
Response on NDIS Support Coordination and Connection Reform Consultation

Submitted on behalf of Neurological Alliance Australia by Rohan Greenland (Chair) and Anne Wilson (Deputy Chair)

October 2026

Executive Summary

Neurological Alliance Australia (NAA) welcomes the opportunity to respond to the Department of Health, Disability and Ageing consultation on the proposed commissioned Support Coordination and Connection (SCC) service. NAA supports stronger quality, safeguarding and consistency. These standards should allow services to respond to individual needs as they change while preserving participant choice, trusted relationships and access to specialist expertise.

NAA members represent people with neurological and neuromuscular conditions across the life course. Coordination needs can change quickly with progression, relapse, seizures, changes in cognition or communication, hospital discharge, loss of a carer or breakdown of essential support. SCC and the more intensive SCC+ service should be based on individual circumstances – current and foreseeable needs - with a timely transition between levels. A person should not have to reach crisis before receiving appropriate coordination.

NAA recommends a mixed commissioning model combining capable regional generalist providers with specialist providers able to deliver SCC and SCC+ across regional boundaries. Generalist services should have funded access to neurological and neuromuscular expertise when a participant's circumstances require it. Funding should reflect complexity, specialist input and rural outreach; contracts should protect meaningful choice and continuity. The Department and NDIA should co-design eligibility, workforce standards, safeguarding and transition arrangements with participants and specialist organisations before procurement.

NAA's *Blueprint for a National Action Plan for Neurological Conditions* calls for early intervention and equitable, lifelong care coordination across health, disability and aged care.¹ SCC can help people connect these systems, provided it does not replace clinical

¹ https://neurologicalalliance.org.au/wp-content/uploads/Blueprint-for-National-Action-Plan-25-Aug-2025_FINAL.pdf

care or independent advocacy. The model must also record service gaps when a needed referral cannot be fulfilled.

About Neurological Alliance Australia

Neurological Alliance Australia is a national alliance of 50 not-for-profit organisations (see membership on p 9) representing the needs of over 4.5 million Australians living with neurological and neuromuscular conditions². NAA advocates on shared priorities to improve quality of life for people living with these conditions, strengthen access to care and support, and increase investment in neurological research treatment and care.

This submission draws on the experiences and expertise of its member knowledge of diverse neurological and neuromuscular conditions, as well as its Neuro Survey 2026. The survey received 3,805 responses. Among respondents living with a neurological or neuromuscular condition, only 38.7% of 1,998 described their care as coordinated, while 51.1% of 2,543 found neurological medical care difficult to access. Of 578 carers who answered a relevant question, 38.4% wanted more help navigating systems.³

Despite the survey not being a representative study of NDIS participants or SCC users, it does illustrate the practical consequences of fragmented services. NAA members bring experience of people whose needs may be progressive, episodic, acquired, rare or present from childhood. For these communities, effective coordination depends on SCC workers who understand the person's goals, communication and support arrangements, and who can draw on specialist advice when needed. NAA's Neurological Nursing Workforce Strategy Priority Action Plan⁴ describes complementary clinical roles in assessment, treatment and care planning and NAA considers that SCC workers should be able to connect participants to these services without being expected to provide clinical care themselves.

Recommendations

NAA makes several recommendations in relation to (1) service provider models and approaches and (2) participants and the SCC service.

Participants and the SCC service

- **Existing model:** Preserve skilled coordination, trusted worker relationships, informed decision-making and practical plan implementation.
- **Improvements:** Set a reliable minimum standard for timeliness, workforce capability, safeguarding and access to specialist advice.
- **Face-to-face and virtual:** Let participant preference, communication, complexity and risk determine the mix of contact.

