2.18SUPPORT COORDINATION POLICY AND PROCEDURE

Purpose and Scope

The purpose of this policy and procedure is to ensure that participants are provided with support coordination services in a transparent and unbiased manner and that they are connected to a range of supports that effectively meet their needs and reduce risk and complexity in their personal circumstances.

This policy and procedure applies to all potential and existing participants receiving support coordination services from Partner In Your Care, their family members, carers and other supporters. It meets relevant legislation, regulations and standards as set out in Schedule 1, Legislative References.

Documents relevant to this policy and procedure:

- *Service Access Policy and Procedure*
- *Assessment, Planning and Review Policy and Procedure*
- *Service Need Assessment Profile (SNAP)*
- *Support Coordination Action Plan Template*
- *Feedback, Compliments and Complaints Policy and Procedure*
- *Privacy and Confidentiality Policy and Procedure*
- *Decision Making and Choice Policy and Procedure*
- *Providing Information, Advice and Referrals Policy and Procedure*
- *Records and Information Management Policy and Procedure*

Definitions[1]

Coordination of Supports - assistance to strengthen a participant's ability to connect to informal, mainstream and NDIS-funded supports. It includes resolving points of crisis, developing capacity and resilience in a participant's network and coordinating supports from a range of sources. Over time as a participant's capacity is strengthened this support may be replaced by Support Connection or the introduction of a LAC or Early Childhood Early Intervention Partner in subsequent plans.

Specialised Support Coordination - includes all the activities outlined in Coordination of Supports but addresses situations where a specialist is required because of high-level risks in the participant's situation. Specialist Support Coordination is delivered in a time-limited, outcomes focused manner and by an appropriately qualified and experienced practitioner such as a Psychologist, Occupational Therapist, Social Worker, or Mental Health Nurse.

Support Connection - assistance for participants to implement their NDIS Plan by strengthening their ability to connect with supports, helping them to understand their plan, assisting with ongoing management of supports, and answering questions as they arise. Support Connection is occasionally referred to Registered NDIS Support Coordinators but is commonly undertaken by Local Area Coordinators (LACs).

Policy

Partner In Your Care supports each participant to exercise meaningful choice and control over their supports in a way that maximises their value for money.

The service ensures that each participant receives transparent, factual advice about their

[1] NDIS 2018-19 Price Guide, National Disability Insurance Agency, July 2018

support options that promotes choice and control.

All participants receiving specialised support coordination receive tailored support from Partner In Your Care to implement, monitor and review their NDIS Plans and reduce the risk and complexity of their situation.

Procedures

The Support Coordinator is responsible for ensuring relevant staff are familiar with the requirements of this policy and have sufficient skills, knowledge and ability to meet the requirements. This includes understanding:

- the role of informal supports and the mainstream service system in helping participants to achieve their goals;
- NDIS legislation and rules, including provisions relating to reasonable and necessary supports;
- conflict of interest and its potential impact on participants' choice and control and decision making;
- how NDIS funding can be managed and the types of providers participants can access based on their funding arrangements; and
- the *NDIS Price Guid*e and how funds can be used to varying levels of flexibility within different budgets (Core, Capacity Building and Capital).

Support Coordinators providing Specialised Support Coordination will meet the professional qualification and registration requirements set down by the *NDIS Provider Registration Guide to Suitability*.

Participants receiving Support Coordination must be provided with information using the language, mode of communication and terms they are most likely to understand. Methods include providing written information in Plain English, explaining information either face-to-face or over the phone and using interpreters and advocates.

Intake

Participants who have Support Coordination funded in their NDIS Plan will choose a Support Coordination provider in collaboration with their NDIS or LAC Planner. The Planner may send a Request for Service to Partner In Your Care, requesting its Support Coordination services for the participant.

Upon receiving a Request for Service or any other type of Support Coordination referral, the Support Coordinator must determine whether Partner In Your Care can provide the required support. This decision should be made in collaboration with Support Coordination staff and consider Partner In Your Care's eligibility and priority of access criteria (see Partner In Your Care's *Service Access Policy and Procedure*).

