MINISTRY OF HEALTH
MANATŪ HAUORA

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9 May 2018

A.E. Cruikshank
fyi-request-7690-b152db69@requests.fyi.org.nz

Dear A.E. Cruikshank

OIA request ref: H201803019

On 30 April 2018 you clarified your Official Information Act (OIA) request for information made on 23 April 2018. In your clarification email you state:

> *"The directive to independence is being given and promoted as policy by support worker trainers, to the support staff, during training sessions by at least one support service provider.*
>
> *The information that such a policy exists was given to a client, by a provider administrative staff member, during an annual client review. This specific request is in response to a conversation with a support reviewer during an annual care review with a client, the client having a care plan, reasonably recently reviewed by SupportNet, not in any way changed in content from the previous one, or altered to cover this policy of independence.*
>
> *The discussion included comments as to why certain tasks, allocated on the care plan, were not being attended to as regularly or thoroughly, or even at all, as previously and the response from the administrative reviewer was because support workers are being actively trained to encourage clients into independence.*
> *As any further anecdotal information would come from the perspective of a support worker, who is not allowed to discuss such issues with their clients, there is no other reliable method to gain this information.*
>
> *Thus this request.*
>
> - *Either the Ministry has put in place policy or guidelines that cover the information requested in this inquiry, or it hasn't.*
> - *If this policy of independence is contained, even obliquely or as unstated intent in the policy or training guidelines issued as any sort of MOH requirement or suggestion, or made available in any form to service providers for inclusion in staff training requirements, or for purposes of administration of service provision then I wish ALL documentation of such policy be provided by the Ministry."*

We have interpreted your request to be for policies that promote independence through the Ministry's Disability Support Services (DSS). DSS articulates a philosophy and an

over-riding objective of enhancing disabled people's independence. This is defined in the DSS tier one service specification, which covers all DSS contracted services and in a number of its tier two service specifications.

The Ministry does not issue policies about what it's contracted service providers must include in their workforce training. That is a matter for the individual service providers to determine.

In response to your request for information:

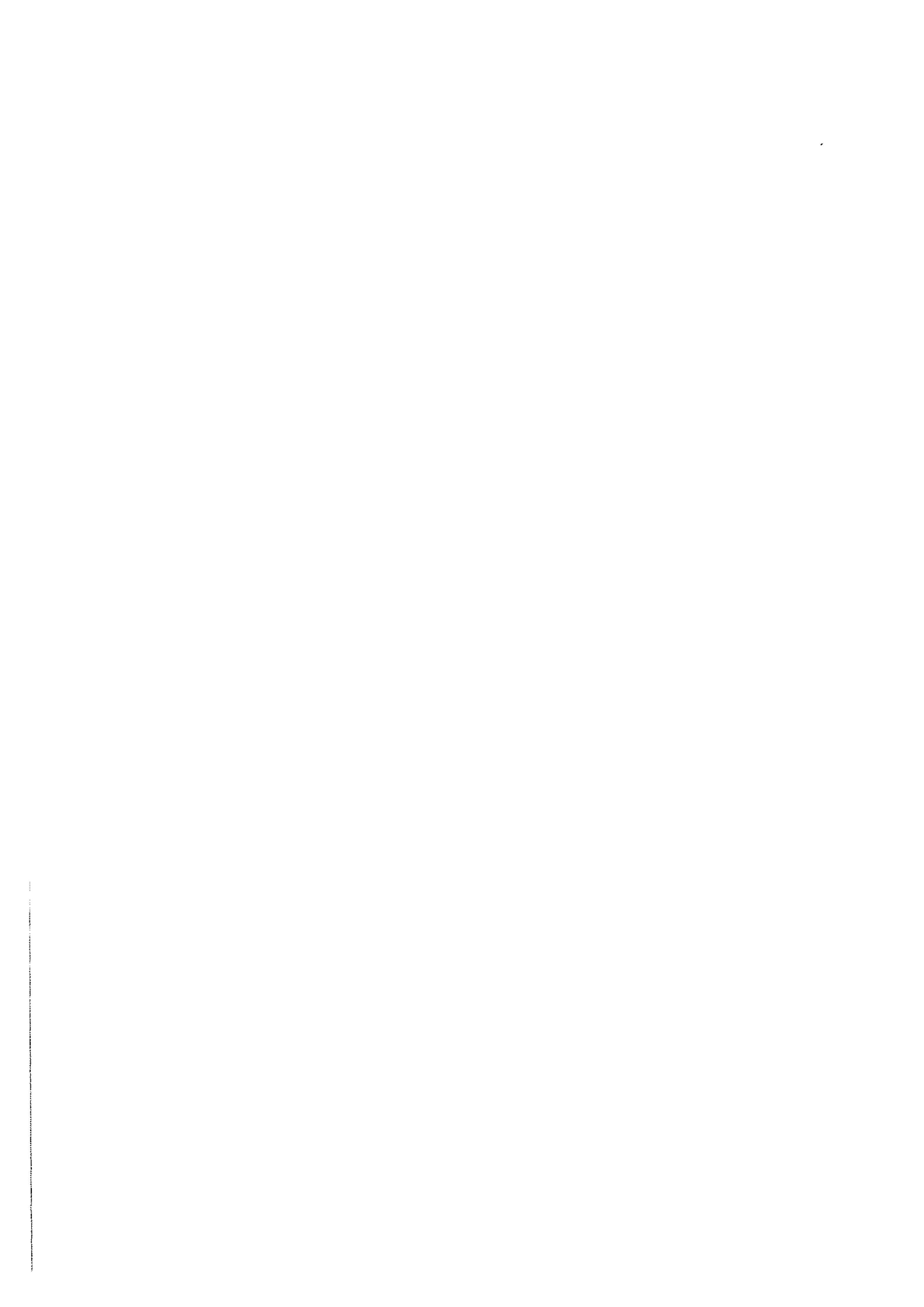
<table>
<tr><td rowspan="3">If this policy of independence is contained, even obliquely or as unstated intent in the policy or training guidelines issued as any sort of MOH requirement or suggestion, or made available in any form to service providers for inclusion in staff training requirements, or for purposes of administration of service provision then I wish ALL documentation of such policy be provided by the Ministry.</td><td>Appendix One contains DSS tier one service specification</td></tr>
<tr><td>Appendix two contains DSS Home and Community Support Services tier two service specification</td></tr>
<tr><td>All other DSS service specifications or contract guidelines with references to enhancing disabled people's independence can be found on the Ministry of Health website –

