MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

14 October 2025

Tēnā koe

Official Information Act request

Thank you for your letter dated 4 July 2025, which was received by the Ministry of Social Development (the Ministry) on 14 July 2025. You requested the following documents:

1. *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting 2002*
2. *NASC Managers Manual 2005*
3. *Discretionary Funding Requirements*
4. *Supported Independent Living Specification and Guidelines*
5. *Intensive Service Coordination Guidelines*
6. *SPA Tool (or its equivalent)*
7. *Memoranda of Understanding between Ministry of Health and ACC (see page 27)*
8. *Health and Disability Sector Standards (as listed in section 8.1, pages 19 and 20)*
    a. *Needs Assessment Standards (1999)*
    b. *Service Co-ordination Standards (1999)*
    c. *Standards for NASC Organisations*
9. *Standards for Needs Assessment (MOH 1994) and (MOH 1999) (page 34)*
10. *Guidelines for Service Coordination (MOH 1995)*
11. *Standards for Service Coordination (MOH 1999)*
12. *Support Package Allocation Tool (SPA)*
13. *Benchmark Indicators (page 3)*
14. *Guidelines to Eligibility for Public Funded Health and Disability Services in New Zealand (page 4)*
15. *Ministry Review Panel Processes (page 25)*
16. *What People Can Buy With Disability Fundings Ministry of Health Purchasing Guidelines (p30)*
17. *The Ministry Agreement that Lifelinks was contracted under at 24/06/11, please.*
18. *Ministry of Health NASC Service Specifications/earlier than August 2019*

I have considered your request under the Official Information Act 1982 (the Act). I have enclosed the documents you have requested with this letter however please note the following:

- Document 6 and 12 in your request are the same document.
- The Benchmark Indicators referred to in number 13 related to the Support Package Allocation Tool (SPA).
- Discretionary Funding requirements are part of the NASC service specification.
- Documents referred to in number 8 of your request can be found in the NASC Standards 1999.

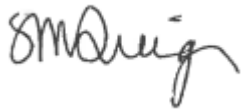
Please note, due to the volume of documents, I have provided your response in four parts.

I will be publishing this decision letter, with your personal details deleted, on the Ministry's website in due course.

If you wish to discuss this response with us, please feel free to contact OIA_Requests@msd.govt.nz.

If you are not satisfied with my decision on your request, you have the right to seek an investigation and review by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz or 0800 802 602.

Ngā mihi nui

pp. 

Anna Graham
General Manager
Ministerial and Executive Services

Printed from: https://www.disabilitysupport.govt.nz/carers/what-is-carer-support/what-people-can-buy-with-disability-funding-purchasing-rules/guidance-for-the-sector-on-changes-to-the-purchase-rules

Printed on: 1 October 2025

Guidance for the sector on changes to the purchase rules

This information provides definitions and explanations intended to support the disability sector to implement the revised Purchase Rules that were announced on 18 March 2024 and later updated on 24 April 2024.

This information:

- provides an explanation of what is generally within the scope of flexible funding, and what is generally not
- explains how supports for commitments made before 18 March can be considered
- provides some definitions of terms used in the Purchase Rules, and
- gives some explanation of how the Purchase Rules could be applied in certain situations or to particular things.

While this document does discuss the application of the Purchase Rules to some items or costs, it is not intended to be an exhaustive list. It continues to be guidance on applying the Purchase Rules, rather than a set of additional rules.

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What support is in scope

In this section

- What is in scope, generally?
- How does scope differ between different service lines
- What is excluded, generally?

What is in scope, generally?

There are some differences in scope, to reflect the different purposes of various flexible funding supports.

Across all flexible funding it is possible to pay for:

- Contributions to the cost of support being provided. This includes, but is not limited to:
- Wages and other costs of employing someone to provide support.
- Invoices for the costs of service providers who have provided support,
- Costs of activities that support the disabled person while a break is taken
- Expenses that are a necessary part of supporting the disabled person. This includes, but is not limited to:
- supplies and products (for example rubber gloves, PPE) that may be required by a person delivering support to carry out the task,
- fuel and mileage costs of transport where a support person drives the disabled person somewhere locally,
- local transport costs (after the Total Mobility Scheme has been accessed) that do not require the use of support workers, where this is a more cost-effective way of supporting the disabled person to participate in activities. Examples include driving services, ride share services etc.
- the cost of entries to events or activities, travel on public transport, or other similar costs that a person might incur in the course of being available to and supporting the disabled person.
- Self-care services such as massages, pedicures and other appearance or therapeutic care that are for the direct benefit of the disabled person. This may form part of personal care (toe and fingernail cutting, barbering or hair washing as a mainstream option), or may support some disabled people to manage physical activity through sports massage etc. Please note that:
- costs continue to need to be related to the individual's specific experience of disability (rule two),
- costs need to be reasonable, and this needs to be a cost-effective alternative to other options (rule three), and
- there are some limits to this where another agency has responsibility for therapeutic care (rule four).

How does scope differ between different service lines

Items that support the disabled person to carry out tasks more independently (except where those items are part of what is provided for or managed under EMS) are generally available through IF HM and PC, EIF, CiCL, and EGL Personal Budgets.

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Items that support the disabled person to self-regulate, limited to: Tablet devices, noise cancelling headphones, sensory items (such as fidget spinners etc.) and weighted blankets, are able to be funded from Carer Support, Individualised Funding Respite, EIF and EGL Personal Budgets, where this creates a break for family carers.

These items – and only these items – can be purchased through Carer Support and IF Respite.

Tablet devices and noise cancelling headphones can be purchased no more than once in an allocation period (usually 12 months).

Where an item is sought, the existing purchase rules must continue to be applied, including:

- Rule Two – it must support the disabled person to overcome a specific disability related challenge they experience
- Rule Three – it must be a reasonable and cost-effective way of doing so, and
- Rule Four – it must not be something that another government agency has funding responsibility for, or is managed and prioritised through Equipment and Modification Services (EMS) (including if the other agency or EMS waitlists or declines to provide the item in this circumstance).

Ready-made meals can also be purchased through IF HM and PC, EIF, CiCL, and EGL Personal Budgets, where this offsets the cost of funded support. Ready-made meals have their own section in the 'information on specific support costs' pages.

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What is excluded, generally?

Across the flexible funding services DSS funds, some things are excluded entirely:

- Gifts and other forms of recognition for support provided voluntarily.
- Travel-related costs for disabled people, whānau , and/or persons providing support, including:
- Accommodation
- overseas and domestic travel, and
- food

Travel-related costs are discussed in the 'Some definitions' and the 'Information on specific support costs' pages below.

Continuing to support ongoing commitments

The revisions to the Purchase Rules are not intended to limit the ability of any disabled person to maintain their current engagement in employment, a course of study, therapy, or a

timebound programme that support is required for.

We have already undertaken to honour financial commitments made prior to 18 March 2024.

We are introducing some further measures to recognise more fully the range of situations where disabled people have relied on the previous scope of flexibility to organise their lives and support.

We are clarifying that the disabled person can continue to use their flexible funding to access the support they did prior to the revisions to the purchase rules where:

- they have committed to employment, a course of study, therapy, or a timebound programme, and
- they have relied on the availability of flexibility under the previous Purchase Rules to support them to participate in those commitments, and
- that commitment has been made before 18 March 2024.