The must respond to the Planner or referrer to accept or reject the Request for Service within one working day.

Where services cannot be provided, the person will be provided with a clear reason based on Partner In Your Care's eligibility criteria, Priority of Access requirements or waiting list processes, as per the *Service Access Policy and Procedure*. Where appropriate, the General Manager – Life Skills & Accommodation may also provide alternative referrals for the participant, as per Partner In Your Care's *Providing Information, Advice and Referrals Policy and Procedure*.

If Partner In Your Care accepts the Request for Service or referral, the General Manager – Life Skills & Accommodation must contact the participant or their representative within two working days of acceptance and arrange a meeting with them within five working days of acceptance.

Consistent with Partner In Your Care's *Service Access Policy and Procedure*, in their first contact with the participant or their supporter, the General Manager – Life Skills & Accommodation must assess whether the person requires any support to access the service. They will:

- advise the person of their right to involve a support person in their dealings with Partner In Your Care;
- provide information and assistance to access a support person if required;
- where physical access issues or other issues such as availability of, or access to, transport, are identified, consider whether Partner In Your Care is accessible for the person, and if not, how it could be made accessible; and
- where a language or cultural barrier is identified, engage an interpreter or an appropriate external agency to support the person.

Staff will provide information in ways that suit participants' individual communication needs. This includes using the language, mode of communication and terms that the participant is most likely to understand. Methods include providing written information in Plain English, explaining information either face-to-face or over the phone and using interpreters and advocates.

At the initial meeting, the General Manager – Life Skills & Accommodation must provide the participant with the service and participant-related information set out in Partner In Your Care's *Service Access Policy and Procedure*. The General Manager – Life Skills & Accommodation must also explain Partner In Your Care's Conflict of Interest provisions (see Partner In Your Care's *Conflict of Interest Policy and Procedure* and the additional detail provided below). Should the participant agree to proceed with Partner In Your Care's services, they must then agree upon a Service Agreement, as set out in Partner In Your Care's *Assessment, Planning and Review Policy and Procedure.* Service Agreements are to be prepared within no more than 7 working days of the Intake meeting, and ideally within 5 working days.

Conflict of Interest

Conflict of interest information must be provided or explained to each participant using the language, mode of communication and terms they are most likely to understand.

The General Manager – Life Skills & Accommodation must explain:

- the difference between support coordination or specialised support coordination and other supports funded under the participant's NDIS plan, including the requirement that supports provided be reasonable and necessary; and
- that any choice the participant makes about providers of other supports will not impact on the provision of their support coordination.

The General Manager – Life Skills & Accommodation must also declare the potential conflict of interest in Partner In Your Care providing Plan Management and how this potential conflict of interest will be addressed (for instance, providing information about a range of support options, supporting and acting upon the participant's decisions, highlighting Partner In Your Care's feedback and complaints processes, etc.).

Participants must also be informed about their right to change Support Coordinators and how they can go about doing so, as well as Partner In Your Care's feedback and complaints processes (see the *Feedback, Compliments and Complaints Policy and Procedure*).

Where Partner In Your Care is delivering Support Coordination or Specialised Support Coordination to a participant in conjunction with any other NDIS support, staff delivering each service must keep documentation on the participant's file that:

- sets out the arrangements in place to keep information separate between teams;
- describes the participant's options for their supports;
- evidences there is no remuneration provided to staff to increase participant numbers, particularly through internal referral channels;
- confirms there are no commissions or percentages received on any funds managed; and
- confirms that the conflict of interest and above information has been disclosed to the participant.

Initial Support Coordination Meeting

Following the Intake meeting, the General Manager – Life Skills & Accommodation will match the participant with an appropriate Partner In Your Care Support Coordinator, considering where possible the participant's preferences such as gender, age, cultural and other relevant factors. The Support Coordinator is responsible for contacting the participant within two working days of their Intake meeting, to arrange their first Support Coordination meeting. Depending on the Support Coordinator's capacity, the General Manager – Life Skills & Accommodation may undertake this contact.