² <https://www.aihw.gov.au/reports/neurological-conditions/neurological-conditions/contents/summary>

³ <https://neurologicalalliance.org.au/wp-content/uploads/Neuro-Service-Gaps-and-Innovation-Survey-Report-Aug-2026.pdf>

⁴ <https://neurologicalalliance.org.au/wp-content/uploads/Priority-Action-Plan-for-a-Neurological-Nursing-Workforce-Strategy-August-2026-Final.pdf>

- **Participant groups:** Make SCC available where ongoing navigation is needed and SCC+ where circumstances require intensive, specialist coordination.
- **SCC workers:** Require NDIS and mainstream-system knowledge, listening skills, cultural safety, supported decision-making and specialist referral capability.
- **Safety:** Explain rights and service limits, protect complaints from retaliation, and manage conflicts of interest transparently.
- **Other considerations:** Continue genuine co-design and maintain clear interfaces with at least health, aged care and education.

Service Provider Models and Approaches

- **Commissioning arrangements:** Use a mixed model with regional generalist capacity, direct or protected specialist SCC and SCC+ across regions, and genuine participant choice.
- **Specialist pathways:** Permit cross-region neurological and neuromuscular including coordination pathways where individual needs call for specialist capability and require generalist providers to have formal, funded access to that expertise when needed.
- **Lead organisations:** Select for governance, safeguarding, participant-centred delivery, local relationships and demonstrated ability to work with specialist providers.
- **Lead organisation model:** Test any single-lead proposal against risks to choice, specialist access and the viability of smaller providers.
- **Regional areas:** Align service areas with useful local pathways while permitting cross-boundary specialist support.
- **Variable need:** Allow rapid changes in intensity and timely movement between SCC and SCC+ without a break in service.
- **Funding and payment:** Fund core capacity, complexity, specialist input, training, safeguarding, handovers and rural or remote delivery.
- **Quality, workforce and safeguarding:** Apply consistent, enforceable standards, independent complaints routes and conflict-of-interest controls.
- **Workforce retention:** Retain experienced coordinators through funding certainty, supervision, career pathways and supported transition.
- **Local knowledge:** Assess effective community connections alongside condition-specific expertise.
- **Regional, rural and remote areas:** Combine outreach, face-to-face and virtual services, with payment for travel and thin-market costs.
- **Additional barriers and complex needs:** Provide needs-based SCC+ and flexible specialist input where risks or cross-system demands rise.
- **Transition arrangements:** Fund individual handovers of at least three months after receiving providers are identified, with longer periods when needed.

Responses to the consultation questions

Participants and the SCC service

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

Good coordinators help participants understand plans, find suitable supports, make informed choices and respond when arrangements fail. An established worker may know how a person's condition affects communication and function over time. That relationship matters during discharge, relapse and other transitions.

NAA **recommends** retaining trusted relationships and skilled, participant-led plan implementation.

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

Participants need timely responses, clear responsibilities and a reliable minimum standard, including when needs change suddenly. Generalist workers should know when to draw on specialist expertise. NAA's survey findings on fragmented care reinforce the need for better connections, although navigation alone cannot create unavailable services.⁵

NAA **recommends** stronger training, safeguarding and specialist pathways while retaining effective existing providers.

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

The participant's choice should guide delivery alongside communication needs, risk and complexity. Face-to-face visits may be important for building trust, understanding a home situation or addressing cognitive and safeguarding concerns. Virtual contact can speed follow-up and bring specialist advice to regional areas.

NAA **recommends** a flexible mix, with travel and accessible technology funded where needed.

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

Base SCC/SCC+ on coordination need across systems, fluctuating function, informal support and risk, not diagnosis. Recognise foreseeable deterioration and urgent equipment, home modification or discharge needs. Participants should receive reasons and a practical route to reconsideration when their assessed level does not reflect their needs.

NAA **recommends** transparent, individual SCC and SCC+ criteria that consider foreseeable change and carer sustainability.

⁵ <https://neurologicalalliance.org.au/wp-content/uploads/Neuro-Service-Gaps-and-Innovation-Survey-Report-Aug-2026.pdf>

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

Workers need integrity, attentive listening, adaptability, NDIS and mainstream-system knowledge, local connections and cultural safety. They should support the person's decisions, understand the effects of progressive and episodic disability, and know when to seek specialist or clinical advice. SCC+ workers need deeper coordination and risk-management capability.