https://www.health.govt.nz/our-work/disability-services/contracting-and-working-disability-support-services/contracts-and-service-specifications.</td></tr>
</table>

I trust this information fulfils your request. You have the right, under section 28 of the Act, to ask the Ombudsman to review my decision.

Yours sincerely,

Jill Lane
Director
Service Commissioning



Appendix One

Disability Support Services
Tier One Service Specification

1. Introduction

This Tier One Service Specification applies to Disability Support Services purchased by the Purchasing Agency under an Outcome Agreement, irrespective of delivery setting.

Tier Two Specifications (and Tier Three Specifications, if any) define the service specific requirements funded under this Outcome Agreement and must be read in conjunction with this Tier One Service Specification.

2. Disability Support Services

Disability Support Services (DSS) is a group within the National Health Board Directorate of the Ministry of Health. Its aim is to build on the vision contained in the New Zealand Disability Strategy of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in 'A society that highly values our lives and continually enhances our full participation.'

With this vision in mind, DSS aims to enhance disabled people's quality of life and enable their community participation and maximum independence. This is achieved by creating linkages that allow disabled people's needs to be addressed holistically, in an environment most appropriate to them. The vision of DSS is to ensure "Disabled people and their families are supported to live the lives they choose".

DSS seeks to ensure that people with impairments experience autonomy on an equal basis to others. Support options are required to be flexible, responsive and needs based. They must focus on the person and, where relevant, their family, whānau and aiga, and enable people to make informed decisions about their lives.

3. DSS Principles

The following Disability Support Service principles will be incorporated in the provision of services by the Provider under this Outcome Agreement. These principles reflect the Purchasing Agency's commitment to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the objectives of the New Zealand Disability Strategy and the Code of Health and Disability Services Consumers' Rights.

3.1 People are individuals who have the inherent right to respect for their human worth and dignity

a) The individual needs and goals of the person receiving services are met

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b) The rights of the Person to privacy and confidentiality are respected.

3.2 People have the right to live in and be part of their community

a) Services have as their focus the achievement of positive outcomes for People, such as increased independence, self-determination and integration into their community

b) Services contribute to ensuring that the conditions of the everyday life of People are the same as, or as close as possible to norms and patterns, which are valued in the general community (normalisation)

c) Participation in the local community is maximised through physical and social integration

d) An innovative, flexible approach to meet changing needs and challenges is adopted.

3.3 People have the right to realise their individual capacities for physical, social, emotional and intellectual development

a) Services promote recognition of the competence of People, and enhance the image of people with a disability

b) A Person-led approach permeates all services with individualised services appropriately responding to the particular life skills, needs and goals of individual Persons.

3.4 People have the same rights as other members of society to services, which support their attaining a reasonable quality of life

a) Services form part of a co-ordinated service system with other services available to the general community

b) There is extensive co-operation and integration with Providers of other support services for people with a disability.

3.5 People have the right to make choices affecting their lives and to have access to information and services in a manner appropriate to their ability and culture

a) The Person's involvement in decision-making regarding individualised services received is evident

b) Service provision ensures that no single organisation providing services exercises control over all or most aspects of the life of the Person, unless the Person chooses otherwise

c) Providers demonstrate that as an organisation they are accountable to people using their service

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3.6 **People have the same rights as other members of society to participate in decisions which affect their lives**

a) Providers ensure that People are involved (or have advocacy support where necessary to participate) in decision-making about the services, which they receive

b) People are provided with, and encouraged to make use of avenues for participation in the planning and operation of services, which they receive

c) Opportunities are provided for consultation with People in relation to the development of the organisation's policy.

3.7 **People have the same rights as other members of society to receive services in a manner which results in the least restriction of their rights and opportunities**

a) Opportunities are provided for People to reach goals and enjoy lifestyles which are valued by the individual.

3.8 **People have the right to pursue any grievance in relation to services without fear of the services being discontinued or any form of recrimination**

a) Providers ensure appropriate avenues exist for People to raise and have resolved grievances about services, and to ensure that a person raising any such grievance does not suffer any reprisal

b) People have maximum protection from neglect, abuse and exploitation.