This extends to:

- contributing to the costs of delivering support
- expenses that are a necessary part of supporting the disabled person, and
- the travel-related costs of support workers (accommodation, transport, meal allowances) can continue to be paid where those costs are incurred as part of supporting the disabled person when they engage in domestic travel (including between cities and regions) for work.

It does not extend to the purchase of items that are otherwise no longer in scope.

An ongoing commitment can be demonstrated by, for example:

- employment agreements
- explicit inclusion in a support plan pre-dating 18 March 2024, where this demonstrates an intended ongoing use of a particular support, or
- the individual already receiving or engaging in a course of therapy, a course of study, employment, or a time-bound programme that support is required for.

In general, there should be limited circumstances where evidence of a requirement for continuing support is sought, as it will often be clear from plans, ISPs, and past patterns of transactions.

Resuming supports that have been re-planned

The purpose of supporting ongoing commitments is to mitigate any potential risks to continuing in employment, study, and therapy.

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We are aware that some people may have reorganised their supports and family lives to continue in employment, study, or therapy after the 18 March 2024 revision of the Purchase Rules.

Where that is the case, disabled people may resume any previously in place supports that they consider mitigate risks to their continuing in employment, study, or therapy, so long as those supports are:

- the costs of delivering support
- expenses that are a necessary part of supporting the disabled person, and/or
- the travel-related costs of support workers (accommodation, transport, meal allowances) can continue to be paid where those costs are incurred as part of supporting the disabled person when they engage in domestic travel (including between cities and regions) for work.

All of these claims must continue to be within your existing allocation, and any other conditions upon accessing flexible funding

Retrospective costs

Some disabled people and families may also have begun to pay for some supports they were previously receiving, such as therapy, privately after the 18 March revisions to the Purchase Rules.

Where those costs were part of support delivered previously, costs incurred between 18 March and 24 April 2024 may be claimed for retrospectively. Where you are claiming for these costs under Carer Support, the usual 90 day claiming period applies, although we encourage you to make these claims sooner, and to mark them clearly as “RETROSPECTIVE PAYMENT FOR CONTINUING IN EMPLOYMENT, STUDY, OR THERAPY”.

All of these claims must continue to be within your existing allocation, and any other conditions upon accessing flexible funding.

Some definitions

A number of terms are used in the revised Purchase Rules that many people have asked about to ensure they are applying them correctly. We set out some of them here, to provide clarity on what is intended by these terms.

In this section:

- What is a 'necessary expense'?
- What is 'for the direct benefit of the disabled person'?

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- What does costs of Overseas travel cover?
- What is included in domestic travel?
- What is included in local travel?
- What is a 'ready-made' meal?
- What is a sensory item?

What is a 'necessary expense'?

An expense is a necessary part of providing care if, in the view of the person managing the package, within their context it is not possible to provide the desired support to carry out a particular task or participate within a particular activity without the expense.

Rule Three – that the expense be reasonable and cost-effective – continues to apply to ensure that public money is used in an economical manner.

Applying rule three may involve a conversation with staff working for a host or another processing role before a claim proceeds. This is an ordinary check and balance on the use of public money.

What is 'for the direct benefit of the disabled person'?

Means, the disabled person is the recipient of, for example, the massage or therapy, and it creates a disability-related benefit by supporting the disabled person to improve their independence.

While disabled people may indirectly benefit when their family members and carers experience self-care services such as massages, pedicures and other appearance or therapeutic care, this is now out of scope of the purchasing rules.

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What does costs of overseas travel cover?

Costs of overseas travel refers to the costs of accommodation, food, and transport while travelling for the disabled person, their family and whānau and anyone providing support. The costs of a person providing support while overseas (for example wages) however are not excluded from this scope of support.

Please note there continues to be a requirement, where wages are required for international trips over 21 days, for IF hosts to seek DSS approval.

What is included in domestic travel?

Domestic travel refers to the costs of travelling between cities or regions to, for example, go on a break.

What is included in local travel?

Local travel means travel within a local community where the disabled person usually lives, works, engages in recreation, and otherwise lives their life. Local travel will usually be:

- within a region
- in or to areas around a city, and/or
- an equivalent distance where someone lives on or near the border between regions.

What is a 'ready-made' meal?

A ready-made meal is any meal prepared ahead of time, that can be eaten at a time of the person’s choosing.

Ready-made meals can contribute to the person having greater choice of what they eat, and when they eat it.

Take out or food deliveries have some of the features of ready-made meals, and this may be appropriate, occasionally. In practice, it is unlikely that regular use of takeout or food deliveries will be more cost-effective than paying for support to prepare meals.

What is a sensory item?

A range of items may support disabled people to self-regulate where they can find particular kinds of sensory stimulation overwhelming.

While a wide range of things might serve this purpose, the range of things we are providing access to, through flexible funding, is limited to small, portable items, and does not extend to larger and more expensive options such as spa pools, trampolines, play gyms etc.

Rule three, that a purchase is reasonable and cost-effective, continues to be in effect. We would not expect that most purchases of small items would require in-depth consideration. If you are unsure about purchasing a specific sensory item, get in touch with your Host or EGL site – they can support you in your decision.

Information on specific support costs

This section sets out answers on some specific issues that have been raised with Whaikaha, to provide confidence in how the Purchase Rules are applied.

In this section

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- Purchase of some items for respite
- Funding activity costs
- Applying Household Management and Personal Care definitions
- Cost offsets and 'Corresponding reductions in support'
- Transport costs
- Ready-made meals
- Self-care services like podiatry, massages, and haircare costs for disabled people
- Costs in managing flexible funding
- Food, where it is not part of travel-related expenses
- Continence products
- Personal trainer or gym membership for the disabled person
- Tuition/tutoring
- Costs of laundry service or laundromat
- Costs of occupational therapy driving assessment
- The cost of extra driving lessons
- Mileage for parents
- Mileage for a volunteer/family member
- Costs related to sustaining a living situation
- Therapies
- Software for tablet devices
- Support at work
- Support at a course
- Support where a child is not attending school full-time
- Day programmes
- Sign language interpreters and communicators

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Purchase of some items for respite

Tablet devices, noise cancelling headphones, sensory items (such as fidget spinners) and weighted blankets, are all able to be funded from Carer Support, Individualised Funding Respite (IF Respite), EIF and EGL Personal Budgets, where this creates a break for family carers.

These items – and only these items – can be purchased through Carer Support and IF Respite.

Tablet devices and noise cancelling headphones can be purchased no more than once in an allocation period (usually 12 months).

Purchases of tablet devices and noise cancelling headphones must continue to meet the requirements of all four purchase rules. Tablet devices and headphones can be purchased where:

- They are related to the specific disability-related challenges that the disabled person encounters.
- They are reasonable and cost-effective. It is not cost-effective, for example, to purchase another tablet device or set of headphones if the disabled person has one that works and was purchased from a previous year's allocation; and
- Attempts have been made to access relevant other agency funding, including, for example, Ministry of Education funding for some devices.

Funding activity costs

In the context of IF Respite/Carer Support:

- Carer Support and IF Respite generally are allocated because disabled people and whānau require breaks more often, or of more intensity, than other whānau might. If an activity provides relief care, we consider that the cost of the activity includes the cost of providing support and expenses necessary to provide that support.
- Activities that accommodate or include disabled people can simultaneously provide a break for the main carer. Where this is the case, the organisation providing the activity is effectively the relief carer, and flexible funding can contribute to those activities as a cost of providing support.
- It continues to be the case, for example, that an organisation providing a programme can be the relief carer claiming the Carer Support subsidy.

