying a generic approach. SCC+ funding should be higher than SCC funding to reflect the more intensive coordination, specialist capability and cross-system navigation required for participants with complex, progressive or fluctuating disability. Funding should also recognise the costs of training,

supervision, quality assurance, safeguarding, workforce development and rural or remote service delivery.

A per-capita payment model could provide greater funding certainty and support workforce planning, provided it is based on an efficient price that reflects expected activity, service intensity and participant complexity. This could include adjustments for participants entering or exiting a service area and additional loadings for complex needs or regional, rural and remote delivery. The NDIA should look at pricing models in other sectors including health that can be replicated.

MS Australia recommends funding and payment approaches that recognise the complexity of participant's support needs and funds the full cost of delivering support coordination services. It should also recognise the costs of staff training & supervision, workforce development, safeguarding, quality assurance and rural or remote service deliver.

What quality, workforce and safeguarding requirements should apply?

Commissioned providers should meet consistent quality, workforce and safeguarding requirements across both SCC and SCC+. These should align with current requirements for registered NDIS providers, including strong complaints and incident management, conflict of interest controls, communication with participants, supervision, workforce capability and quality assurance systems.

Workforce requirements should support consistent recruitment, induction, training, supervision and ongoing professional development. Standardised training and resources would help reduce variability in service quality and strengthen participant outcomes. For SCC+ providers, additional capability requirements should apply to ensure workers can access specialist knowledge and support when responding to complex circumstances, including progressive neurological conditions.

Providers should also be assessed against participant-centred quality indicators, including continuity of support, timeliness of response and escalation, participant experience, complaints and incident trends, unplanned service gaps, and evidence that choice, control and supported decision-making have been upheld.

Safeguarding and quality measures should be proportionate and support continuous improvement, rather than operate solely as compliance requirements. This would help ensure SCC and SCC+ services are safe, consistent, high quality and focused on participant outcomes.

MS Australia recommends that commissioned providers should meet consistent quality, workforce and safeguarding requirements that align with current requirements for registered NDIS providers, including strong complaints and incident management, conflict of interest controls, communication with participants, supervision, workforce capability and quality assurance systems.

How can the future SCC model attract, build and retain workforce capability?

The future SCC model should attract, build and retain workforce capability by providing certainty, appropriate funding and a clear professional development framework. Retaining the expertise that already exists in the Support Coordination workforce is essential, including the trusted relationships workers have built with participants. These relationships support safety, continuity and participant outcomes.

Commissioning and transition arrangements should include specific workforce retention strategies, particularly where existing providers are unsuccessful and may exit the market. Wherever possible, experienced workers should be supported to transfer with participants to new commissioned providers to preserve continuity and reduce disruption.

Providers need clarity on the future model, commissioned regions, participant numbers and funding levels for SCC and SCC+. This certainty will help organisations plan, retain staff and build the workforce required to meet demand. Appropriate remuneration, manageable caseloads, supervision, workforce wellbeing supports and ongoing professional development will also be important.

Standardised induction and training resources should be developed to support consistent service delivery and quality across the sector. For SCC+ providers, this should include access to specialist training, including neurological disability expertise, so workers can respond effectively to complex, progressive and fluctuating needs.

MS Australia recommends the future SCC model should attract, build and retain workforce capability by providing certainty, appropriate funding and a clear professional development framework and resources with an emphasis on retaining the existing expertise in the support coordination workforce.

How should local knowledge and community connection be defined and assessed?

Local knowledge should be defined as a provider's demonstrated understanding of the service systems, pathways, barriers and communities within the area they support. This includes relationships with other disability providers, health networks, allied health services, rehabilitation services and community organisations, as well as knowledge of local service gaps and referral options.

For specialist and SCC+ providers, local knowledge should be assessed alongside specialist expertise. Providers supporting people with MS and other neurological conditions may operate across multiple regions but still bring valuable cohort-specific knowledge, established referral networks and experience responding to complex needs.

Assessment should therefore consider both evidence of regional connections and demonstrated expertise with relevant participant cohorts. This could include previous service delivery in the area or nearby areas, evidence of partnerships, understanding of local pathways, and feedback from participants, providers and community stakeholders. Quantity of local relationships should not be the only measure; quality and effectiveness are equally important.

MS Australia recommends that local knowledge and community connection should be defined as a provider's demonstrated understanding of the service systems, pathways, barriers and communities within the area they support. Specialist and SCC+ providers should have their specialist expertise assessed alongside local knowledge.

How can SCC services best support participants in regional, rural and remote areas?