The Initial Support Coordination Meeting must be undertaken within 5 working days of the Intake meeting. For participants receiving Specialised Support Coordination, the assessment must include a functional assessment using Partner In Your Care's Service Need Assessment Profile (SNAP) to help determine in detail the range of supports the participant may require.

All assessments must also include a *Participant Risk Assessment*, and *Home Risk Assessment* where required, as per Partner In Your Care's *Risk Management Policy and Procedure*. Particularly where participants are receiving Specialised Support Coordination, Support Coordinators should use these risk assessments to thoroughly understand the risk factors experienced by the participant in the context of their high-risk circumstances and/or complex needs.

Participants or their nominee (if the participant does not have capacity) must be involved in the evaluation of their situation and identification of the supports they require, consistent with the provisions set out in Partner In Your Care's *Assessment, Planning and Review Policy and Procedure*. Where participants are receiving Specialised Support Coordination, this evaluation and identification should focus on the supports they require to prevent or respond to a crisis, incident or breakdown of support arrangements, as well promoting the safety of the participant and others.

Any immediately relevant referrals should be provided to the participant during the meeting, in accordance with Partner In Your Care's *Providing Information, Advice and Referrals Policy and Procedure*. Referrals to (and from) other providers must be documented for each participant on their file.

The meeting should also focus on explaining the type and number of hours of Support Coordination that are funded in the participant's NDIS Plan, and how this will be managed across the Support Coordination period. For instance, if a participant has been funded for 15 hours of Support Coordination in total, this could be delivered in five hours in the first month, three hours in the second month, two hours each second month thereafter then three hours prior to Plan Review. This conversation is important to set expectations for the participant and

their supporters in terms of the communication they'll have with their Support Coordinator.

The meeting should result in a mutually agreed *Support Coordination Action Plan*, a unique, tailored and whole-of-life program that reflects the participant's specific needs, desires and aspirations and enables them to achieve the goals in their NDIS Plan. Copies of the Action Plan must be provided to the participant and attached to their Service Agreement in their file.

All support coordination arrangements must focus on addressing barriers to participation for the participant. In addition, as a time-limited support, support coordination activities should help participants to build their own capacity to participate in NDIS processes and effectively coordinate their own supports. As such, Support Coordination and the resulting Action Plan should take an educative approach to helping participants to activate their NDIS Plan (i.e. link to service providers), monitor the quality and cost of supports, manage flexibility within their plan and prepare for Plan reviews.

Support Coordination Action Plans must include clear goals for the duration of the participant's first NDIS Plan that aim to decrease the need for support coordination services. They must also include actions to support transition of support coordination responsibilities from the Support Coordinator to their participant or their supporters by the end of the intended Support Coordination period.

Specific activities that could be included in a *Support Coordination Action Plan* include:

- assisting participants to access and begin to use the NDIS Participant Portal;
- assisting participants to search for, contact and select providers;
- assisting participants to enter into Service Agreements with preferred providers;
- ensuring service bookings are completed in the Participant Portal;
- making referrals for any assessments in the plan or other supports, in accordance with Partner In Your Care's *Providing Information, Advice and Referrals Policy and Procedure*;
- ensuring any urgent equipment requests are managed;
- ensuring participants are informed about service provider feedback processes;
- reporting to the NDIA;
- ensuring skill building supports are implemented and followed by personal support workers, and are complimentary to other plans that already exist in a participant's life (such as behaviour management plans, individual learning plans or skill development plans);
- supporting participants to monitor plan expenditure to ensure they can manage their budget over a 12-month period;
- strengthening and enhancing participants' abilities to coordinate supports and participate in the community;
- assisting participants to resolve points of crisis;
- ensuring participants are accessing any eligible supports through the Health, Justice, Education and Housing sectors;
- assisting participants to start to think about their next plan and develop their goals prior to their plan review;
- preparing participants for plan reviews by developing new goals, evaluating current supports and exploring new supports;
- assisting participants to fill in and return any NDIS review documentation; and
- in extenuating circumstances, supporting participants to request additional funded supports by seeking an earlier plan review.