In the context of IF Household Management and Personal Care:

- The scope of these services is specific to providing supports that assist the disabled person to complete tasks and participate in activities
- Our general position is that the scope of IF HM and PC allows the disabled person to pay a support worker, and their expenses (for example entrance tickets, transport costs)

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when undertaking an activity, but that the disabled person and their family must pay their own costs of participating in the activity (for example their entrance tickets etc.).

Applying Household Management and Personal Care definitions

Rule One of the purchase rules confirms funding must be used in line with the purpose for which it was allocated. This may include the specification under which the allocation was made.

Nothing in the revision of the Purchase Rules is intended to affect the relative balance of HM and PC activities that people currently undertake.

We encourage people to work broadly in line with the balance of HM and PC allocated as reflecting the balance of needs in an individual situation.

We acknowledge that this may also be affected by means-testing eligibility for HM.

If the relative balance of support types required has shifted significantly this is something an individual and their whānau might discuss at their next full NASC review.

We don't expect that Hosts need to seek any greater degree of evidence about whether specific costs should be coded to HM or PC as a result of the changes to the Purchase Rules.

Cost offsets and 'Corresponding reductions in support'

A number of changes in the Purchase Rules refer to the ability to purchase items where they reduce the need for other support.

Where you are supporting someone to purchase an item that may support them to do things more independently, or purchase ready-made meals which may reduce the need for other support, it is enough that you apply Rule 3 to determine cost effectiveness. You do not need to undertake any further processes (such as quantifying cost savings etc.).

Where an item has ongoing usefulness, this will be taken into account in applying rule three – cost effectiveness, in considering future purchases for the same purpose or need.

Transport costs

Domestic travel refers to the costs of travelling between cities or regions to, for example, go on a break.

These costs can no longer be paid from flexible funding.

Travel to and from school is funded by the Ministry of Education Specialised School Transport Assistance (SESTA).

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Local transport is part-funded by other agencies through the Total Mobility Scheme. NZTA and Regional Councils subsidise the costs of local transport for eligible people, which we understand includes most disabled people.

Our expectation is that these subsidies are accessed before considering the use of disability support funding to pay for local travel undertaken independently of a support worker.

'Expenses that are a necessary part of providing support' may include the costs a support worker incurs when taking the disabled person to go to the supermarket or engage in other activities outside the home. These costs can continue to be met from flexible funding.

If you have accessed the Total Mobility Scheme the disabled person can also use flexible funding for additional disability-related costs for local transport that don't require the use of support workers, where this is more cost-effective. Examples including driving services, ride share services etc.

In Between Travel refers to the time and travel costs that support workers incur when they are travelling from one client to another, as part of working for the same employer. In Between Travel is not generally paid to support workers where disabled people and families are managing their funding, as they employ people to work with them, rather than with multiple families.

If someone providing support must travel more than 15km to work, and the person's specific requirements mean that there are few or no alternative workers who are more available, 'exceptional travel' may be funded in line with the general In Between Travel guidance. You can find out more in section 4 of the implementation guidance for providers and funders on Health NZ's website.

Generally, In Between Travel is unlikely to be relevant to managing your flexible funding yourself.

If you are a Flexible Disability Support Provider managing personal budgets, and either ordinary or exceptional In Between Travel has been included in the personal budget, you can continue to claim for those costs.

Ready-made meals

A ready-made meal is any meal prepared ahead of time and can be eaten at time of the person's choosing.

Ready-made meals can contribute to the person having greater choice of what they eat, and when they eat it.

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Ready-made food may be a more cost-effective support than having someone come in to cook a meal. Purchases of ready-made food should only be made when this reduces the need for paid support for meal preparation.

We know that many disabled people also have children or other dependent family members that they would otherwise require support to prepare meals for. Ready-made food can be used as their contribution to household tasks which are shared amongst whānau , where this is a cost-effective way of doing so.

Take-out or food deliveries have some of the features of ready-made meals, and this may be appropriate occasionally. In practice, it is unlikely that regular use of takeout or food deliveries will be more cost-effective than paying for support to prepare meals.

Self-care services like podiatry, massages, and haircare costs for disabled people

Yes, disabled people can use their allocation to contribute to the cost of support being provided.

This includes purchases that fall under self-care services, such as massages, pedicures and other appearance or therapeutic care that are for the direct benefit of the disabled person.

A disabled person can still pay for podiatry (toenail cutting) and haircare costs, such as going to a hairdresser to get their hair washed, rather than getting a support worker to come into the home to wash their hair or cut their toenails.

Costs in managing flexible funding

Flexible funding has historically paid for some administration costs. These costs are factored into the calculations used to create the IF hourly rate. Most of these costs are unaffected by the changes to the Purchase Rules.

Some management costs are part of supporting people to manage their disability support. These include, but are not limited to:

- additional HR advice, payroll support, and other support to be a good employer
- additional planning and facilitation support, and
- in some instances, paying higher duties allowances or other costs of staff managing all or part of support.

Some expenses can be a necessary part of delivering management support. These include, but are not limited to:

- costs of office supplies necessary to manage timesheets etc.

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- technology used to access online platforms and reasonably undertake management tasks (historically, one laptop under $1,500 every 3 years, and a printer).

These forms of support continue to be available, as do recognition payments for Agents.

Food, where it is not part of travel-related expenses

Food, where it is not a part of travel-related expenses

Ready-made meals continue to be available for the disabled person to use under IF HM and PC, Enhanced Individualised Funding, and EGL Personal Budgets, where this is a cost-effective way of delivering household management.

Food has been excluded where it is part of travel-related costs.

Food, such as takeout, as a way of family taking a break from routines, is also excluded from being purchased using flexible funding.

There may be instances where a support worker accompanying a disabled person to an activity incurs some food-related or meal costs. In considering food-related costs, please bear in mind that any worker will usually have to provide their own lunch etc. as part of conditions of employment.

Where meal costs have been included in terms and conditions of employment (for example, as part of working longer shifts) these terms and conditions should continue to be honoured, but no such new arrangements should be entered into.

Continence products

We are aware that some people we support have used flexible funding where the level of continence products available through Health NZ does not fully meet their needs.

No-one will lose access to essential services through the revisions to the Purchase Rules.

If you have accessed continence products through Health NZ, and require further products to maintain personal cares, the additional products can be considered “Items that support the disabled person to carry out tasks more independently” and can be purchased through flexible funding.

Personal trainer or gym membership for the disabled person

Training and gym attendance can provide direct therapeutic benefits to the disabled person, and may be an activity that also provides a break for a family carer while the disabled person undertakes the activity.

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Where that is the case, the personal trainer or participation in the gym is effectively relief care, and is an activity that can be funded as support and necessary expenses for providing that support.

Tuition/tutoring

Tuition can support some disabled people where their experience of disability means they face additional hurdles to educational success. It may also be an activity that provides a break for a family carer while the disabled person undertakes the activity.

Where that is the case, the tutor is effectively relief care, and the cost of tutoring can be included as a contribution to the cost of supporting the disabled person while a family carer takes a break.

Costs of laundry service or laundromat

There are a number of mainstream and disability-specific services that may be useful in delivering household management. For example, commercial cleaning services have been used by many people as an alternative to a support worker to provide some household management tasks.

For some people, laundry services may also be a cost-effective option to carry out that component of household management. This might particularly be the case where, for disability-related reasons, there are increased amounts of laundry required to be done.