SCC services can best support participants in regional, rural and remote areas through flexible delivery that combines virtual support, face-to-face engagement and outreach where needed. This is particularly important in thin-market locations where participants may have fewer provider options and reduced access to specialist services.

Participants should not be disadvantaged because of where they live. Commissioning arrangements should allow specialist providers, including SCC+ providers, to support participants across regional boundaries where local expertise is unavailable. Virtual delivery and telehealth can help improve access to specialist knowledge but should be supplemented by face-to-face support when participant needs, complexity or risk require it.

Funding must also recognise the higher cost of delivering services in regional, rural and remote areas, including travel, outreach and workforce challenges. Rural and remote loadings should be built into payment models to ensure services are viable and participants can access timely, high-quality support.

MS Australia recommends that SCC services can support participants in regional, rural and remote areas through flexible service delivery models, commissioning specialist service providers and funding that recognises the increased costs of delivering in these areas.

How can SCC services best support participants facing additional barriers or complex needs?

Participants facing additional barriers or complex needs require flexible, person-centred and specialist support. Their coordination needs often extend beyond NDIS-funded supports and involve navigating health, housing, community and other service systems.

SCC+ should be the primary pathway for participants experiencing increased complexity, risk or significant cross-system coordination needs. This should include access to workers with specialist expertise, including neurological disability expertise, and the capability to identify risk, coordinate across systems and support decision-making.

The model should include timely referral pathways to SCC+ and allow flexible service intensity where participant needs increase. For people with complex needs, this may require lower caseloads, multidisciplinary collaboration and additional funding to reflect the higher level of work involved.

SCC+ should be commissioned separately from specialist providers with a demonstrated track record supporting defined cohorts, so participants can access the expertise required to achieve safe and effective outcomes.

MS Australia recommends that participants facing additional barriers or complex needs should have access to SCC+ services delivered by specialist providers with flexible funding to allow changes in service intensity and requirements.

What transition arrangements would minimise disruption and support successful implementation?

Transition arrangements will be critical to successful implementation and should be staged, participant-centred and transparent. Participants, providers and workers need early, clear communication about what will change, what will remain the same, key timeframes, and how participants can exercise choice within the new model.

Existing trusted relationships should be preserved wherever possible. Many participants, particularly people with MS and other neurological conditions, rely on support coordinators who understand their condition, circumstances, risks and local service context. Where current providers are unsuccessful in commissioning processes, there should be sufficient notice and time to support an orderly transition of participants and staff. Wherever practicable, arrangements should facilitate the transfer of both participants and their existing Support Coordinators to successful commissioned providers. This would help retain experienced workers, preserve continuity and reduce disruption.

A minimum transition period of three months should be provided following the announcement of new providers, regions and service arrangements. During this period, current Support Coordinators should be funded to support transition activities, such as preparing handover reports, participating in handover meetings and assisting participants to understand their options. Alternatively, new providers should receive additional first-year funding to undertake in-depth initial engagement with participants and rebuild understanding of their needs from first principles.

For participants with complex or higher-risk circumstances, transition should include risk stratification, documented handover requirements, confirmation that essential supports are in place, and enhanced follow-up where participants cannot be contacted or have not made an active choice. A participant's transfer should not be considered complete until responsibility is clear, relevant information has been lawfully transferred, and continuity and safeguarding risks have been addressed.

MS Australia recommends that transition arrangements should be staged, participant-centred and transparent. There should be a minimum period of three months to transfer participants, funding to support transition, preserving trusted relationships where possible, additional support for participants with complex or higher risk circumstances and opportunities for experienced staff to move to commissioned provider.

Participants and the SCC service

What is working well in support coordination today that you would like to see in the new SCC service?

Support Coordination remains a critical service in helping participants understand and implement their NDIS plans, connect with formal and informal supports, exercise choice and control, and work towards their goals. Effective Support Coordination also builds participant capability over time by strengthening understanding of the NDIS, developing confidence in decision-making and supporting greater independence where appropriate.

The original intent of Support Coordination – connecting participants with the right supports while promoting independence, safeguarding participant rights and supporting goal achievement – remains highly relevant and should be preserved in any future model.

The SCC model should preserve the core purpose of Support Coordination by ensuring participants can access skilled workers who support informed decision-making, connection to formal and informal supports and achievement of participant goals. SCC+ should provide enhanced coordination for participants with progressive, complex or fluctuating conditions who require specialist expertise and more intensive support.