Initial Coordination

Following the Planning meeting and agreement on a *Support Coordination Action Plan*, the

Support Coordinator must investigate and coordinate suitable supports in order to implement the participant's NDIS Plan. Informal supports, mainstream providers and other NDIS providers that have the appropriate skills and experience to deliver the required support should be considered in this exercise.

The Support Coordinator must also consult with the participant and, with the participant's consent, the participant's support network and mainstream services (where relevant) to ensure supports meet the participant's needs.

Where the participant is receiving Specialised Support Coordination, this role may be undertaken by a different Support Coordinator who is not an allied health professional e.g. Occupational Therapist, in collaboration with the original Support Coordinator.

In all cases, the Support Coordinator must provide the participant with a range of service providers to select from, for each type of support they require. Partner In Your Care can be included, provided its conflict of interest is declared (as set out above) and the participant is not pressured in any way to select this option.

The service providers recommended to the participant should be based on the participant's specific requirements and the nature and number of relevant providers in their local area. If one of the providers is Partner In Your Care, staff must be objective in their advice and avoid influencing the participant to choose its services. Where there is only one provider available, staff must make this clear to the participant and detail what their rights are regarding making complaints and using an advocate to help ensure they receive the type and quality of support they require.

Should the participant's preferred provider (or any provider) be unable to provide the required supports, the Support Coordinator should explain other options available or alternatively what support could be provided in the future and check whether the participant would like to be added to the provider's waiting list.

An alternative option for participants who self-manage their NDIS funds is to directly employ support workers and the Support Coordinator should provide them with detailed guidance about the benefits and challenges of this approach.

Part of a participant's decision-making process may include meeting or speaking to potential providers. Support Coordinators must support them to do these things in order to support their informed choice and control.

It is also important to consider the participant's overall NDIS budget and the cost effectiveness and efficiency of different options The Support Coordinator must be prepared to think creatively about how funds can be used to varying levels of flexibility within the different budgets (Core, Capacity Building and Capital) in the participant's NDIS Plan, while adhering to the requirements of the *NDIS Price Guide*.
It is also important that each budget is clearly explained so that the participant is fully aware of possible shortfalls and surpluses in each one. Funds should be used in a way that is directed by the participant and for the purposes intended by the participant. Where possible, funded supports should be complemented by informal, community and mainstream services to achieve the objectives of the participant's plan.

The Support Coordinator must record all details of their support coordination on the participant's file, including the options provided, the participant's decision regarding each option and the basis for their final decision.

Once the participant has selected a provider or providers, the Support Coordinator must assist

them to contact them and reach agreement on the services to be provided. This includes developing and agreeing upon Service Agreements with those providers. Particularly for participants receiving Specialised Support Coordination, the Support Coordinator must proactively engage with selected providers to ensure they understand and adequately respond to the risk and/or complexity of the participant's situation, and collaborate with other relevant providers to do so, where required.

Ongoing Support

Ongoing support provided by Support Coordinators to recipients of Coordination of Supports or Specialised Support Coordination might include:

- active management and ongoing adjustment of supports due to the participant's changing needs;
- management of multiple/complex supports from a range of providers;
- crisis resolution and developing resilience; and
- regular monitoring and outcome reporting for the participant and NDIA (see below).

Support Coordinators are also responsible for helping participants to resolve service delivery issues. This could include working closely with specific providers to ensure the required outcomes are being delivered, supporting the participant to change providers and building their capacity to interact with their providers.

Where a participant is accessing Partner In Your Care's services and experiencing service delivery issues, their Support Coordinator must engage openly and honestly with the staff delivering these services in order to resolve the concerns. Similarly, all Partner In Your Care staff are expected to work with Support Coordinators and participants to understand how well services are meeting participants' needs. They must also respond quickly and effectively to any complaints that arise, in accordance with Partner In Your Care's *Feedback, Compliments and Complaints Policy and Procedure*.