Costs of occupational therapy driving assessment

Access to specialist driving assessments is prioritised and managed through the Equipment and Modifications system. As such, it cannot be funded through flexible funding.

The cost of extra driving lessons

In some instances, disabled people may require additional driving lessons, or greater time, to accommodate disability-related challenges they encounter to learning to drive. Additional driving lessons may also be an activity that provides a break for a family carer while the disabled person undertakes the activity.

Where that is the case, the driving instructor is effectively relief care, and the cost of additional driving lessons can be included as a contribution to the cost of supporting the disabled person while a family carer takes a break.

Mileage for parents

For some disabled people, the motion of being driven in a car can support them to self-regulate. A number of families use a log book to claim specifically for the mileage involved in

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doing so.

Where someone is being driven as part of a strategy to support them to self-regulate, mileage can be considered to be a necessary expense for the support being provided.

Mileage for a volunteer/family member

Some disabled people and their whānau rely on family and friends who come from out of town to provide support.

Necessary expenses include costs that a person might incur in the course of being available to and supporting the disabled person.

If the travel involved is within region, or a similar distance if someone lives near the border of a region, it is considered to be local travel, and can be funded as a necessary expense to provide support.

Costs related to sustaining a living situation

We are aware that, for some people, EGL personal budgets have been used to provide a level of support that would otherwise usually only be available through residential care.

We want to reassure individuals in that situation, and the providers who work with them, that where this is the case the revisions to the purchase rules will not be applied in a way that affects their ability to maintain that living situation.

We are working to put in a process across the EGL sites to ensure that the application of the Purchase Rules in these situations are clear, and that people, family, Hosts and providers are aware of how to apply the rules in those situations.

We understand that this is a relatively small number of individuals, known to their EGL sites, who will be in contact to discuss any concerns.

If you are concerned that a package allocated by your NASC organisation, or supported by your Host organisation, creates an alternative to residential care and is at risk of ceasing to be viable as a result of the revised purchase rules, please raise this with the Connector or with your Portfolio Manager in the first instance, who can seek further direction.

Therapies

Where a disabled person has been engaged in a course of therapy before 18 March, that therapy can continue to be funded from flexible funding, including where other agencies might otherwise have funding responsibilities for that therapy.

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Examples where other agencies may have funding responsibilities include (but are not limited to):

- speech language therapy;
- psychologist involvement in behaviour support; and
- occupational therapy.

If something is a form of therapy that is prioritised by another government agency, new courses of therapy cannot be entered into (including where the main carer would get a break whilst that therapy occurs).

Some things may have some therapeutic benefits, but can also be understood to be a respite activity.

These are not forms of therapy that we consider to be within another agency's funding responsibility. Whether they are treated as an activity that provides respite, or as a form of therapy, they are within scope of flexible funding. This includes:

- equine therapy;
- art therapy;
- music therapy

Software for tablet devices

If you are purchasing a tablet device that supports self-management, and there are disability-specific apps or software that you wish to purchase, these can be considered a necessary expense as part of delivering the support. These costs can be met from your flexible funding.

Support at work

Work and Income provides some funding to support people who experience additional costs as a result of disability or health conditions when working. Information about this funding can be found at Job and Training Support Funds - Work and Income.

We encourage you to use these funds first.

Where you have committed to an employment arrangement before 18 March 2024 on the basis that you could use your flexible funding in a way that would enable you to commit to, and maintain employment, you may continue to use your funding in the same way to:

- contribute to the costs of delivering support
- meet expenses that are a necessary part of supporting the disabled person, and

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- pay for the travel-related costs of support workers (accommodation, transport, meal allowances) where those costs are incurred as part of domestic travel (including between cities and regions) for work.

Support at a course

Where you have committed to a course of study before 18 March 2024 on the basis that you could use your flexible funding in a way that would support you to participate, you may continue to use your funding in the same way to:

- contribute to the costs of delivering support, and
- meet expenses that are a necessary part of supporting the disabled person.

Your flexible funding cannot be used to support you to participate in any new course of study that you had not committed to before 18 March 2024.

If you are part way into a qualification (including, but not limited to, a degree or diploma), you may continue to use your flexible funding to support you to complete your studies, even if you have not signed up to all the necessary components of study yet.

Where you are considering undertaking a new course of study, and you require support to do so, you should seek to access support from the training and education provider.

Support where a child is not attending school full-time

In some instances where disabled children are not attending school full-time, flexible funding has been used to provide support where the child may need to go home at unpredictable times.

This has been part of supporting successful, if longer, transitions into fulltime schooling, and to enable family members to maintain their employment.

Unfortunately, flexible funding is no longer able to be used in this way, at this time. All children have a right to be educated, and providing support for children to participate in schooling successfully sits more clearly with the responsibilities of the education system.

Day programmes

In some instances where day programme funding is not able to provide support throughout the whole working week, flexible funding has been used to provide support to attend additional day programmes, or for other support to the disabled person throughout the working day.

This has been part of supporting disabled people to form connections with others, engage in activities outside the home, and to enable family members to maintain their employment.

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Unfortunately, flexible funding is no longer able to be used in this way, at this time. Day programme and vocational funding is the responsibility of MSD.

However:

- Where Enabling Good Lives Personal Budgets have had Community Participation funding integrated into them, personal budgets can continue to be used for vocational activities.
- Where an organisation that holds Day Programme contracts also runs programmes that provide relief care through, for example, Carer Support, those activities can continue to be claimed for.

Sign language interpreters and communicators

If you have accessed interpreter services that are available to you through existing funding (such as iSign and Job Support funds), you may consider using your flexible funding for any further unmet communication needs.

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Disability Support Services

Te Kāwanatanga o Aotearoa
New Zealand Government

Review Panel Terms of Reference

As at 1 July 2025

Purpose of the Review Panel

1 The purpose of the Review Panel is to provide assurance to the Associate Deputy Chief Executive (ADCE), Disability Support Services (DSS), within the Ministry of Social Development (MSD) that certain Needs Assessment and Service Coordination (NASC) organisation and Enabling Good Lives (EGL) site decisions are in accordance with Cabinet's decisions and relevant policy and service specifications.

Application of the Operational Policy and Guidelines 2025/26

2 The Review Panel must comply with the Operational Policy and Guidelines 2025/26 in carrying out its work.

How the Review Panel must carry out its work

3 In carrying out its work, the Review Panel must:

3.1 have regard to the needs of individuals, fairness, and equity within the legal requirements to manage the budget for disability supports;

3.2 operate in ways that are consistent with the principles of good public decision making, including ensuring all relevant factors have been taken into consideration and that the decision is reasonable, transparent, consistent, and appropriately documented[1]; and

3.3 consider alternatives to residential care and higher cost community packages, in a way that is equitable and ensures overall affordability of packages.

Appointment and Composition of the Review Panel

4 The Review Panel members are appointed by the ADCE, DSS, who can also approve changes to the membership of the panel.

5 The Review Panel will comprise four employees of DSS who, collectively, have a deep understanding and knowledge of the following:

5.1 delivery of residential care;

5.2 pricing of DSS funded supports;

5.3 budget and financial management;

[1] For more information, see The Judge Over Your Shoulder » Crown Law

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5.4 equity principles, including the provision of support that is culturally appropriate for tāngata whaikaha Māori and Pacific disabled people;

5.5 the NASC, EGL site and provider operating environment and processes;

5.6 clinical care for those with high needs;

5.7 any other skills and knowledge considered necessary.