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4. Population Outcomes

Population Outcomes form part of the Results Based Accountability framework. The Population Outcomes relate to the wellbeing of an entire population rather than the clients of a single service or provider. Population Outcomes are not the responsibility of any one provider, agency, service or programme.

The Outcome Statements for disabled people in New Zealand and their family/ whānau and carers provide a "Line of Sight" from service level activity to wider population level outcomes. The Provider contributes to these outcomes but is not accountable for progress under the Population Outcome Statement.

For the purposes of this Population Outcome Statement the definition of disabled people is all *disabled people in New Zealand* (not just those People using Disability Support Services).

4.1 Experience Statements

The Experience Statements provide context for the Population Outcome Statement and illustrate what the population group might experience if the outcome statement was being met.

4.2 Population Indicators

Population indicators are the measures the Purchasing Agency uses to track progress towards the Outcomes described in the Population Outcome Statement. Providers are not measured directly against these indicators, but contribute to these as part of a suite of disability support services funded by the Purchasing Agency. Outcomes for People using specific services are measured via Performance Measures contained in Tier Two Specifications.

Population Indicators are likely to change over time as DSS improve collection and measurement tools to support the Outcome Statement.

4.3 Population Outcomes Table

The table below illustrates the DSS Population Outcome Statement, Experience Statements and Population Indicators.

Disabled People in New Zealand are safe, healthy, have choice and control and are equal citizens			
Are SAFE	*Are HEALTHY*	*Have CHOICE & CONTROL*	*Are EQUAL CITIZENS*
• Feel safe and are safe in multiple environments (that is, at home, in the wider community and at work) • Have a 'voice'; are empowered to communicate, are heard and decisions are acted upon • Are free from all forms of abuse • Are respected and valued by others in the community • Have trust-based	• Have a balanced sense of wellbeing/whānau ora; which encompasses cultural, physical, mental and spiritual elements • Are active in their culture or faith of choice • Have role models and role model positive lifestyles and choices • Lead self-determined wellbeing and support others in their wellbeing journey.	• Have a home of their choice • Have the support, information and other resources needed to achieve effective communication and get on with life • Have nurturing and loving relationships with others • Have a job of choice • Have an education of choice • Have the information	• Are treated with dignity and respect • Are acknowledged and valued • Have a wide range of positive relationships with social and professional peers • Are welcomed in the community and are valued as equal and also diverse members • Are actively engaged as

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relationships with others.		needed to make informed choices and lead lives to the fullest • Can fulfil self-determined aspirations • Are financially secure and free from poverty. • Have access to transport for participation in the community and recreational pursuits	leaders and decision-makers • Are aware of and exercise rights and duties • Support and benefit from the principles of Te Tiriti O Waitangi.

Population Indicators

• Rate of reported abuse.	• Rate of Emergency Department admissions • Depression rate • Life expectancy • Enrolment rate with Primary Health organisations • Rate of annual health checks.	• Rate of personal budget use • Rate of disabled people with qualifications • Employment rate.	• Access rate by Māori to DSS services • Access rate by Pacifika peoples to DSS Services • Access rate by Asian people to DSS Services.

4.4 Carer Outcomes Statement

DSS also has a responsibility to carers, family and whānau of disabled people. The table below details the Population Outcome Statement for this population group.

Family/ whānau and carers in New Zealand are healthy, supported, valued and enjoy life
• Families/whānau and carers of disabled people: • Feel valued and are appreciated for the skills, roles and contributions made • Have a balanced sense of wellbeing / whānau ora; which encompasses cultural, physical, mental and spiritual elements • Feel well and are supported to stay well • Are active and engaged learners and have access to training and education to meet people's needs • Have the information and resources needed to fulfil their roles of choice • Are respected for their diversity and choices • Are culturally safe and supported • Are financially stable • Enjoy life and live life to the fullest • Fulfil collective and individual goals and aspirations

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- Have trust-based and mutually respectful relationships with their loved ones
- Are included in communities of choice
- Are identified as being part of hapu and iwi.

Population Indicators

- Carer depression rate
- Carer injury rate
- Rate of carer uptake of the carer support subsidy
- Employment rate.

5. Eligibility

People able to access Disability Support Services are those who are eligible for New Zealand Public Health Services, according to the Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand available on the Ministry of Health Website, and who have been assessed with a physical, intellectual or sensory disability, including ASD (or a combination of these) which:

a) Is likely to continue for at least six months.

b) Limits their ability to function independently, to the extent that ongoing support is required.

Generally, Services funded by the Purchasing Agency are available to those under the age of 65 years. The major exception to this is Equipment Support Services funded by the Purchasing Agency, which are available to eligible disabled people of all ages.

The Purchasing Agency will also fund Services for people with:

a) Some neurological conditions that result in permanent disabilities.

b) Some developmental disabilities in children and young people, such as autism.

c) Physical, intellectual or sensory disability that co-exists with a health condition and/or injury.

Specific eligibility and access criteria to Services provided under this Agreement are defined as part of the attached Tier Two Service Specifications.

The Purchasing Agency generally does not fund Services for people whose primary diagnosis is for:

a) Personal health conditions such as diabetes or asthma.

b) Mental health and addiction conditions such as schizophrenia, severe depression or long-term addiction to alcohol and drugs.

c) Conditions more commonly associated with ageing such as Alzheimer's disease.