Support Coordinators must keep a clear record of any issues that arise, of the actions taken, and the resolution of the issue, in participants' files and Partner In Your Care's *Feedback and Complaints Register* (where applicable).

Support Coordination Monitoring and Review

Support Coordinators must meet with participants receiving Specialist Support Coordination on at least a monthly basis and with recipients of Support Coordination at least three-monthly. These Monitoring and Review meetings should focus on ensuring service delivery remains appropriate and relevant to the participant's needs and is helping them achieve their goals. Where a participant's progress is different from expected outcomes, their *Support Coordination Action Plan* must be updated and attached to their Service Agreement. If the participant wishes to change their service delivery outside of regular Monitoring and Review meetings, they can request a review with their Support Coordinator at any time.

Common outcomes that the NDIA expect participants receiving Support Coordination to achieve include:

- being supported to work towards their goals;
- being well connected with informal and mainstream supports;
- helping participants and their service network to better understand how to be involved in NDIS processes, such as establishing agreements with service providers, such as

establishing agreements with service providers, managing budget flexibility and setting and refining goals, objectives and strategies;
- supports being managed within the budget parameters in their NDIS Plan;
- having genuine choice and control of service providers;
- where possible, being confident to manage their support with no or a reduced need for support coordination in subsequent plans;
- being able to manage any issues that arise with service provision; and
- being able to address issues or barriers in accessing service provision within their existing funded supports in the first instance or seek a plan review if required.

Reporting

Support Coordinators are expected to provide Progress Reports on participants' specific goals, outcomes and success indicators. Reporting requirements are set out in the initial Request for Service provided for each participant by the NDIA. All reports requested by the NDIA must be provided to the participant.

Progress Reports are typically expected at 8 weeks after referral and 9 months after the commencement of Support Coordination services. An Outcomes Report is usually required 6 weeks prior to a participant's plan review.

Report templates may be provided by the NDIA. If not, reports should address:
- the level of Support Coordination required, and the date support commenced;
- hours funded in the participant's current plan and hours used to date;
- the participant's goals for the plan period and expected outcomes;
- a summary of the support provided to the participant;
- progress made towards reaching the goals;
- support required to assist the participant achieve their goals;
- current barriers preventing the participant from achieving their goals;
- areas of the participant's current situation that require attention, e.g. lack of informal supports, aging carer, risk issues, etc.;
- risks to the participant or others;
- immediate specialist assessments the participant requires connection with;
- identified provider connection/s required;
- Service Agreements and Service Bookings to be established;
- mainstream support required;
- community support required;
- evidence or other information that may be relevant for the NDIA to consider when determining reasonable and necessary supports for the participant;
- other support required including working towards a specific goal for the participant's second plan; and
- justification for the any recommendation for additional supports and details of the expected outcomes (including the risk and impact on other supports).

Reports should track progress towards expected outcomes. If any of these outcomes are not met, barriers must be clearly identified, and strategies put in place to address them.

All reports must be approved by the General Manager – Life Skills & Accommodation before they are provided to the participant. Copies of reports should also be kept on the participant's file.

Monitoring and Review

This policy and procedure will be reviewed at least annually by the Management Team. Reviews will incorporate staff, participant and other stakeholder feedback.

Partner In Your Care's *Continuous Improvement Register* will be used to record identified improvements and monitor the progress of their implementation. Where relevant, this information will be incorporated into Partner In Your Care's service planning and delivery processes.

Endorsement Date:	Reviewed Date:	Reviewed Date:	Reviewed Date:	Reviewed Date:
12/11/2018	10/09/2019	01/06/2021	21/11/2022	
Reviewed by / Rob Nelson Signature:	Reviewed by / Rob Nelson Signature:	Reviewed by/ Bianca Yee Signature:	Reviewed by/ Bianca Yee Signature:	
This policy and procedure will be reviewed at least annually and changes endorsed by the Management Team.				