6 The Review Panel will include at least one registered health professional. The role of the registered health professional on the Panel is to analyse any health evidence that it receives with a referral and provide advice on the implications of that health evidence for the issues the panel is considering. The health professional will not carry out health assessments for the Panel.

7 The Review Panel will make recommendations by consensus wherever possible. Where consensus is not possible, the Chair will call for a vote, in which case the matter will be decided on a simple majority. In the event of a tie, the Chair will have a casting vote.

8 The provision of advice by registered health professionals on the panel will be provided in accordance with the standard required by the appropriate regulatory body.

9 Complaints directed at Panel members in the conduct of their responsibilities, in good faith, under these terms of reference will be responded to by MSD.

10 The Review Panel may from time-to-time seek advice from:

10.1 the Deputy Chief Legal Advisor DSS within MSD or their delegate;

10.2 any other person, whether employed by MSD or otherwise, they consider has expertise on any matter that the Review Panel otherwise feels unable to resolve.

11 The Review Panel will be supported by a secretariat of employees of DSS who will:

11.1 triage applications to the Review Panel, and send them back to the NASC or EGL site for reconsideration or more information as required;

11.2 collate agendas, prepare papers, take minutes, prepare reporting, ensure that decisions are reported back to all parties in a timely way and with the rationale clearly explained, and

11.3 bring to the Chair's attention any urgent matters for consideration between meetings.

Frequency of meetings and a Quorum

12 The frequency of meetings will be determined by the Chair in consultation with other members of the Review Panel, having regard to the volume of requests, the need to consider them comprehensively and in a timely way, and the need to be responsive to emerging situations.

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13 A quorum will exist when two of the four panel members attend the meeting, either in person or online.

Status of recommendations by the Review Panel

14 The Panel provides assurance to the ADCE, DSS that certain decisions by NASCs and EGL sites are in accordance with relevant criteria (arising from the Independent Review, other relevant policy, and service specifications) by

14.1 reviewing information supporting the decision supplied by the NASC or EGL site to determine:

i whether the evidence shows that the criteria have been met; or

ii whether the evidence does not show that the criteria have been met.

14.2 The Review Panel then make recommendations to the ADCE, DSS on which NASC or EGL site decisions satisfy the relevant criteria, and which ones do not satisfy the relevant criteria. These recommendations are based on the outcomes of their work and are from them collectively.

15 Following final sign-off, the secretariat will write to the NASC or EGL site setting out the reasons for not endorsing their decision. a NASC or EGL site will be advised that:

15.1 Either the information supplied supported their decision, and they can implement it;

15.2 Or the information supplied does not support their decision, and they are not able to implement it.

16 If they wish to do so, a NASC or EGL site can supply additional relevant information to the Review Panel. The Review Panel will consider this additional information.

17 In carrying out this work, the Review Panel and the ADCE, DSS, will be exercising MSD's contract management responsibilities of providing assurance as to the proper and consistent application of relevant criteria. We consider this is not the exercise of a power or function of the Chief Executive beyond what has already been agreed under the contracts MSD has in place with NASCs.

18 The Review Panel's decisions relate to levels of support that can be allocated within existing contracts or through personal budgets or individualised funding arrangements (where these are allowed within existing policy). The Review Panel holds no delegation to make decisions about new contracts, or funding outside of existing arrangements.

Matters in scope of the Review Panel

19 The Review Panel will continue to provide an assurance function for at least the next 12 to 18 months while the disability support system is stabilised and strengthened, and assurance processes are built into the system.

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20 While NASCs and EGL sites will have discretion about how they manage expenditure within their Annual Budgets, certain decisions about high-cost packages will continue to require endorsement from the Review Panel prior to implementation.

21 From 1 July 2025, NASCs and EGL sites are required to seek consideration by the Review Panel in the following situations:

21.1 A persons' residential care, EGL Personal Budget, or community support package exceeds $105,000 for the first time.

21.2 A person's residential care, EGL Personal Budget, or community support package already exceeds $105,000 and increases.

22 NASCs and EGL sites can only request consideration of a decision by the Review Panel if they can provide assurance that they have sufficient funding available within their Annual Budget, or that all of the exceptional circumstances criteria have been met.

23 A NASC or an EGL site can make an exception to the residential affordability criterion in the following circumstances:

23.1 there is a reasonably foreseeable and imminent risk of serious harm that cannot be addressed through non-residential support options;

23.2 the initial assessment of the NASC or EGL site is that they are unable to provide immediate assurance that they can afford the residential entry within their current annual budget; and

23.3 the NASC or EGL site provides assurance to the Panel that they are or will take reasonable and practicable steps to return to being within their Annual Budget by year-end.

Further detail on the application of the thresholds

24 Decisions on whether the thresholds for referring funding packages to the Review Panel should exclude the following:

24.1 Expenditure that is not funded through the DSS appropriation[2].

24.2 One-off expenditure (such as for Early Investment or Immediate Resourcing within EGL sites) that is for less than 12 months.

24.3 Community participation and Very High Needs funding for people within EGL sites that has been transferred to the DSS appropriation.

24.4 Specialist Behaviour Support.

[2] DSS funding is currently contained within the Supporting Tāngata Whaikaha Māori and Disabled People Multi-Category Appropriation, although this may change in the future.

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25 When the Review Panel is considering a package that includes funding that is excluded from the calculation of thresholds, it may need to consider whether the package, as a whole, including the funding from other sources, appropriately responds to all of the disability-related needs identified.

26 Price increases in the following situations do not need to be referred to the Panel:

26.1 Price increases of less than $5,000 a year to the DSS contribution to support packages that are managed by Health NZ.

26.2 Price increases for residential care that result solely from implementation of the CGH Pricing Model from 1 December 2025.

27 Residential and community packages allocated by either NASCs or EGL sites do not need to be referred to the Review Panel if they remain the same or decrease (unless they meet one of the other criteria for being considered by the Panel).

Quality of information required

28 The evidence required to support a referral shall:

28.1 whenever possible, be primary evidence (e.g., recent health practitioner notes or reports, needs assessments or good life plans) rather than secondary information (e.g., discussions about primary evidence);

28.2 be sufficient to show that all the criteria relevant to a decision have been met; and

28.3 be sufficiently recent to show what has changed, resulting in a decision needing to be referred to the Panel.

Ability of the Chair to consider NASC or EGL site decisions urgently

29 From time-to-time situations may arise between Review Panel meetings where urgent action is required to protect the health and safety of the disabled person and those supporting them, or to avoid a person being held in an inappropriately restrictive environment.

30 In this situation, the Chair of the Review Panel may consider the issue without a full meeting of the Review Panel being called. In these cases, the criteria they consider are whether the information shows that:

30.1 the situation falls within one of the priority groupings for residential service;

30.2 all other reasonably practicable options to effectively manage immediate risks to the health and safety of the disabled person or those who support them have been considered;

30.3 doing so will not compromise another higher priority entry; and

30.4 the temporary placement has been consented to by the disabled person in line with Right 7 of the Code of Health and Disability Services Consumers' Rights.

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31 The Chair of the Review Panel has the authority to advise the NASC or EGL site, as appropriate, that:

31.1 Either the information supplied supported their decision, and the Panel endorses their decision, so they are able to implement it.

31.2 Or the information supplied does not support their decision, so the Panel is unable to endorse it, so they are unable to implement it.

