

Fair Foundations Submission to the NDIS Support Coordination and Connection Reform Consultation

2 October, 2026

About Fair Foundations

Fair Foundations is a place-based, not-for-profit organisation supporting culturally diverse communities across South West Sydney for over 50 years. Our experience includes delivering NDIS Support Coordination and other disability services, alongside broader community services. This submission draws on our direct practice experience, local service-system knowledge and work with participants who may face language, cultural, socioeconomic or other barriers to accessing appropriate supports.

As a service provider, Fair Foundations supports reform that improves participant outcomes, meaningful choice and control, service quality, safeguarding, workforce capability and provider accountability. The ultimate test of the new SCC model should be whether participants can access appropriate supports, make informed decisions, progress towards their goals, remain safe, sustain important support relationships, strengthen their navigation capability and avoid both under- and over-servicing.

Fair Foundations supports nationally consistent standards and oversight through a non-exclusive regional network or panel that preserves participant choice and prevents any single organisation controlling allocation, market access or specialist and local providers. Provider capability, including trusted relationships, local knowledge, cultural responsiveness, language skills and specialist expertise, should be assessed rather than assumed based on provider type, size, identity or location.

Please note that the following responses focus on the areas where we can best contribute our expertise; therefore, we have not answered every question in either section. The questions and responses retain the consultation's original numbering and are not presented consecutively.

Section A - Questions about what participants want

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

The new model should preserve the elements of good support coordination that directly help participants use their plans and achieve their goals:

- continuity of effective participant-worker relationships;
- support to understand plans, budgets, service agreements and provider options;
- informed provider selection and negotiation;
- coordination across NDIS, health, housing, education, mental health and community systems;
- timely identification and escalation of risks or service breakdowns;

- support for plan reviews and goal assessment; and
- capacity-building so participants can increasingly coordinate, self-direct and change supports.

In practice, these functions include helping participants understand their plans, assess providers, negotiate services, navigate multiple service systems, prepare for plan reviews, assess progress towards goals and build their capacity to self-direct supports.

In our experience, effective Support Coordination depends not only on knowledge of the NDIS but also on the worker's ability to establish trust, communicate accessibly and coordinate across multiple service systems. Participants may require assistance to understand their options, compare providers, resolve service gaps and navigate the interaction between disability supports and health, housing, education, mental health and community services. Continuity can be particularly important where a worker has developed a sound understanding of the participant's goals, communication needs, circumstances and existing supports.

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

The priority improvements should be:

- clearer role boundaries between SCC, advocacy, supported decision-making, crisis response, case management, plan management and direct service delivery;
- consistent competency and supervision requirements;
- stronger conflict-of-interest controls;
- accessible complaints and escalation pathways;
- needs-based service intensity, including a clearly defined SCC+ response;
- outcome-focused performance monitoring; and
- genuine participant choice within commissioned arrangements.

SCC should coordinate and connect services, build participant capability and identify or escalate risk. It should not make decisions for participants, replace advocacy or supported decision-making, manage participant funds, provide a default crisis-response function or assume the responsibilities of health, housing, justice or education systems. These distinctions reflect the consultation paper's proposed boundaries. The NDIS Review similarly found overlapping roles, gaps and insufficient ongoing support for some participants with very complex circumstances.

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

SCC workers should demonstrate competencies in:

- person-centred and rights-based practice;
- supported decision-making and accessible communication;
- NDIS plans, budgets and service agreements;
- provider selection and conflict-free referral practice;
- risk identification, safeguarding and escalation;
- cross-system navigation;
- case coordination without drifting into undefined case management;
- professional boundaries and recordkeeping;
- trauma-informed practice;
- disability-specific and psychosocial capability where relevant; and
- cultural responsiveness, interpreter use and local-system knowledge.

SCC+ should require demonstrably higher capability in complex risk, multi-system coordination, service breakdown and participant safety. Qualification and experience thresholds should be nationally consistent but allow recognition of relevant professional and lived-experience expertise.

Fair Foundations expects Support Coordinators to hold relevant qualifications, have at least three years' experience supporting people with complex needs, meet worker screening requirements, understand the NDIS Practice Standards and demonstrate high-level communication capability when working with CALD communities.

Section B - Service provider models and approaches

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

As a provider, we support a **non-exclusive regional network or panel** commissioned under nationally consistent service, workforce, safeguarding, conflict and outcome standards.

Participants should be able to choose and change among commissioned providers. The NDIA should retain responsibility for provider accreditation, performance monitoring and market stewardship rather than transferring effective market control to one commercial entity.

Where collaboration is required, the model should use genuine consortium or network governance with:

- transparent participant-allocation rules;
- shared performance information;
- fair contract terms and timely payment;
- meaningful participant governance;
- independent dispute escalation;
- protection against arbitrary removal; and
- enforceable inclusion of specialist, local and culturally responsive capability where regional need justifies it.

This model better protects the participant consequences that matter: choice, continuity, access, safety and outcomes, while still enabling coordinated regional capacity. The consultation paper states that commissioning must balance outcomes, quality, capacity, efficiency, local responsiveness and choice.

9. What provider types would be best placed to be a lead organisation? Why do these characteristics matter?

If a lead role remains, selection should be based on demonstrated capability, not size or provider identity. Required characteristics should include:

- participant-centred governance and measurable outcomes;
- high-quality SCC and SCC+ capability;
- robust safeguarding, complaints and incident systems;
- transparent conflict management;
- workforce supervision and surge capacity;
- regional service-system knowledge and verified referral pathways;

- capability to support accessible and culturally responsive delivery;
- fair partnership and contract-management practice; and
- willingness to operate under independent allocation and review.