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Disability support services are also not funded for most people with impairments such as paraplegia and brain injury caused by accident or injury.

6. Cultural Acceptability

6.1 Cultural Values

The Provider will deliver services in a culturally appropriate and competent manner, ensuring that the integrity of each Person's culture is acknowledged and respected. The Provider will take account of the particular needs within the community served in order that there are no barriers to access or communication, and that services provided are effective.

6.2 Services to Māori

All contracted providers, whose service users may include Māori, shall demonstrate in their Quality Plan how the policies and practices of their provider organisation and service delivery shall benefit Māori. This reflects objectives of the New Zealand Disability Strategy, to ensure that mainstream providers of disability services are accessible to, and culturally appropriate for, disabled Māori and their whānau.

This approach also reflects the priorities of the Disability Support Services Māori Disability Strategy – Whāia Te Ao Mārama, including:

- Improved outcomes for Māori disabled
- Better support for whānau
- Good partnerships with Māori
- Responsive disability services for Māori.

6.3 Services to Pasifika

Services to Pasifika are to recognise differences especially as they relate to linguistic, cultural, social and religious practices. The Provider must develop and maintain linkages with key cultural groups in order to facilitate consultation and in planning, implementation, monitoring and review of services.

The Provider will deliver services to Pasifika and their aiga in accordance with the priorities set out in Faiva Ora – the Disability Support Services' Pacific Disability Plan. These are:

- Pasifika are aware of and understand disability issues and know how to access disability services
- Disability support services meet the needs of Pasifika People
- Pasifika family members and carers are supported to provide effective care.

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Services to Pasifika peoples will be provided in accordance with the 'Organisational Guidelines for Disability Support Services: Working with Pasifika People with Disabilities and their Families' (Le Va September 2014).

7. Quality Management

The Provider is required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services, mitigating risks and ensuring quality management and governance to achieve the best outcomes for People.

7.1 Written Policy, Procedures, Programme, Protocol, Guideline, Information, System or Plan

Where the Provider is required to develop a written policy, procedure, programme, protocol, guideline, information, system or plan in order to meet any specification under the Outcome Agreement, the Provider will develop such a document and demonstrate systems for reviewing and updating all such documents regularly.

7.2 Quality Plan

The Provider will have a Quality Plan designed to improve outcomes for People. This plan may be integrated into regular business plans. The plan will outline a clear quality strategy and will identify the organisational arrangements to implement it. The plan will be of a size and scope appropriate to the size of the Provider's organisation and services, and will at least include:

- an explicit quality philosophy
- clear quality objectives
- quality improvement and risk management systems
- systems for monitoring and Quality Audit compliance
- designated organisational and staff responsibilities
- input from People into services and into development of the Quality Plan
- how the Purchasing Agency will address Mäori issues including recognition of:
    i. Mäori participation with Strategic, Governance, Management and Service Delivery planning, implementation and review functions
    ii. Mäori as a Government Health Gain priority area
    iii. Mäori Health priority areas
    iv. The Ministry Mäori Health and Disability Policy and Strategies, and the Mäori Health Clause Appendix 6 of the Outcome Agreement
    v. Mäori specific quality specifications, monitoring requirements and service specific requirements.

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7.3 Employee's Registration, Education and Training

a) All employees will receive disability awareness training, including education on the rights of people with disabilities (with reference to the UNCRPD and the Code of Consumers Health and Disability Rights), disability values and appropriate attitudes towards people with disabilities.

b) Employees will, where relevant, be registered with the appropriate New Zealand statutory body (including the relevant health professional organisations), and will hold a current New Zealand practising certificate.

c) Employees will receive orientation and ongoing support and training to enhance service delivery, including access to continuing education to support maintenance of professional registration and enhancement of service delivery/clinical practice, and to ensure practice is safe and reflects knowledge of recent developments in service delivery.

The Ministry encourages providers to support their staff to attain Foundation Skills Level 2 of the National Certificate in Health, Disability, and Aged Support as a minimum qualification, or the New Zealand Certificate in Health and Wellbeing (Level 2).

Providers are encouraged to make use of the Let's Get Real: Disability Framework to assess and improve staff competencies(http://www.tepou.co.nz/library/tepou/lets-get-real-disability

7.4 Training and Supervision of Trainees and Volunteers

Volunteers and other relevant support employees will receive training to enable them to provide services safely, and will work only under the line management supervision and direction of appropriately qualified staff.

Trainees will at all times be clearly identified as trainees, and will provide services only under the supervision and direction of appropriately qualified staff.

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7.5 Internal Audit Process

The Provider will have in place service audit/peer review processes that incorporate input from relevant peers from similar services.

7.6 Personnel Identification

Staff, trainees or volunteers undertaking or observing service delivery will identify themselves to People and their family/whānau.

7.7 Risk Management

a) The Provider will have a risk management plan in place to:

i. identify key risks including risks to health and safety, People, and financial sustainability

ii. evaluate and prioritising those risks based on their potential severity, the effectiveness of any controls and the probability of occurrence

iii. manage those risks and where possible mitigating them

iv. minimise the adverse impact of internal emergencies and external or environmental disasters on People, staff and visitors

v. work with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services

vi. manage accidents and hazards to safeguard People, staff and visitors from avoidable incidents, accidents and hazards.

b) Risk management policies processes and procedures will include definitions of incidents and accidents that are compliant with the Ministry of Health Reportable Events Guidelines, and will clearly outline the responsibilities of all employees, including:

i. taking immediate action to minimise further harm

ii. reporting, monitoring and corrective action to minimise incidents, accidents and hazards, and improve safety

iii. debriefing and staff support as necessary.