32 It is recognised there may be less information available when urgent action is proposed than would normally be required by the Review Panel. As a result:

32.1 If the NASC or EGL site is advised by the Chair of the Review Panel that they have reached a view that the available information supports their decision, the arrangement must be put in place for the shortest duration in which it is reasonable to manage the risk and maintain the wellbeing of the disabled person. This will generally be less than 6 weeks.

32.2 The Review Panel will reconsider the decision as soon as possible, to maintain oversight of residential and community support costs generally and to set expectations of longer-term solutions – in particular whether a transitional period in residential care will be considered, or whether a community alternative should be pursued.

Appeal of Review Panel Recommendations

33 Where a disabled person, their family, or the NASC/EGL site involved is concerned that the Review Panel has not followed this Terms of Reference in making its recommendation, they may seek a review of the decision by the Deputy Chief Executive for DSS at MSD.

34 The principles of natural justice apply to any appeal.

35 Following the Appeal, the Deputy Chief Executive, DSS can:

35.1 decide whether to accept the Panel's advice; or

35.2 refer the Panel's advice back to the Panel for re-consideration.

36 The Deputy Chief Executive of DSS must set out their reasons in writing to the disabled person or their nominated representative, and the NASC/EGL site involved, within six weeks of the review being sought.

Reporting of Review Panel Recommendations

37 The Review Panel must provide regular reports to, and at a frequency agreed with, the ADCE on:

37.1 the recommendations it has made (including packages it has not endorsed to review);

37.2 the costs involved;

37.3 the rationale for its recommendations; and

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37.4 any trends and emerging issues.

38 The Review Panel must do so at a level of detail consistent with maintaining the privacy and anonymity of the individuals involved.

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Support Needs Assessment and Service Co-ordination

Policy, Procedure and Information Reporting Guidelines

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Developed by the Ministry of Health for use by needs assessment and service co-ordination providers

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Introduction

The New Zealand Disability Strategy challenges those involved in the provision of Na/sc services to recognise that they have a primary responsibility to be of service in a meaningful way to disabled people and their families, while still recognising their need to work within the constraints imposed by other stakeholders, including the funder.

In addition, following a review and consultation process of needs assessment and service co-ordination (hereon referred to as Na/sc), it has become evident that a greater level of consistency and transparency of Na/sc processes throughout the country is required. This is particularly so in the flow of information between the disabled person, the Na/sc service, specialised assessors and services, service providers and the Ministry of Health (MOH).

The Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines identify:

1) policy and procedures that apply at each point of the disabled person's contact with the Na/sc system, hereafter referred to as the disabled person's pathway (See diagram pg 8)
2) information that needs to be collected and disseminated at each point of the disabled person's pathway.

The Guidelines specify minimum requirements. These requirements pertain to processes that should be followed and information that should be recorded. Services may have additional policy, procedure and information needs that are relevant to their own business and these requirements should be integrated into these Guidelines.

In instances where the disabled person cannot represent themselves because of impairment or competence, their representative will do so.

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Why do Policies and Procedures need to be consistent?

Consistent policies and procedures will help to promote equity of access to services and outcomes across different disability groups, ages, and geographic regions.

Why does the collection of Information need to be consistent?

The answer depends on the perspective you take as the information needs of the different stakeholders vary.

- The disabled person is contributing personal information and this needs to be collected, considered and disseminated in an appropriate and respectful manner.
- Separation of the activities associated with the collection of needs assessment information and that associated with service co-ordination information must be evident. The needs of the disabled person must be identified independently from service co-ordination and resource limitations.

- The Na/sc service needs to collect information from the disabled person to carry out all of its functions.
- The Specialised Assessment Services need information in order to determine the appropriateness of referrals, respond to these and carry out their role.
- The Support Service Providers need information in order to best provide services to meet the disabled person's outcomes.
- The MOH needs information for the purposes of ensuring appropriate services are purchased, providers are paid, budget expenditure monitored, gaps in services and resources are identified, future services planned and service trends identified.

The overall benefit to the disabled person is that nationally consistent information collection and reporting will

- promote equity of access
- promote equity of services nationally
- ensure the disabled person does not have to repeat information
- promote the collection of disability information in a consistent manner

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Principles of Policy, Procedure and Information Reporting

The principles that underlie the Guidelines are:

- That a disabled person's self-identified and prioritised needs are accurately recorded.
- That a minimum standard will promote processes that have the disabled person at the centre of them.
- That collected information will be used to assist in the identification of a disabled person's disability support needs.
- That information will only be shared with those for whom the disabled person has given consent.
- That the disabled person should not have to repeat information unnecessarily.

Why have Guidelines?

The purpose of the Policy and Procedure Guidelines is to provide certainty of process for the disabled person. The Information Guidelines establish a framework for information collection, dissemination and reporting. These Guidelines should be read in association with the Service Specifications. The Guidelines provide for a minimum requirement. It is anticipated that Na/sc services will build on this foundation and continue to strive for improvement.

What are Standard Procedures?

Standard Procedures are activities that every Na/sc service must adhere to. They relate to:

- Eligibility
- Needs assessment
- Service co-ordination
- Payment systems
- Reporting to the MOH
- Complaint and appeal

Quality Requirements

These Guidelines are about Policy, Procedure and Information Reporting. They assume you are familiar with Na/sc quality requirements and those documents guiding service delivery including:

- Standards for Needs Assessment
- Standards for Service Co-ordination
- Standards for NASC Agencies
- New Zealand Disability Strategy 2001

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- Health of Older People Strategy Consultation Document 2001
- New Zealand Health Strategy
- Positive Aging Strategy
- Health and Disability Commissioner Code of Rights and Responsibilities
- Informed Choice and Consent