Our LEEP members who currently use support coordination services find the relationship with their support coordinator invaluable to their NDIS experience:

'I love the flexibility on how to best utilise my Support Coordinator. She has been fantastic with sourcing services that she knows will work for me but then also coordinating things at the time of NDIS review. She also has incredible knowledge of the system and how to ensure we are making the most out of my NDIS plan for my needs'. - **LEEP Member Hannah**

'My support coordinator works for MSWA. She always replies promptly to my queries, understands MS as a disability and also understands the NDIS'. - **LEEP Member Anne**

'The personal approach- my single point SC contact knows the content of my plan, my goals, who we have trialled before and we have an existing relationship'. - **LEEP Member Rachel**

MS Australia recommends that the new SCC service model retains the existing established relationships that participants have with experienced support coordinators and a focus on building participants understanding of the NDIS, developing confidence in decision-making and supporting greater independence where appropriate.

What would you most like to see improved in the new SCC service?

Our LEEP members would like to see the following improved in the new SCC service:

- Training and expertise of SCC workers and management;
- Ensuring that quality and control is maintained;
- Maintaining the same level of professionalism they currently experience with good support coordinators; and
- Mandatory reporting of providers who are committing fraud.

MS Australia and our Member Organisations believe that the introduction of commissioned SCC services provides an opportunity to improve consistency, quality and safeguarding across all providers delivering Support Coordination.

Participants should be able to expect a consistent minimum standard of service regardless of where they live or which provider they access. Improved regulatory oversight, workforce capability standards and quality requirements would support greater consistency across the sector.

However, the new model should not result in a generic service that reduces access to specialist knowledge and expertise. Participants living with progressive neurological conditions can experience significant changes in need associated with relapse, episodic deterioration and/or progressive functional decline.

This is also an opportunity to introduce standardised quality, workforce and safeguarding requirements across Support Coordination. Eligibility and service pathways should explicitly recognise progressive and fluctuating disability and enable participants to move between SCC and SCC+ as their needs and circumstances change.

MS Australia recommends that the new SCC service should improve the training and expertise of SCC workers, improve quality & safeguarding and introduce a consistent minimum standard of service that also incorporated access to specialist knowledge and expertise. Improvements should ensure that current high-quality support coordinators and providers continue as part of the system.

When should SCC be a face-to-face service or a virtual service?

Our LEEP members believe it is essential to offer both face-to-face and virtual services with an emphasis on what works best for each individual participant and ensuring the SCC service has appropriate local knowledge:

'I think it is essential to offer both. I both meet face to face and virtually with my support coordinator depending on what we are working on. I do think though that dependent on the participant and reason support coordination is included in a plan, virtual only should not necessarily be an option'. - **LEEP Member Hannah**

'As an older person, I like to be able to visualize who I am talking to. After the initial meeting, I am happy to move forward with a virtual service if it is with the same individual'.
- **LEEP Member Anne**

'When it is best for the participant, not the org. Local knowledge can't be overstated in SCC, so even if virtually delivered, it remains important to have local people providing SCC'.
- **LEEP Member Rachel**

Virtual support can improve accessibility and responsiveness, particularly in regional, rural, remote and thin-market areas, and can be more cost-effective. However, face-to-face engagement remains important where participant circumstances are more complex, where risks are present, or where there are communication or cognitive barriers.

For people living with neurological conditions, observing participants within their own environment can provide important context regarding function, safety, support requirements and coordination needs.

The SCC model should support flexible delivery arrangements, including face-to-face and virtual services, with the method of delivery determined by participant preference, complexity, risk, communication needs and individual circumstances.

MS Australia recommends the SCC model support flexible delivery arrangements with an emphasis on participant preferences and individual needs.

What participant groups will benefit most from the SCC service? What do their needs for connection and coordination of supports look like?

Participants most likely to benefit from SCC include:

- Participants with limited informal supports;
- Participants with comorbidities, complex needs, cognitive impairment, and those requiring assistance to navigate service systems and connect with appropriate supports;

- Participants in rural and remote locations;
- People from culturally and linguistically diverse (CALD) background;
- People from Aboriginal and Torres Strait Islander communities; and
- People from lower socio-economic backgrounds.

However, all participants should have the option to access SCC if their individual needs require.

'I think that the most important thing to remember is that we are all individuals with different characters, ideals and ideas therefore if everyone in a group is treated the same, there will still be some who are not catered for correctly. Older people often need an understanding person to help them. They would need ongoing access to the same SCC. Most groups probably need similar services although younger, more able people can probably manage with less help'.

- **LEEP Member Anne**

Participants most likely to benefit from SCC+ include those with:

- Progressive neurological conditions;
- Complex physical disability;
- Significant cognitive and/or intellectual impairment;
- Behaviour support needs;
- Multiple and interacting support needs;
- Significant cross-system coordination requirements, including health and housing;
- Unstable or high-risk housing arrangements; and
- Increased safeguarding risks.

