CARE MANAGEMENT POLICY AND PROCEDURE

Version 2.0: June 2026

CARE MANAGEMENT (SUPPORT AT HOME) POLICY AND PROCEDURE

Purpose and Scope

Care Management is a core activity of the Support At Home (SAH) Program that prioritises wellness, reablement and individualised choice. The purpose of this policy and procedure is to outline Bilingual Care's care management approach in the delivery of approved, funded and agreed care services. It ensures that care management reflects each consumer's individual needs, goals, preferences and culturally appropriate practices. It also requires Bilingual Care to assist the consumer to understand, access and navigate the level of support they require in a simple and transparent manner that effectively meets their needs.

This policy and procedure applies to Bilingual Care's staff and health professionals responsible for care management, including volunteers and contractors (associated providers). All staff and health professionals are accountable for their own practice and must work within their professional scope, registration requirements, the *Aged Care Code of Conduct* and relevant clinical guidelines and activities pertaining to care management.

This policy and procedure must be read in conjunction with Bilingual Care's *Service Access and Intake Policy and Procedure*, *Initial Assessment and Care Planning Policy and Procedure*, *Care Review Policy and Procedure* and *Service Exit Policy and Procedure*. It meets relevant legislation, regulations and Standards.

Applicable Strengthened Aged Care Quality Standards

- *Standard 1: The Individual*
- *Standard 2: The Organisation*
- *Standard 3: The Care and Services*
- *Standard 4: The Environment*
- *Standard 5: Clinical Care*

Definitions

Care Management Activities - activities that may be delivered directly i.e. communicating with the consumer and/or their registered supporter, or indirectly i.e. completing a specific activity on behalf of the consumer without their direct involvement. Care management is to include a balance of direct and indirect activities and is dependent on the consumer and their changing needs.

Providers are responsible for delivering at least one mandatory Care Management activity to each consumer every month (minimum duration of activity is 15 minutes).

- ***Included*** Care Management activities that can be claimed from SAH funding are for Care Planning, Service Planning and Management, care plan monitoring, review and evaluation, budget updates, case conferencing, support and education with the consumer and/or their registered supporter, and includes care discussions with relevant health professionals, as required.

- ***Excluded*** Care Management activities that cannot be claimed from SAH funding are administration and associated costs e.g. scheduling services, rosters, claims management, staff travel, staff training and education, program governance and compliance activities, (SIRS reporting and complaint resolutions), record keeping, human resource activities (recruitment, performance management), and AT-HM Services and activities.

Care Partner – a dedicated Case Manager assigned under the Support at Home Program to assist consumers choose and manage services, coordinate care plans, manage budgets and act as liaisons with health providers. Care Partners can be appropriately experienced and trained aged care workers, or have a health-related qualification, or both, based on the different models of care delivery, the workforce and the types of services delivered by the provider.

Care Plan – a person-centred document used to formalise a consumer's choice and control over their services. Care Plans are a key resource that documents a consumer's needs, goals, preferences and how funded aged care services will help the consumer achieve their goals. Care Plans will have a different focus for each person.

Care Planning – a personalised, collaborative process that determines and outlines a consumer's assessed needs, goals and care preferences. It acts as a road map for delivering tailored, person-centred support.

Care Plan Review - formal reassessment of a consumer's health, medical or aged care needs at least every 12 months and/or to update the *Care Plan* for circumstances such as:

- when needs, health or living circumstances change
- to access different and or additional services, or
- to adjust care goals or move to a higher funding level.

Note: additional services are when a consumer receives approval for a short-term pathway such as the AT-HM scheme or End of Life pathway, or the consumer wants to change their services or frequency of services.

Care Plan reviews should be based on a wellness and reablement approach, evaluate outcomes and success of the supports that have been provided, and are an opportunity to renegotiate and update the consumer's *Individualised Budget* where required. A consumer can request a *Care Plan* review at any time as needed.

Care Notes - records of important communications, interactions and observations with the consumer. This can include:

- observations and conversations about their needs, goals, care and or services, including discussions with the consumer's family, carers, registered supporters and representatives
- records of meetings or case conferences held in relation to the consumer
- documentation of emerging risks, outcomes of risk, and/or clinical assessments undertaken and mitigation strategies
- information on reported incidents or near misses along with subsequent investigations (unless recorded in a specific Incident Management System)
- details of complaints raised and actions taken (unless recorded in a specific Complaints Management System) and
- information on billing issues or changes to service delivery.