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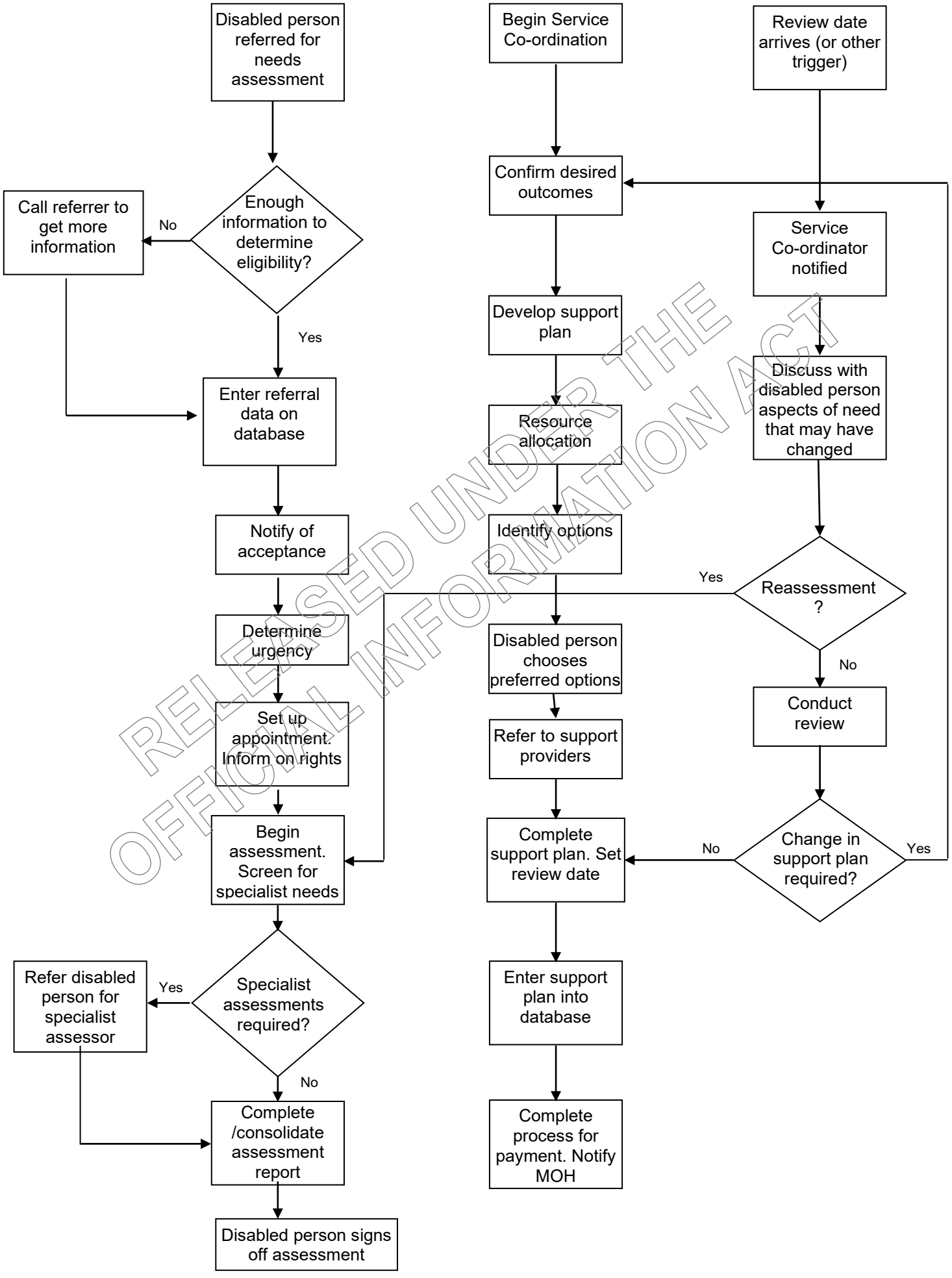
Disabled Person's Pathway

Needs Assessment | ***Service Co-ordination*** | ***Review***



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Access to Na/sc

Goals of Guidelines

The guidelines in this section have the following goals:

- To ensure that access to Na/sc is simple
- To ensure Na/sc services provide information to support access to their services.

What Information Should Disabled People and Referrers Have About Na/sc?

The Na/sc should ensure disabled people and referrers have information about:-

- Contact information, i.e. phone, fax, email, address (postal and actual)
- Who is eligible for a needs assessment
- How to access a needs assessment
- The purpose of needs assessment
- Where the needs assessment takes place
- The purpose of service co-ordination
- What the disabled person can expect
- That for eligible disabled people there is no cost for assessment and service co-ordination.
- Other information the Service may want to provide includes:-
- Mission statement - the philosophy of the agency
- Profile of staff
- Hours of service.

What Information Should Referrers Have About Na/sc?

Usual referrers should receive information on how to access the service along with:

- Referral form (service may provide electronic template)
- Eligibility criteria
- Response criteria – how referrals are prioritised and timeframes for response
- Indicators of urgency.

Providing referrers with this information will help to create a more responsive service and reduce inappropriate referrals.

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Referral to Na/sc

Goals of Guidelines

The guidelines in this section have the following goals:

- To ensure the Na/sc provider understands and implements a consistent referral process
- To ensure the Na/sc provider receives the information required to determine the disabled person's
  - Eligibility
  - Priority for response.

What is a Referral?

A referral is a documented request for needs assessment and/or service co-ordination. The disabled person, referrer or Na/sc service may complete it.

The referral must be documented, as it is the starting point to the needs assessment and service co-ordination pathway.

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What Information needs to be recorded at Referral?

Heading	Content
Date of referral	Record the date of referral to Na/sc
Status of referral	Is this a new referral? Does it relate to an existing disabled person?
Disabled Person's Details	Record the disabled person's: ▪ Name - as appears on birth certificate - preferred name ▪ Address ▪ Telephone, fax, email (disabled person's preferred method of communication) ▪ Date of Birth ▪ Gender ▪ NHI ▪ Disability/Health status ▪ Community Services card ▪ Ethnicity - ask the disabled person for their own description and record this ▪ Communication method e.g. sign or other language, is an interpreter required ▪ GP ▪ Other people at person's home receiving support ▪ Alerts e.g. dog at the disabled person's home
Disabled person Preference	Assessor ethnicity, gender
Next of Kin or *Alternative Contact or* *Carer details*	Record the: ▪ Name – as appears on the birth certificate - preferred name ▪ Address ▪ Telephone
Referrer Name and Address	Record name and contact details of the referrer
Reason for Referral	Detail: ▪ Reason and purpose of the referral ▪ Events that may have led to the referral ▪ Needs that can be identified
Does the disabled person agree to the referral?	Indicate: ▪ Disabled person's knowledge of referral ▪ Disabled person's agreement to referral ▪ If it is not the disabled person providing the consent, record who Where disabled person has not agreed, describe the situation
Timeframe for response	Indicate ▪ the priority for response ▪ timeframe for response Is this referral urgent? Why?

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Are there any variations in the requirements for completing the Referral Form?

These are minimum guidelines that should be followed. Some aspects will not be relevant to a particular disabled person's circumstances and the Na/sc may have additional information requirements.

It may not be possible to gather all the information e.g. the referrer may not know. However completing as much as possible will help with the next steps in the process.

What happens once the Referral Form is received?

The Na/sc service needs to determine if the person is eligible for an assessment and determine the priority for response.

Eligibility Criteria for DSS Funded Services

Disabled people and their carers are eligible for a needs assessment should the person with the disability meet the Ministry of Health definition of disability:

> *"A person with a disability is someone who has been assessed as having a physical, psychiatric, intellectual, sensory, or age related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required."*

A carer is someone who has principal, active responsibility for the ongoing and frequent care of a person with a disability according to the above definition. The carer is not paid by the MOH to carry out this role.

The Na/sc must make every effort to confirm eligibility before commencing a needs assessment.

Exclusions

- People who are covered under the Accident Insurance Act 1998.
- People who require an assessment solely as a result of a mental health need - these assessments are usually contracted for by MOH through mental health assessment services or community mental health teams. There are, however, regional variations.
- People who require assessment as a result of a personal health need. A personal health need is defined as when a person's level of independent function is reduced by a condition that requires ongoing supervision by a health professional.[1]

[1] In some regions the na/sc service may be contracted to manage access to and allocation of some personal health services e.g. convalescent care.

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- People who are not a New Zealand resident

Eligibility and exclusion information is repeated in the Na/sc Service Specification. There may be additional criteria specific to your services contract arrangements or Locality.

Timeframes for Response

First contact with the disabled person will be made within two working days of receipt of the referral or enquiry on behalf of the disabled person.

Notifying the Disabled Person

If the disabled person is not eligible for a needs assessment and the referral is declined, the Na/sc should promptly redirect the disabled person or referrer to the service best able to assist the disabled person to meet their need. It is inappropriate for the Na/sc to leave the person with no direction.

Once a referral has been accepted the disabled person should be notified:

- That the referral has been accepted
- Timeframe for assessment
- Where appropriate, appointment details
- The purpose and process of needs assessment and service co-ordination.