NAA **recommends** core competencies, supervision and access to neurological and neuromuscular expertise.

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

Participants should know the service's role, their right to change provider and how to raise concerns without losing support. Complaints should have a route independent of the worker or lead provider. Where the organisation also delivers other supports, disclose conflicts and offer genuine alternatives.

NAA **recommends** accessible rights information, strong safeguarding and clear protection against retaliation.

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

Co-design with diverse participants, carers, First Nations and culturally diverse communities, specialist organisations with condition-specific expertise. SCC needs consent-based pathways to health, rehabilitation, neurological nursing, aged care and education. For progressive conditions, capability building may mean maintaining participation rather than reducing support.

NAA **recommends** a specialist role in both design and delivery, and evaluation of choice, continuity and unmet need after commencement.

Service Provider Models and Approaches

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

Commission regional generalists and cross-region specialists directly where viable. People should be able to change provider if a relationship is unsafe or ineffective. Contracts should measure timely connections, continuity, safety and meaningful participant outcomes, with appropriate adjustment for complexity. The commissioning model should explicitly permit specialist providers or networks to serve participants across regional boundaries, with funded specialist advice available to generalist services.

NAA **recommends** mixed commissioning with enforceable choice and cross-region specialist access.

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

Lead organisations need strong governance, safeguarding, workforce and operational capability, a record of high-quality support coordination and the capacity to cover the service area. They must recognise when expertise beyond their own team is required and maintain practical referral and partnership arrangements. Organisational size alone does not establish capability.

NAA **recommends** assessing lead providers on participant outcomes and their ability to collaborate fairly with specialist organisations.

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

A lead may improve coverage, oversight and consistent standards. The Department should compare this proposal with a multi-provider model and publish how choice, complaints and specialist access would work in each. Subcontracting should not leave specialist providers carrying unfunded complexity or make their expertise invisible to participants.

NAA **recommends** that any lead model include transfer rights, independent oversight and fair terms for specialist partners.

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

Use health and disability boundaries as a starting point, then test them against referral patterns, travel, thin markets and specialist catchments such as Aboriginal community controlled services and regional hospitals.

NAA **recommends** service areas that fit local systems while allowing cross-region and national specialist delivery.

5. How might SCC providers manage variable participant need?

Contracts should fund capacity for a sudden increase in need as well as planned contact. Triggers may include hospital admission or discharge, a relapse, faster progression, changing cognition, loss of a carer or repeated support failure. Caseloads should reflect travel, communication support, risk and the number of services to coordinate, rather than a uniform participant count. Participants need a dedicated worker and timely interim help while a change from SCC to SCC+ is assessed.

NAA **recommends** clear escalation timeframes, flexible intensity and continuity during any eligibility decision.

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

A blended approach could fund core regional capacity and adjust payment for complexity, specialist consultation, temporary surges, interpreters, travel and outreach. It should cover supervision, safeguarding, training and handovers. The model must avoid incentives to ration support, favour easy-to-serve participants or generate unnecessary contacts.

NAA **recommends** testing the payment design in metropolitan and thin-market settings before wider rollout.

7. What quality, workforce and safeguarding requirements should apply?

Commissioned organisations and delivery partners should meet clear requirements for induction, supervision, supported decision-making, consent, privacy, incident response, accessible complaints and conflict-of-interest controls. Monitor waiting times, handovers, specialist referrals and participant-reported choice and safety. For progressive conditions, maintaining participation despite changing needs can be a good outcome; a fall in coordination hours is not necessarily success. Common standards should allow different delivery approaches. Functional decline associated with a progressive condition should not be treated as evidence that coordination has failed.

NAA **recommends** enforceable standards and public reporting that measures outcomes rather than contact volume alone.