Care Notes are to be regularly reviewed by Care Partners to ensure holistic understanding of a consumer's situation and needs and to inform ongoing Care Planning Support.

Clinically Qualified Care Partner - service coordination by a professionally qualified Care Partner (e.g. RN, Physiotherapist, social worker). A Clinically Qualified Care Partner is required for consumers with more complex care needs e.g. consumers receiving services under the End-of-Life Pathway, or for all consumers with a classification of level 6 or higher.

End-of-Life Pathway - supports older consumers during the final stages of life under the Support at Home Program who have been diagnosed with less than 3 months to live. The pathway provides services such as urgent support and funding for personal care, domestic assistance and general nursing. It works alongside any government-funded palliative care a consumer already receives.

End-of-Life Care Partner - a suitably qualified clinician responsible for multi-disciplinary team coordination in ensuring end-of-life care is holistic, complementary and person-centred, and services are coordinated and provided seamlessly.

Goals of Care – the process of identifying what matters most for the consumer (e.g. comfort, independence, staying at home), what support services align with those values, what should be avoided if it doesn't support consumer goals, and who will make decisions if the consumer can't speak for themselves. This applies across consumers with chronic illness, frailty, disability, dementia, palliative care, or after major health changes.

Multidisciplinary Team (MDT) - a collaborative group of health professionals from different disciplines or specialties who work together to plan, coordinate, deliver and review support services based on a consumer's assessed needs and goals to ensure person-centred and holistic care.

Relationship-based Support and Planning - involves the care partner building rapport, trust and empathy with the consumer and understanding their age-related health issues and needs in the context of the consumer's life. A trusting relationship between the consumer and care partner enables better understanding of the consumers expectations for service delivery, increased engagement and decision making, effective service planning and timely response to the consumers changing needs. This in turn can lead to improved outcomes, better continuity of care and increased consumer satisfaction.

Restorative Care Pathway - a short term, intensive pathway under the Support at Home Program that provides coordinated allied health and/or nursing services to restore or maintain function and support independence.

Restorative Care Partner - a suitably qualified clinician responsible for coordinating, managing and overseeing a consumer's restorative care episode, including goal planning, multi-disciplinary team coordination, monitoring and exit planning.

Service Agreement - legally binding contract between a service provider and the consumer. It outlines exactly what services will be provided, agreed costs, terms and conditions of service, rights and responsibilities of both parties to ensure mutual expectations are met. The *Service Agreement* must comply with the conditions set out in the *Aged Care Act 2024 (Cth)* and *Aged Care Rules*, and use inclusive and plain English that avoids legal jargon, words and phrases.

Serious Incident Reporting Scheme (SIRS) - SIRS requires serious incidents (e.g. abuse and neglect) to be notified to the Aged Care Quality and Safety Commission. Providers are

responsible for preventing incidents and reporting serious ones. See Bilingual Care's *Consumer Incident Management Policy and Procedure* for detailed guidance.

Registered Supporter - a trusted person, a family member or friend, chosen by the consumer who helps the consumer make and communicate decisions about their aged care requirements. Both the consumer and supporter must agree to the arrangement and provide consent. A registered supporter can access information and speak to providers on behalf of the consumer but do not have the legal authority to make decisions. Registration to be a registered supporter is via the My Aged Care portal – see Bilingual Care's *Decision Making, Dignity and Choice Policy and Procedure* for further details.

Policy

Bilingual Care is committed to delivering care management in accordance with the *Aged Care Act 2024 (Cth)*, *Aged Care Rules 2025*, *Strengthened Aged Care Quality Standards* and *Aged Care Code of Conduct*, ensuring Bilingual Care's services are safe and reflect individual values and needs for overall wellbeing. Effective care management means that there are accountable and quality services delivered by having ongoing assessment, planning and coordination of Support at Home services by a Care Partner. The Care Partner monitors and adjusts supports so that they remain aligned and appropriate to the consumer's needs and goals, provide value for money, and support them to lively safely and comfortably in their own home as long as possible.

Bilingual Care will ensure care management activities are coordinated and delivered by a Care Partner who will work with the consumer to develop a personalised *Care Plan* for their individualised needs before care commences. Bilingual Care is committed to promoting personalised care planning and applying trauma informed, culturally safe, wellness and reablement approaches within the person-centred and rights-based framework.