7.8 Prevention of Abuse and/or Neglect

a) The Ministry has zero tolerance of any form of abuse or neglect of People using its funded services.

b) The Provider will safeguard People and their family/whānau , advocates, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment or neglect when interacting with the Service. The Provider will have policies and procedures on preventing, detecting and eliminating abuse and/or neglect. These will clearly outline the responsibilities of all staff who suspect actual or potential abuse, including immediate action, reporting, monitoring and corrective action. These procedures will also include reference to the Complaints Procedure.

c) The Provider will ensure that relevant employees are able to participate in family, inter-agency or court proceedings to address specific cases of abuse and neglect.

7.9 Where Services are declined

The Provider will have policies and procedures in place to manage the immediate safety of People for whom entry has been declined and where necessary, the safety of their immediate family/whānau and the wider community. These include:

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- Applying agreed criteria for providing services
- Advising the Person and/or their family/whānau of appropriate alternative services
- Recording that entry to the service has been declined, giving reasons and other relevant information.

7.10 Exit from Service

The Provider will collaborate with other services to ensure People access all necessary Services. When a Person is transferred or exits from services and accesses other appropriate services they will do so without avoidable delay or interruption.

The Provider will have policies and procedures for planning discharge/exit/transfer from services. These will facilitate appropriate outcomes as defined with the Person. The policies and procedures will include:

- defined employees' responsibilities for discharge planning
- incorporating discharge planning into the Person's plan of care/service plan, where appropriate from or before admission
- full involvement of the Person in planning service exit
- involvement of family/whānau, including advising them of service exit, as appropriate
- assessment and management of any risks associated with the service exit
- informing the Person on their condition, possible future course of this, any risks, emergency contacts, and how to access future treatment, care or support services
- where appropriate involving the Needs Assessment Service Coordination service, original referrer and the health professional having ongoing responsibility for the Person in planning discharge and informing them of confirmed service exit arrangements
- a process for monitoring that service exit planning does take place, which includes assessment of the effectiveness of the service exit planning programme.

7.11 Death/Tangihanga

The Provider will have policies and procedures to follow in the event of a death including:

- appropriate and culturally sensitive procedures for notification of next of kin
- any necessary certification and documentation
- appropriate cultural arrangements, particularly to meet the needs of Māori, are taken into account in the care of the deceased, until responsibility is accepted by the family/whānau or a duly authorised person.

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8. Service Acceptability

8.1 Service Information

Potential and current People, and referrers, will have access to appropriately presented information in order for eligible people to access the Provider's services. Service information will include at least the following:

- the services and supports to be provided
- the location of those services
- the hours the service is available
- when the service may be available to the person
- how to access the service (e.g. whether a referral is required)
- consumer rights and responsibilities including a copy of Health & Disability Commissioner's Code of Rights
- availability of cultural support
- after hours or emergency contact if necessary or appropriate
- the complaints procedure
- any other important information in order for people to access services.

8.2 Advocates

a) The Provider will inform People, in a manner appropriate to their communication needs, of their right to have access to an advocate at any time, including supporting them to make a complaint.

b) The Provider will allow advocates reasonable access to facilities, People, employees and information to enable them to carry out their role as an advocate.

c) An advocate may be a Health and Disability advocate or an informal advocate of the Person's choice.

8.3 Person/Family/Whānau and Referrer Input

a) The Provider will regularly offer People/families/whānau and referrers the opportunity to provide feedback and use the feedback to improve service delivery.

b) Feedback methodologies used will be appropriate to the communication needs of the People.

c) The Provider will make the feedback methodologies and results available to People and the Purchasing Agency.

d) People/Family/whānau and referrer input will be reflected in the maintenance and improvement of quality of service, both for the individual People, and across the Service as a whole.

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8.4 Rights of People

The Provider will comply with all aspects of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and the UNCRPD.

8.5 Complaints Procedure

The Provider will enable People/families/whānau and other people to make complaints through a process for the identification and management of complaints. This process will meet the requirements of the Health and Disability Commissioner's Code of Rights, and will ensure that:

- the complaints procedure itself is made known to and is easily understandable by People/families/whānau, and staff
- all parties have the right to be heard
- the person handling the complaint is impartial and acts fairly
- complaints are handled at the level appropriate to the complexity or gravity of the complaint
- corrective actions to address the complaint are undertaken in a timely manner and the complainant is kept informed about these actions, and positively engaged in the process as much as possible
- it sets out the various complaints bodies to whom complaints may be made, and the process for doing so. People/families/whānau will further be advised of their right to direct their complaint to the H&D Commissioner and to the Ministry of Health, particularly in the event of non-resolution of a complaint
- complaints are handled sensitively with due consideration of cultural or other values
- Māori and their whānau will have access to a Māori advocate if, desired, to support them during the complaints process
- People who complain, or on whose behalf families/whānau complain, shall continue to receive Services which meet all contractual requirements
- complaints are regularly monitored by the management of the Service and trends identified in order to improve service delivery
- records are maintained of all complaints, including the outcomes and improvements that arise.