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

Workers need stable funding, fair conditions, manageable caseloads, supervision and professional development. Core training should cover neurological progression, episodic change, fatigue, cognition and communication, with access to condition-specific mentoring. Existing expertise should be retained where workers and participants want the relationship to continue.

NAA **recommends** funded workforce transition and career pathways that support both generalist and specialist practice.

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

Local knowledge means knowing which services are available, how to reach them, where gaps exist and how different communities prefer to engage. Assessment should include participant feedback and evidence of effective relationships with health, rehabilitation, housing, disability and community services. A specialist provider serving several regions may have valuable local partnerships without an office in each.

NAA **recommends** assessing practical connections and specialist expertise together.

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

Combine outreach, local partnerships and virtual specialist access across boundaries, including partnerships with Aboriginal community controlled organisations where appropriate. Face-to-face contact must remain available where communication, risk or participant preference requires it. Payment should cover travel and the time needed to build pathways in thin markets. count a referral only when suitable support is accessible.

NAA **recommends** recording referrals that cannot be fulfilled so service shortages are visible to the NDIA and other systems.

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

Workers should offer interpreters, accessible formats, flexible appointments and culturally safe support. Needs may involve cognitive or communication impairment, unstable housing, carer strain, concurrent health care and safeguarding risks. SCC+ should be available when these factors create intensive coordination needs, with specialist input and manageable caseloads.

NAA **recommends** needs-based SCC+ access and timely escalation as circumstances change.

12. What transition arrangements would minimise disruption and support successful implementation?

Publish options and timelines early. Once receiving providers are known, fund at least three months for introductions, consent-based records transfer and joint handovers, extending where needed. Additional follow-up is needed for people who cannot readily respond to notices, are approaching a hospital discharge or rely on intensive support. No transfer should be treated as complete until the incoming provider has accepted responsibility. Specialist pathways should be identified before procurement and participant transfers so established expertise, referral networks and trusted relationships can be retained.

NAA **recommends** staged transition with funded handovers and monitoring of gaps, complaints and uncompleted transfers.

For more information about this submission and the work of Neurological Alliance Australia please contact:

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Current Organisational Members

- Australian NPC Disease Foundation (ANPDF)
- Brain Foundation
- Brain Injury Australia
- Cerebellar Ataxia Australia
- Childhood Dementia Initiative
- Cure CASK
- Dementia Australia
- Dystonia Network of Australia
- Emerge Australia (ME/CFS)
- Epilepsy Action Australia
- Epilepsy Australia
- Epilepsy Foundation
- FARA Australia
- FAST Australia (Angelman Syndrome)
- Fight Parkinson's
- FND Hope
- FSHD Global Research Foundation
- Fragile X Association of Australia
- Genetics Alliance Australia
- Huntington's Australia
- Homer Pack
- Klim Foundation
- Leukodystrophy Australia
- Meningitis Centre Australia
- Migraine Australia
- Mito Foundation
- Machado-Joseph Disease (MJD) Foundation
- Motor Neurone Disease Australia
- Multiple Sclerosis Australia
- Muscular Dystrophy Australia
- Muscular Dystrophy Foundation Australia
- Myasthenia Alliance Australia
- Myositis Association Australia
- Nerve Connection Foundation
- Neurological Alliance Queensland
- Neurological Council of WA
- Neuromuscular WA
- Palliative Care Australia
- Parkinson's Australia
- Polio Australia
- Post Polio Victoria
- Save Our Sons Duchenne Foundation
- SCN2A Australia
- Spinal Cord Injuries Australia
- Spinal CSF Leak Australia
- Spinal Muscular Atrophy Australia
- Stroke Foundation
- The Australian Young Onset Dementia Special Interest Group
- Tuberous Sclerosis Australia
- Young People in Nursing Homes National Alliance

Current Individual Members – individual researchers from:

- Macquarie University, NSW
- Murdoch Children's Research Institute, VIC
- Neuroscience Research Australia and University of NSW
- Perron Institute for Neurological and Translational Science, WA
- University of Sydney