No provider, including a large organisation, locally embedded organisation or culturally specific organisation, should be presumed suitable without assessment. Some organisations may bring established relationships and referral pathways; however, cultural safety should be demonstrated through governance, workforce capability, participant experience and outcomes.

A lead providing affiliated direct services presents a heightened concentration risk and should face strong structural separation, referral audit and independent oversight.

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

Potential advantages include clearer accountability, simplified contracting, pooled infrastructure, coordinated capacity and more consistent practice.

The principal risks are participant-facing:

- reduced choice and continuity;
- provider allocation driven by organisational interests rather than participant preference;
- a single point of service or governance failure;
- weaker access to specialist capability;
- difficulty changing provider;
- concentration of participant information and decision-making power; and
- increased conflict where the lead or affiliates deliver other services.

Provider-market consequences may also follow: smaller or specialist providers may become dependent on one organisation's commercial decisions, with risks of unfair terms, delayed payment, opaque allocation or arbitrary removal.

If used, the lead model should function as a **governed consortium**, not a principal-subcontractor hierarchy. Independent oversight, transparent allocation, fair terms, shared data, participant choice and enforceable escalation are non-negotiable.

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

Requirements should include:

- national SCC and SCC+ practice standards;
- mandatory competency and screening requirements;
- accessible communication and supported decision-making capability;
- supervision, reflective practice and continuing professional development;
- worker and organisational registration appropriate to risk;
- participant-accessible complaints and incident systems;
- outcome, safety and referral reporting;
- independent audit;
- conflict declarations and internal-referral auditing; and
- prohibition of commissions, targets or incentives that steer participants to affiliated services.

Fair Foundations expressly acknowledges its dual-provider status. Where SCC and other disability services sit within one organisation, participants must receive factual disclosure and genuine external

options; referral and direct-service decisions should be separated; internal referrals documented and audited; and choosing an external provider must never disadvantage the participant.

15. How can the future SCC model attract, build and retain workforce capability, including retaining participant relationships?

The model should support:

- nationally defined competencies and career pathways;
- structured induction;
- funded supervision and professional development;
- SCC+ specialist pathways;
- manageable weighted caseloads;
- screening and safe recruitment;
- communities of practice;
- competitive remuneration; and
- transition arrangements that preserve effective participant-worker relationships where the participant wants continuity.

Cultural capability, interpreter use and local-system knowledge should be recognised as workforce competencies within this broader framework, not as substitutes for core SCC competence.

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

Local knowledge should be treated as an **observable capability**, assessed through evidence of:

- current referral pathways across NDIS, health, housing, education and community systems;
- accurate knowledge of provider availability and access barriers;
- partnerships and escalation pathways;
- workforce capable of communicating with communities in the region;
- ability to support outreach and warm referrals;
- participant and partner feedback; and
- demonstrated updating of local service knowledge.

Community connection is not simply having an office, a long history or a particular organisational identity. Assessment should test whether these relationships contribute to improved access to appropriate supports, continuity, engagement and participant outcomes.

Our practice in South West Sydney also demonstrates that local knowledge must be current and actively maintained. Provider availability, eligibility requirements, referral pathways and service capacity can change frequently. Effective local navigation therefore relies on established relationships across service systems, knowledge of practical access barriers and the ability to make warm referrals and follow up when a connection has not been successful. For participants who face language, cultural or other access barriers, this practical capability can be critical to converting a referral into meaningful access to support.

18. How can SCC best support participants who face additional barriers?

The starting point should be an individual assessment of barriers and strengths. Responses may

include:

- outreach;
- interpreters and translated or Easy Read information;
- augmentative and alternative communication;
- supported decision-making assistance;
- trauma-informed and recovery-oriented practice;
- specialist disability or psychosocial expertise;
- coordinated work across health, housing, justice and family systems;
- additional time to build informed choice; and
- SCC+ escalation where complexity or risk warrants it.

Cultural responsiveness, local relationships and identity matching can support engagement. Their contribution to safety and quality should be demonstrated through governance, workforce capability, participant experience and outcomes.

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

Transition should be staged and participant-led, with:

- early accessible information about eligibility and provider options;
- individual transition plans;
- participant consent to information transfer;
- continuity of effective worker relationships wherever possible;
- no forced change solely because a current provider is outside a lead's preferred supply chain;
- workforce-transfer pathways with fair employment arrangements;
- defined handover standards;
- continuity funding during overlap;
- independent review where allocation disrupts an established relationship;
- special arrangements for participants at high risk; and
- active market monitoring before and after commencement.

The consultation identifies continuity, workforce quality and provider readiness as transition priorities. The NDIS Review also recommended gradual implementation with people with disability closely involved in design and testing.

Conclusion

Fair Foundations considers genuine participant choice, including the ability to choose and change providers; nationally consistent competency, quality and safeguarding standards; independent participant allocation, performance monitoring and oversight; transition arrangements that protect continuity of effective participant-worker relationships; and a non-exclusive regional network that preserves diverse local, specialist and culturally responsive capability rather than concentrating control in a dominant lead-provider supply chain to be essential features of a successful SCC model.

For Further Information, contact:

Dr Pandora Patterson, Chief Executive Officer

Pandora.Patterson@fairfoundations.org.au