9. Safety

9.1 General Safety Obligation

The Provider will protect People, visitors and staff from exposure to avoidable/ preventable risk and harm. The Provider will comply with the New Zealand Health and Disability Sector Standards 2008 (and any related standards) and the Health and Safety in Employment Act 1992 as appropriate to the Service being delivered.

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9.2 Equipment Maintained

The Provider will ensure that equipment the Provider is responsible for is safe and maintained to comply with safety and use standards, and manufacturer's guidelines.

9.3 Infection Control/Environmental and Hygiene Management

The Provider will safeguard People, staff and visitors from infection. The Provider will have environmental and hygiene management/infection control policies and procedures which minimise the likelihood of adverse health outcomes arising from infection for Peoples, staff and visitors. These will meet any relevant profession-specific requirements and the relevant requirements of New Zealand Health and Disability Services Sector Standards.

9.4 Security

The Provider will safeguard People, employees and visitors from intrusion and associated risks. The Provider will have written, implemented, and reviewed policies and practices relating to security to ensure that buildings, equipment and drugs are secure. The provider will have written safety and emergency plans for the evacuation of its premises. The Provider will have written safety and emergency plans for the evacuations of any other premises it uses for service delivery, where is practicable to do so.

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10. Information Management Requirements

10.1 Information Action Plans

The Provider will develop an agreed information action plan for its services. The information action plan will include the Provider's plans for achieving any information requirements as set out in the Service Specifications. The information action plan may be included as part of the Provider's quality plan, as required in clause 7.2.

The information action plan will include the key targets outlined below, and will also establish its own targets. The key targets to be included in the information action plan are:

a) recording of Services/treatment by National Health Index (NHI) number

b) information required as a result of ACC legislation.

The Provider will assess its own performance against the key targets and against its information action plan, and report its progress to the Purchasing Agency at appropriate intervals.

10.2 Record keeping

The Provider must keep and preserve Records and protect the security of them in accordance with statutory obligations and make them available to the Purchasing Agency in accordance with their reasonable instructions and their rights to access such Records.

For the purposes of this Specification, Records are all written and electronically stored material held by the Provider, or on behalf of the provider by staff or sub-contractors, which are relevant to the provision of services.

10.3 Continuity

In the event of the Provider ceasing to provide the Services, the Provider must:

a) transfer Records relating to People to the new provider of Services.

b) preserve Records not transferred to another Provider.

10.4 Retention of Health Information

In relation to health information that relates to an identifiable individual, the Provider must keep records for a minimum of ten years beginning on the day after the date shown in the health information as the most recent date on which the Provider provided Services to that individual, where this information is not held elsewhere.

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Appendix Two

Disability Support Services
Tier Two Service Specification
Home and Community Support Services

1. Introduction

This Tier Two Service Specification provides the overarching Service Specification for all Home and Community Support Services funded by Disability Support Services (DSS). It should be read in conjunction with the DSS Tier One Service Specification, which details requirements common to all services funded by DSS.

2. Service Definition

This Service Specification is for Home and Community Support Services (the Services) that DSS will purchase from the Provider for eligible people who need support in their home and community.

DSS want to purchase Services that focus on People's Goals through promoting discussion and agreement between the Person, the Service Provider and their Support Worker(s) and Other Staff Member(s).

The Services may include Personal Care, sleepover/night support; and Household Management.

2.1 Key Terms

The following are definitions of key terms used in this Service Specification:

Term	Definition
Approved Assessor	An assessment facilitator employed by a Needs Assessment Service Coordination Service organisation (NASC). The Approved Assessor may have the title of Needs Assessment Facilitator or Assessment Facilitator.
Goal/s	An aspiration or target, or objective or future condition that the Person wishes to achieve in relation to the Person leading an everyday life.
Home	Home means residential premises in New Zealand in which the Person lives. Home does not include any hospital, rest home, or other institution. Note: Where a contractual arrangement exists whereby the

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Term	Definition
	resident pays for, or the facility owner is obliged to provide the Home and Community Support Services usually purchased by the Ministry of Health, then this definition does not apply.
Personal Plan	A plan agreed with the Person that specifies how the Goals identified in the Support Plan will be met.
Needs Assessment Service Co-ordination (NASC)	These organisations are funded by the Ministry. Their roles are to determine eligibility, assess the Person's level of disability support needs, and to co-ordinate support services to meet those needs. NASCs co-ordinate such services, but do not themselves provide the services.
Other Staff Member	An individual who is responsible for delivering Services on behalf of a Service Provider. This includes the provision of direct care or support Service to the Person and covers all staff who are: (a) Employed; or (b) Contracted
People/Person	The use of the term "People" or "Person" should be read as substitutive for Service User or Client. It refers to the people who are eligible, have been referred by NASC, and are receiving the services described in this specification.
Personal Plan	Used in this specification to describe the various planning exercises and their output that relate to the Person being supported.
Support Plan	A plan agreed with the NASC and the Person that specifies their overall Goals and Type or Amount of Services.
Support Worker	An individual who is responsible for delivering the Service on behalf of a Service Provider. This includes the provision of direct care or support Service to the Person and covers all staff who are: (a) Employed (b) Contracted; or (c) Volunteer support workers accountable to the service provider
Type or Amount of Services	The quantity or nature of Services approved by the NASC in accordance with their legislation, contractual obligations and operational policies, as set out in the Support Plan.