Bilingual Care will ensure the Care Partner completes a mandatory direct Care Management activity at least once a month (e.g. phone call or meeting) to ensure consumer's *Care Plans* accurately reflects their changing needs.

Bilingual Care expects all staff to strictly comply with the *Aged Care Code of Conduct* and to treat all consumers with dignity, respect, uphold their rights, and keep them safe.

Bilingual Care will provide active oversight, budget reviews and risk monitoring even if consumers choose to partially self-manage their services. Bilingual Care will only use the Care Management account for care management activities for ongoing service provision (not short-term pathways) as per SAH program requirements.

About Care Management

Care management is a collaborative, consumer focused approach and set of activities designed to coordinate medical, social and support services to ensure the overall safety, well-being and quality of life of an individual and reduce overall healthcare costs. It ensures that the delivery of approved funded aged care services reflects individual needs, preferences and culturally appropriate practices, whilst assisting consumers to understand and access the level of support they require.

Care management involves regular and ongoing contact and communication with the consumer, their family (including registered supporters and representatives) to establish relationship-based support and planning between the Care Partner, the consumer and those

that support them. It includes scheduled check-ins and reviews to ensure needs are identified and addressed in a timely manner.

Care management involves initial and ongoing:

- establishment and review of *Service Agreements* and helping consumers to understand their rights and obligations and Bilingual Care's responsibilities
- care planning
- services planning and management
- development, review and evaluation of consumers' *Care Plan* and quarterly *Individualised Budget*
- monitoring of services provided
- providing information and education about the consumer's care and services
- support to connect to health and other services, as needed, and
- assistance to request a My Aged Care Support Plan review, if needed.

Care management will be different for each consumer based on their individualised needs, goals, support network, communication preferences, level of involvement and cultural background.

Care management applies to all consumers receiving services under the ongoing Support at Home classifications, and short term funding pathways (Restorative Care Pathway and End-of-Life Pathway) which also require mandatory care and management activities. Note: the 10% set aside for Care Management from a consumers ongoing budget (if applicable) does not apply for these short-term classifications).

Care management resource allocation is based on each consumer's required needs, emerging risks and complexity of an individual's circumstances, psychosocial factors and is not solely based on an individual's Support at Home classification. Care management also applies to self-managed consumers who require a base level of care management for Bilingual Care to meet their obligations.

Care management is **mandatory** and must be delivered to each consumer **at least monthly**. This should be a **direct** care management activity of **at least 15 minutes**.

Support at Home consumers who receive ongoing services will have 10% deducted from their quarterly budget for care management and be allocated into Bilingual Care's Care Management account and is pooled with the care management funding from all other consumers within a Service Delivery Branch. The pooled funding model for care management provides for a flexible approach for providers to meet the changing care needs of their consumers.

Procedures

Principles

To ensure effective service delivery and positive outcomes, Bilingual Care will deliver Care Management underpinned by the following principles:

- adopt a person-centred approach to meet the unique needs, preferences and circumstances of every consumer
- provide culturally safe services, including for Aboriginal and Torres Strait Islander people
- empower consumers by providing greater choice and autonomy in their care, fostering ownership and engagement
- provide flexibility to accommodate changes in individual circumstances

- develop, implement and regularly review Care Plans that are centred on consumer-defined goals, and reflect the needs, preferences and input of consumers, their families, and support networks
- promote self-esteem and independence by supporting consumers to achieve person-centred goals through taking reasonable risks
- provide care coordination, holistic initial assessments and regular ongoing reassessments to monitor needs, risks and outcomes, and adjust services in a timely manner
- identify consumers' strengths and ways they can be actively involved in managing and achieving their goals
- utilise assessment findings, including information from My Aged Care and other providers, to inform and direct care planning, service delivery and risk management
- coordinate and engage appropriate service providers and multidisciplinary supports to meet the needs of each consumer, their family and support networks. This may include medical practitioners, nurses, allied health professionals, support workers, carers and other relevant providers, as needed
- ensure service providers engaged in care delivery are appropriately skilled, qualified and supported to meet the assessed needs of consumers
- facilitate regular communication, information sharing and case conferencing (where appropriate) between the consumer, their supports and service providers to ensure coordinated and effective care
- support safe and effective medication management by facilitating access to pharmacist or medical practitioner-led medication reviews and promoting consumer understanding of medications, as applicable
- monitor service quality, consumer outcomes and satisfaction, and respond to feedback, incidents and emerging risks in line with continuous improvement requirements
- support integration across services and sectors, including timely referrals, transitions of care, and collaboration with health and community services, and
- use appropriate systems, documentation and digital solutions (including My Aged Care systems where required) to support care coordination, communication, monitoring and reporting.