NDIS participants living with MS and other neurological conditions frequently experience several of these characteristics, including progressive functional decline, episodic deterioration and increasing complexity over time.

SCC+ eligibility should explicitly recognise participants living with progressive neurological conditions, significant cognitive impairment, complex physical disability, limited informal supports and significant cross-system coordination needs. These cohorts frequently require higher levels of coordination capability and specialist expertise consistent with the intended purpose of SCC+.

MS Australia recommends that SCC should be available to participants who need support to navigate the NDIS, mainstream services and community supports, including people with limited informal supports, complex or fluctuating needs, cognitive impairment, rural or remote access barriers, or social and cultural barriers. SCC+ should be available to participants with progressive neurological conditions, complex physical disability, significant cognitive or intellectual impairment, multiple interacting support needs, safeguarding risks, unstable housing or significant cross-system coordination needs.

What experience, skills and knowledge do you look for in an SCC worker?

Our LEEP members look for the following experience, skills and knowledge when in a support coordinator:

- Lived experience of disability and working with people with disabilities and knowledge of the disability sector;

- Integrity, honesty and good communication skills;
- The ability to listen, understand and give help when requested and needed;
- Adaptability and ability to think on their feet;
- Appropriate training and education; and
- Local knowledge including which providers are reliable and trustworthy.

MS Australia and our Member Organisations believe that SCC worker should have training and understanding of the NDIS Act and rules, pricing arrangements, mainstream health and community systems, supported decision-making, person-centred practice, safeguarding and conflict of interest management. As outlined in our responses above, incorporating workforce capability standards and competencies should be into the new model will support consistent, high-quality and safe service delivery.

We believe that SCC workers can be further supported through access to workers and organisations with specialist disability expertise and experience supporting specific participant cohorts.

MS Australia recommends that SCC workers should have strong disability sector knowledge, communication and listening skills, integrity, adaptability, local service knowledge, appropriate training, and access to specialist disability expertise to support safe, high-quality and person-centred service coordination.

What would help you feel safe when receiving SCC services and encourage you to report an issue if needed?

Our LEEP members reported a range of factors that would support them to feel safe when receiving SCC services:

'I think it is essential for any SCC organisation to have a complaints process in place (which is essential for NDIS registration anyway) which should highlight reporting options whether that is within the organisation or options to report to the commission or any other advocacy type services'. - **LEEP Member Hannah**

'I would feel safe receiving services from an SCC if they lived locally to me and I had met them previously either virtually or face-to-face. I would report an issue if I felt that the SCC was not listening to me or not understanding my needs and therefore not taking any notice of my needs'. - **LEEP member Anne**

'I would feel much safer if the SCC provider was NOT government, government managed or government appointed- it leaves far too much room for government cost saving directives to be applied at SCC level - also, government run systems and departments are often bureaucratically heavy and difficult to navigate for the end user'. - **LEEP member Rachel**

Other ways to ensure that participants are more likely to feel safe include:

- Workers are appropriately trained and supported;
- Service expectations, complaints pathways and escalation processes are clear;
- Trusted relationships with workers and providers have been established; and
- The ability to freely exercise choice and control.

Participants should also clearly understand the scope of SCC and SCC+, including what the service can and cannot do, how decisions affecting them are made and how concerns can be raised without fear of losing supports.

The SCC model should include transparent complaints and escalation pathways, mandatory safeguarding training, clear conflict of interest controls and accessible information for participants about their rights, service expectations and escalation options.

MS Australia recommends that participants should feel safe using SCC services through clear service expectations, transparent complaint and escalation pathways, mandatory safeguarding training, conflict of interest controls, trusted worker relationships, accessible information about rights, and assurance that raising concerns will not affect their access to support.

What else should we consider when designing the future SCC service?

Future SCC services should be designed based on the needs and input of NDIS participants. Many participants feel that recent changes to the NDIS have ignored their concerns and not been driven by genuine co-design. Any future changes to Support Coordination must have people with disability at its centre.

MS Australia and our Member Organisations believe SCC+ provides an important opportunity to formally recognise the value of specialist expertise. Where a commissioned or lead-provider model is adopted, participants should continue to have access to specialist expertise rather than relying solely on generalist capability. Formal pathways to condition-specific support will be necessary to ensure the model remains responsive to participants with complex neurological needs.

The future model should explicitly recognise the role of specialist providers in supporting participants with progressive, complex and/or condition-specific needs and establish clear pathways for participants to access that expertise.

MS Australia recommends that future SCC service design should be driven by the needs and input of NDIS participants with genuine co-design. The future model should also explicitly recognise the role of specialist providers in supporting participants who need specialised and targeted support coordination services.