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3. Service Objectives

The Person receives Home and Community Support Services to support them to live an everyday life.

Successful services occur when:

a) The Person is satisfied with the way in which Services have been delivered.

The Person needs to be satisfied that:

- they have been, and are, respected as an individual
- they have an ongoing voice in, and their wellbeing is central to, the Services being delivered
- progress is made on the Person's Goals
- the Goals are regularly reviewed with the Person
- they have received Services at the agreed times without any unexpected interruptions to the Services, such as the support worker not attending.

b) Where the Person is not satisfied with Services the Service Provider will put in place a corrective action plan in a timely manner.

c) The Service links with any other agencies that provide support Services so that they work together to achieve the Person's Goals.

d) The potential for further injury, harm, or decline in the Person's health is prevented or reduced.

4. Service Performance Measures

Performance Measures form part of the Results Based Accountability (RBA) Framework. The Performance Measures in the table below represent key service areas the Ministry and the Provider will monitor to help assess service delivery. Full Reporting Requirements regarding these measures are detailed in Appendix 3 of the Outcome Agreement. It is anticipated the Performance Measures will evolve over time to reflect Ministry and Provider priorities.

Measures below are detailed in the Data Dictionary available on the Ministry's website, which defines what the Ministry means by certain key phrases.

	How much	How well	Better off
1.	# of satisfaction surveys sent	% satisfaction surveys returned	# / % of people who reported satisfaction with the service

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	How much	How well	Better off
2.	# personal plans completed within three weeks of entry into the service	% of personal plans completed within three weeks of entry into the service	
3.		% of personal plans reviewed and signed-off at least once every 12 months	
4.			#/% of goals in personal plans achieved
5.	# of people who reported their support worker did not turn up	% of people who reported their support worker did not turn up	
6.	# of people who reported their support worker did not turn up at the agreed time (defined as within 15 minutes of the agreed time)	% of people who reported their support worker did not turn up at the agreed time (defined as within 15 minutes of the agreed time)	
7.	# of complaints that have been received	% of complaints that have been resolved (i.e. a corrective action plan has been implemented)	
8.		% of staff turnover	
9.		% of support workers assessed as obtaining the Level 2 National Certificate in Health, Disability, and Aged Support	

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5. Service Users

To access the Services the Person must be referred to the Service Provider by a Needs Assessment Service Coordination organisation (NASC).

5.1 Costs

There are no costs to be paid by the Person.

5.2 Access/Entry Criteria

An Approved Assessor will talk with the Person to identify what Ministry funded support the Person may need to be able to lead an everyday life within their Home and community. The NASC will then set Goals with the Person and talk about the Type or Amount of Services the Person will receive and write a Support Plan.

The Person will then be referred to the Service Provider by the NASC. The referral will specify a start date for the Service delivery. The Service Provider will contact the NASC to confirm acceptance of the referral and to confirm the start date for the Service delivery.

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6. Service Components

6.1 Start of Service

At the start of the Service the Service Provider will:

- Confirm the start date of Service delivery with the Person and/ or their family and whanau where relevant.
- Make links with other Services and work with them as required.
- Discuss and agree with the Person who their Support Worker(s) and/or Other Staff Member(s) will be.

6.2 Personal Plan

Services allocated by the NASC will be described, defined and written into the Support Plan by the NASC. The Support Plan will advise the number of hours of support to be delivered, the breakdown of household support and personal support, and a list of identified tasks and activities that the person needs support with. The Provider will use the information in the Support Plan to work with the Person to develop a Personal Plan that describes the support and how it is to be provided.

The Provider and the Person, and their family/whanau where appropriate, will discuss and agree the Personal Plan to meet the Goals identified in their Support Plan.

In this discussion will ensure that:

- the communication needs of the Person are considered
- decisions are made with the Person that encourage personal responsibility for Goal achievement.

The Personal Plan will include but is not limited to:

- the Type and Amount of services to be provided including agreement on the times when services will be provided

- Services allocated by the NASC that will be provided, including agreement on how available hours will be prioritised
- Goals of the Person regarding service provision
- contingency planning
- contact details for the Service Provider
- a review date for the Personal Plan.

Variations from the Support Plan can be made so long as that:

- it is requested by the person,
- it is certain to be in the Person's interest
- health and safety implications have been discussed, documented and any trade-offs are decided by the Person.

Where required the Person should have support from a person of their choice e.g. family/whanau or an advocate, to interpret information and communicate their preferences.

The Personal Plan will be completed within three weeks from the date of referral. Both the Provider and the Person will sign the Personal Plan as being up to date and correct and both will keep a copy.

The Personal Plan will guide the Support Workers and Other Staff Members who go into the Person's Home.

6.3 When urgent services are required

If unplanned Services are needed over a weekend or outside business hours where the Person's safety and health would be at risk without these Services, urgent Services may be provided without a referral or over the approved Type or Amount of Services. Where Services are provided in this way the Provider must advise the NASC on the next working day.

6.4 Where Services are delivered

Services will be delivered in the Person's Home and community, as documented in the Person's Personal Plan.