Roles and Responsibilities

The **Leadership Team** is responsible for:

- ensuring Bilingual Care complies with all Support at Home program requirements including requirements for care management
- overseeing the delivery of coordinated safe, high-quality rights-based care management activities for enhanced continuity of care
- embedding a goal based, person-centred wellness and reablement approach to care and support across the organisation
- ensuring appointed Care Partners complete the required training on the roles of care partners, clinically qualified care partners, care planning and budgets to effectively support care management activities (see Department of Health, Disability and Ageing, Learning Package 2 - Delivering Services Modules: *Module 5 – Care management* and *Module 6 - Self Management options for consumers*[1])
- supporting the ongoing professional development and training for its Care Partners
- maintaining effective clinical and operational governance systems to monitor quality, outcomes and improvement activities as part of continuous improvement

[1] Department of Health, Disability and Ageing (2026) *e-Learning for aged care workers and volunteers*, Australian Government, access 24 June 2026, https://www.health.gov.au/our-work/aged-care-act/prepare/elearning-for-aged-care-workers-and-volunteers#other-learning-resources

- ensuring strong consumer goal setting, reviews, risk identification and management, through relationship-based support and planning
- promoting and ensuring processes in place for supporting the consumer to provide feedback, make complaints without fear of reprisal by having clear and transparent feedback and complaints handling mechanisms in place.
- providing interpreter services or translated materials to support and assist with care and service planning.
- ensuring care management claiming activities delivered and claimed during the quarter (on a payment in arrears basis) are itemised as per other services claimed under the Support at Home program.

The **Care Partner nominated as the Care Management Partner** for Bilingual Care is responsible for:

- completing the required SAH training on the role of Care Partners, clinically qualified Care Partners, care planning, budgets, claiming activities, required reporting and record keeping requirements
- developing and regularly reviewing *Service Agreements, Care Plans* and quarterly *Individualised Budgets*, the consumer's goals for service delivery, assessments (including consumer and Environmental In-home risk assessments), strategies for managing identified risks, Advance Care Planning, if applicable, in collaboration with the consumer, their families and registered supporters
- providing copies of *Service Agreements*, *Care Plans* and *Individualised Budgets* to the consumer
- supporting consumers, their registered supporters and family members to navigate aged care related systems and programs and linking them to additional supports, where identified
- determining any existing supports that will be continued alongside the delivery of support at home services and supporting the consumer in deciding what services they want to receive, consistent with their aged care assessment
- encouraging and facilitating access to advocates, interpreters as needed, to ensure the consumer can convey their needs, goals, preferences, and any cultural supports required based on their preferred method and mode of communication
- collaborating with the consumer to determine how their services will be delivered, including preferences for workers and times / days of service
- providing ongoing support for the consumer to understand elements of the Support at Home Program
- monitoring the consumer's budget ensuring service delivery is within the budget allocation
- reviewing *Care Plans* regularly, when changes to care needs occur, and/or at the consumer's request, in collaboration with the consumer and their family, carers, supporters and/or representatives
- updating *Care Plans* at least every 12 months or at the request of the consumer
- reviewing *Service Agreements* at least every 12 months or more frequently if required (based on the consumer's needs), when changes to care needs occur, or at the request of the consumer
- supporting the consumer to maintain or rebuild independence through wellness and reablement approaches
- monitoring any changing needs by liaising regularly with the consumer, care workers, informal carers, supporters and/or representatives.
- coordinating referrals to allied health services, nursing or community services as required
- engaging with culturally specific organisations (as applicable to consumer needs)

- monitoring and addressing risks related to social isolation, mental health and elder abuse
- undertaking the required and timely SIRS reporting of reportable incidents to the Aged Care Quality and Safety Commission, as required
- supporting the consumer to access the Restorative Care Pathway or End-of-Life Pathway, if required
- liaising with professionals and other providers to facilitate transitions in and out of different care settings (e.g. hospitals, residential respite), including transfer to residential care, as required
- providing consumers with information and resources on age-related health matters
- supporting the consumer to provide feedback and make complaints without fear of reprisal, as per Bilingual Care's *Feedback and Complaints Policy and Procedure*
- communicating with the consumer and those involved with care, when the consumer wishes to cease funded aged care services, to confirm cessation of services and the exit date, and advise other third-party providers involved with care to cease the delivery of services
- communicating with any new providers or professionals regarding consumer's care requirements and supporting the consumer and their family, carers, supporters and representatives to prepare for the transition, and
- ensuring appropriate continuity to care arrangements are in place up to and including exit date, if required.

Staff are responsible for:

- communicating with consumers using the identified preferred communication method e.g. using interpreters, advocates or devices for them to fully understand and follow their *Care Plan*
- supporting the consumer to promote on going well-being and capacity building
- reporting promptly to the Clinical Advisor if there are any changes or risks identified in the consumers care needs for required actions to be taken to maintain ongoing safety, and
- documenting clear case notes in a timely manner on services provided, issues identified and actions taken.

Goals of Care Management

When supporting consumers with care management, the Clinical Advisor will take into account and strive to achieve the following goals:

1. **Improved Aged Care Outcomes**, including:
   - better management of ageing related conditions
   - enhanced preventive and rehabilitative care by embedding wellness and reablement approaches
   - improved understanding for consumers and staff about the goals for service delivery, increasing overall well-being and quality of life
   - increased outcomes for people living with Dementia
   - improved outcomes for Aboriginal and Torres Strait Islander consumers through culturally safe care that respects identities, traditions and values, and
   - improved outcomes for people from Culturally and Linguistically Diverse (CALD) backgrounds, through the use of interpreters, culturally appropriate communication and care planning that respects family and cultural values.

2. **Enhanced Continuity of Care**, including:
   - regular communication with and collaboration across care providers

- minimising duplication of services, and
- smooth transitions between providers and care settings.

3. **Increased Consumer Satisfaction**

4. **Person-centred Care**, including:
   - providing relationship-based support and planning through establishing trust and understanding of the consumer's needs
   - regular and ongoing engagement with consumers, carers, supporters and representatives
   - timely and flexible responses to consumer needs
   - improved communication and support around in-home aged care services, and
   - shared decision making with consent of the consumer, inclusion of family members and carers, especially in Aboriginal, Torres Strait Islander and CALD communities.

5. **Optimised Use of Resources**, including:
   - consolidating service planning and information sharing with primary care services, and
   - reducing use of services including reduced hospitalisation.

6. **Increased Self-determination** – active involvement of consumers through:
   - collaboration and wellness approaches
   - increasing self-sufficiency, self-care skills and empowerment to make informed decisions about their care and services, and
   - supporting them to develop independence and engage in behaviours that promote well-being.

7. **Engaged Carers and Supporters**, including:
   - provision of resources and education to better equip carers and registered supporters to assist consumers
   - better inclusion of carers and registered supporters as active partners in the consumer's care, in line with the consumers wishes, and
   - support for carers to navigate safe aged care systems, and access services in ways that are respectful of cultural context, care giving roles and communication needs.

Care Management

To ensure effective, coordinated and collaborative care management, the Clinical Advisor will undertake the following activities:

- Regular and ongoing communication with the consumer, their family members or those who support them to establish a relationship-based support approach for effective service planning.

- *Service Agreement* to be developed and reviewed to understand the consumer's rights and obligations and to ensure mutual expectations are verified and approved between Bilingual Care and the consumer. See Bilingual Care's *Service Access and Intake Policy and Procedure*.

- Care Planning - needs assessment, goal planning and developing tailored *Care Plans* in collaboration with the consumer and others involved with care to ensure goals,

needs, preferences, level of involvement and cultural practice requirements are met. Copy of the *Service Agreement*, *Care Plan* and *Individualised Budget* are to be given to the consumer. See Bilingual Care's *Initial Assessment and Care Planning Policy and Procedure*.

- Service Planning and Management – organising required supports, coordinating workers, establishing and managing budgets, and ensuring continuity of care by adjusting supports as consumer needs and goals change.

- Development, review and evaluation of consumer's *Care Plans* and their quarterly budget to ensure they reflect changing needs and preferences.