6.5 Delivering services

The Provider will:

a) Deliver Services as agreed in the Personal Plan.

b) Provide the Support Worker/s or Other Staff Member/s with any required health and safety equipment or supplies.

c) Visit the Person at a time agreed with the Person to deliver Services in a way that respects the dignity, rights, needs, abilities and cultural values of the Person, and their family / whanau / aiga.

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d) Respect the Person's Home and privacy within that Home.

e) Ensure Services are delivered by suitably trained and culturally competent Support Workers and Other Staff Members to meet the Goals of the Person as identified in their Support Plan.

f) Improve the health and independence of Maori by targeting Services to best meet Maori need and where possible to provide Services by Maori for Maori.

g) Contact the NASC to arrange a new assessment for the Person if the Service Provider or the Person considers that support needs or goals have changed.

h) Use the Person's feedback to continuously improve the service, and ask the Person if they are happy with the service, using an independent process to do this.

i) Ensure the Person knows:

- how to make a complaint and who to complain to
- how to access an independent advocate
- that, where a complaint is made, an acceptable solution will be agreed and reached in a timely manner.

6.6 Type of Services Delivered

The Provider may deliver a combination of the following services.

6.6.1 Household Management

Services which assist a Person with a disability to maintain, organise and control their household/home environment, enabling them to continue living within their own environment.

6.6.2 Personal Care

Assistance with activities of daily living that enables a Person with a disability to maintain their functional ability at an optimal level.

6.6.3 Sleepover Care or Night Support

A Service where the Support Worker or Other Staff Member is required to sleep at the home of the Person in order to provide intermittent care throughout the night.

6.7 Contingency planning

If for some reason the usual Services cannot be delivered the Service Provider must arrange alternative Services as part of contingency planning for the Person so that they receive Services. This includes:

- when the Support Worker is on leave or unable to attend

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- on public holidays
- in case of a natural disaster or publicly declared pandemic.

7. Guidelines/Policies/Legislation

The Service Provider must provide Services in accordance with:

- The Code of Health and Disability Services Consumers' Rights 1996
- The Health Act 1956
- The Health Information Privacy Code 1994
- The New Zealand Disability Strategy 2001
- Home and Community Support Sector Standard NZS8158:2012
- Health Practitioners Competence Assurance Act 2003
- All other relevant law relating to employment, health and safety, privacy.

8. Exit Criteria

A Person can contact their NASC to ask for a referral to another Service Provider or to stop the Service.

The Provider can stop Services when:

- the period of support identified on the referral ends and an extension has not been requested or is not necessary
- the Person has been transferred to another Provider
- the Person no longer needs the Service because their Goals and independence have been achieved to the maximum extent practicable
- the Person dies.

9. Linkages

Providers must maintain and demonstrate appropriate linkages and relationships as appropriate to the needs of the Person, including:

- Primary medical services
- Needs Assessment and Service Coordination (NASC) services
- Independent advocates or advocacy services
- Client/carer community support services
- Equipment Management Services (EMS)

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- Specialised assessment services
- Mental Health Services
- Behavioural Support Services
- Assessment Treatment & Rehabilitation Services
- Secondary medical and surgical services
- Appropriate ethnic and cultural groups
- Disability consumer groups and relevant NGOs
- Government departments such as Work and Income etc
- Maori social and community services, support groups, and social service organisations e.g. local Kaumatua, marae, whanau groups, counselling, budget and family support services.

10. Exclusions

There are some closely related Services that are not covered under this Service specification. Any Service funded by a separate Service specification or agreement through DSS, ACC, a District Health Board (DHB) or any other government agency are not covered under this Service specification including:

a) Any equipment provision for the Person.

b) Ministry of Health or DHB funded service including:

- Supported Independent Living
- Personal and family health funded household management/ personal care services
- Day care/day services
- Mental health household management
- Registered nursing services.

c) ACC funded services including:

- Community nursing services
- Residential training for independence services or intervention services to any claimant in a residential facility
- The development and provision of the ACC training for independence and maximum abilities group programmes
- Supported Living.

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11. Quality Requirements

11.1 Evaluation

DSS may conduct an:

a) Independent survey to evaluate People's satisfaction with the service.

b) External audit against the Home and Community Support Sector Standard NZ S8158:2012.

c) Independent evaluation of service performance and effectiveness against this service specification, and its intended outcomes.

11.2 Certification

The Provider is required to maintain Certification as required under the Home and Community Support Sector Standards NZS8158:2012.

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12. Purchase Units

Purchase Units are defined in the Ministry of Health's Nationwide Service Framework Purchase Unit Data Dictionary. The following table is a summary list of the tier two Home and Community Support Services Purchase Unit Codes associated with this Service.

Purchase Unit Codes	Purchase Unit Description	Measure	Purchase Measure definition
DSS1009	Home Based Support - Household management	Hour	Household Management services that enable a person to continue living with their own environment. This service is specifically for clients who meet the Ministry definition of disability. The number of hours are determined by the relevant NASC Agency for each client receiving Home support services. The service is for people until the age of 65.
DSS1010	Home Based Support - Personal Care	Hour	Personal Care, Sleepover service(s) that enable a person to continue living with their own environment. This service is specifically for clients who meet the Ministry definition of disability.

13. Reporting Requirements

13.1 Reporting Requirements

Full Reporting Requirements (including any Provider specific reporting requirements) are included in Appendix 3 of the Outcome Agreement.

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