- Monitoring the services provided through proactive identification and management of risks, by undertaking consumer and environmental in-home risk assessments, utilising system alerts, care notes and internal case conferencing to ensure risk mitigation strategies developed in collaboration with the consumer are in place for their ongoing health, safety and well-being.

- Provision of information and education about the consumer's care and services to assist consumers understand their approved services and make informed decisions about their ageing related needs and ongoing care.

- Support to connect to health and other services when needed by undertaking timely referrals to other professionals, ensuring appropriate care and service delivery.

- Assistance provided to the consumer to request a Support Plan review at any time, if needed.

- A Direct Care Management Activity is delivered and documented for each consumer at least monthly and is of at least 15 minutes duration.

- *Care Plans* to be reviewed and updated at least annually or as changes to consumers care needs change. See Bilingual Care's *Care Review Policy and Procedure*.

- Consumers receiving Restorative Care, End-of-Life Care, and self-managed consumers who require base level care management also receive care management activities under the applicable SAH classification. See Bilingual Care's *Restorative Care Policy and Procedure* and *End of Life Care Policy and Procedure*.

- Compliance - all services provided comply with the *Strengthened Aged Care Quality Standards*, and all staff and volunteers uphold the *Aged Care Code of Conduct* in service provision. Additionally,
    - Serious Incidents are to be reported through the Serious Incident Reporting Scheme (SIRS). See Bilingual Care's *Consumer Incident Management Policy and Procedure*, and
    - Monthly statements must be issued to consumers detailing available funds, how the money is being spent and any unspent amounts for financial transparency. A specific Care Management account is in place for claiming and any funds rollovers. See Bilingual Care's *Consumer Budget Management Policy and Procedure*.

- Transition processes are in place for consumers wishing to transition to another provider, pause services or exit the program permanently to ensure continuous and

safe care handover across settings. See Bilingual Care's *Service Exit Policy and Procedure*.

Feedback and Complaints and Continuous Improvement

Staff are to ensure consumers and their families/supporters are made aware of the complaints and feedback process and how to access it without fear of reprisal. Feedback and complaints are to be encouraged to improve services provided. See Bilingual Care's *Feedback and Complaints Policy and Procedure* for further information.

Bilingual Care will undertake periodic surveys of consumers receiving care management to evaluate feedback and identify areas for continuous improvement.

Supporting Documents

Documents relevant to this policy and procedure include:

- *Associated Providers Policy and Procedure*
- *Care Review Policy and Procedure*
- *Case Notes Policy and Procedure*
- *Clinical Governance Framework*
- *End of Life Care Policy and Procedure*
- *Feedback and Complaints Policy and Procedure*
- *Governance Policy and Procedure.*
- *Consumer Incident Management Policy and Procedure*
- *Initial Assessment and Care Planning Policy and Procedure*
- *Personal Care Policy and Procedure*
- *Restorative Care Management Policy and Procedure*
- *Risk Management Policy and Procedure*
- *Service Access and Intake Policy and Procedure*
- *Training and Development Policy and Procedure*
- *Care Plan*
- *Continuous Improvement Plan*
- *Consumer Risk Assessment*
- *Environmental In-Home Risk Assessment*
- *Aged Care Code of Conduct*
- *Statement of Rights*
- *Strengthened Aged Care Quality Standards*
- *Aged Care Act 2024 (Cth)*
- *Aged Care Rules 2025*

References

Department of Health, Disability and Ageing (2025), *Support at Home Program Manual (Version 4.2)*, Australian Government.

Monitoring and Review

This Policy and Procedure will be reviewed at least every two years by the Leadership Team. Reviews will incorporate staff, consumer, and other stakeholder feedback.

Bilingual Care's feedback collection mechanisms, such as consumer satisfaction surveys, will assess:

- satisfaction with the competency and thoroughness of staff supporting consumers with their Care Management activities
- understanding of Bilingual Care's assessment and planning processes for care management
- satisfaction with information and guidance provided
- awareness of and access to information during the assessment and planning process that allows them to make informed choices and remain in control of their care and services.

Bilingual Care's *Continuous Improvement Plan* will be used to record improvements identified and monitor the progress of their implementation. Where relevant, this information will be considered as part of Bilingual Care's service planning and delivery processes.

DOCUMENT CONTROL

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