The disabled person should receive a copy of the Health and Disability Commissioner's Code of Consumer Rights. The service may choose to incorporate the Code into other information for the disabled person e.g. services pamphlet.

The disabled person should be provided with written information of the complaint and appeal procedure.

Consideration should be given to having resources available in a range of formats including other languages and media.

Advocacy

The Na/sc service should provide information to the disabled person regarding: -

- The purpose of advocacy
- Advocacy options
- How to access advocacy

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Needs Assessment

Goals of Guidelines

The guidelines in this section have the following goals:

- To ensure that accurate and pertinent information is gathered in conjunction with the disabled person
- To ensure auditable boundaries between needs assessment and service co-ordination are maintained
- To ensure Na/sc services adhere to established policy and procedures while collecting the level and quality of information required
- To ensure that the needs assessment provides the information required for outcome driven service co-ordination.

What is a Needs Assessment?

The concept of needs assessment is based upon a belief that disabled people and their families can be trusted to define their own needs.

A needs assessment is undertaken in partnership with the disabled person and is a facilitated process of determining the current abilities, resources, goals and needs of a person with a disability and identifying which of those needs are the most important to the disabled person.

It is crucial that the focus is on the positive components of a disabled person's performance while acknowledging the things that limit them. The purpose is to agree what a person needs to maximise their abilities and independence, to overcome barriers and to participate in accordance with their abilities, resources, culture and goals.

A needs assessment can also be the process of determining the needs of the family/ whanau and/or carers as they relate to their role in supporting the person with a disability.

Before the Needs Assessment

The needs assessment facilitator will need to establish with the disabled person:

- Where the assessment will take place. This needs to be where the disabled person feels comfortable and will usually be their home or place of residence
- If they have any preferences on who should carry out the assessment e.g. gender, culture, expertise of the assessment facilitator
- Who they would like to be present at the assessment
- The best time to meet
- Any special requirements
- Other assessments that should be accessed e.g. specialised assessments.

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Cultural Assessment

Acknowledgement of an individual's cultural identity and needs are important for a holistic assessment. This is of particular importance in working with Maori, as the Government through the Treaty of Waitangi has recognised a special relationship between iwi and the Crown,

Appendix 3 outlines a process that Maori have identified as the one that would be most appropriate for them if there was sufficient trained human resource to be able to provide it. It involves having a cultural Support Advisor available for the person receiving the assessment. With suitable modification to meet different traditions and family systems, this process may also be appropriate for other cultures.

Given though that at the moment there may be times when a cultural advisor is not available for every person who identifies as Maori or as wanting/needing culturally appropriate assessment, all assessments should follow the following principles:

Principles for Cultural Support Assessment

- The assessment will aim to enhance a cultural perspective of the needs of the disabled person and their family/whanau by all those involved in providing support
- The assessment will provide a key element in the building of a holistic picture of the needs of the disabled person and their family/whanau
- Assessment and service co-ordination services will be culturally effective and safe
- The Treaty of Waitangi will be the overarching principle for cultural support assessments for Maori
- Maori will be involved in the development and delivery of support services for Maori

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Assessment Forms

The skill of the assessor will ensure that the way in which the information is collected is tailored to meet the disabled person's individual age, experience of disability, needs and circumstances and respond to the disabled person's cultural requirements. A disabled person does have the right to decline to respond to questions. An assessment form that provides cues which should assist the disabled person and their family/whanau to express their needs is attached (See Appendix 1). Na/sc services can seek more information if this will aid the disabled person to better express their needs. It is the process of collaboration between the disabled person and the assessor that is important, not the reporting format.

The use of Cue sheets may be valuable to assist the assessor to respond to the individual.

It is also important that Na/sc services maintain a functional perspective in the assessment. It is the responsibility of the assessor to recognise if there is a need for clinical assessment and make referral to the appropriate specialised clinical assessment service with the consent of the disabled person. Failure to do so may

compromise the disabled person and the process of needs assessment and service co-ordination.

Ethnicity

It is a requirement of the needs assessment facilitator to gather accurate information regarding a disabled person's ethnicity. The New Zealand Disability Strategy 2001 objectives includes the promotion of participation of Maori and Pacific Peoples within their communities and promotion to encourage them to access disability services when they are eligible.

The term ethnicity has a wide meaning. It is not the same as nationality, race or place of birth. Ethnic groups are people who have culture, language, history or traditions in common. These people have a sense of belonging to the group, which may not be based on birth. It is possible to belong to more than one group. At different times of their life people may wish to identify with other groups.

Although it is a personal issue, people must have the choice of responding to the ethnicity question. Should a person choose not to answer the question their response will be 'not stated'

Consent for needs assessment

Informed consent is a requirement before this service can be provided. The rights of disabled people to make an informed choice and to give informed consent are provided by the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulation 1996. Consent can be oral or implied consent. However as there are fiscal consequences attaching to the needs assessment, it is the MOH's preference that consent in writing be obtained from the disabled person where ever possible. The assessment has future fiscal consequences as it is used by Na/sc providers for making decisions about government funded assistance in accordance with government policy and relevant service specifications, and thus the extent to which the individual or their carer is responsible for their own needs.

What is important is the process by which sufficient information is given to the person to make informed choice. If circumstances suggest that the person did not understand or because sufficient information was not given then the consent could be held to be invalid.

A person is free to sign or not. Ultimately the disabled person has the right to refuse services and to withdraw consent to services and where this occurs it should be recorded.

Using the assessment

The process of collecting the information from the disabled person must be tailored to meet the disabled person's individual need and circumstance, e.g. the assessment facilitator must consider age appropriateness in the mastering of activities.

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Within the provided holistic support needs assessment form, the narrative is more important than the tick boxes, e.g. in each category of independence it is quite possible that the disabled person may use equipment. Exactly what this equipment is and how it is used should be detailed in the narrative of the assessment information.

The tick boxes have 3 categories of independence. It is crucial that all needs assessment facilitators use these terms in the same manner.

1) Ind.=Independent- The disabled person can safely initiate and complete the activity unaided by another person

2) Sup.=Supervision-The disabled person requires oversight by another person to safely initiate and complete the activity

3) Ass.=Assistance- The disabled person requires the physical aid of another person/s to have the activity safely initiated and completed.

The descriptions that accompany each section of the assessment below are simply intended to demonstrate some of the issues that may require exploration with a disabled person. **This is *not* a guide-sheet and must not be used as such**.

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Needs Assessment Information

Heading	Content
Session Information	• Complete to the standard required by the Na/sc
Disabled Person's Details	▪ Confirm all referral data is correct and complete any gaps ▪ Complete ethnicity whenever possible. Encourage the disabled person to be as specific as they wish ▪ Record nature of disabled person's disability including a functional perspective. Indicate from whom diagnostic information was sourced. Reference to the disabled person's health and well being may be useful ▪ Describe events that have lead to the assessment. ▪ Identify if the person is an ACC claimant. The case managers' name may be useful. ▪ Disabled person's legal representative refers to E.POA, welfare guardian ▪ Confirm to whom correspondence is to be sent if not the disabled person
C*onsent for information*	Consent to collect and disseminate information must be gained from the disabled person or their representative.
Contacts	The disabled person nominates alternative contacts, which may be e.g. their spouse, partner, next of kin or friend.
Those present and those consulted	Identify other people involved in the assessment including those consulted with and what their roles are
Living situation	Detail the nature of the living situation e.g. accommodation, who the disabled person lives with, compatibility, for how long they have lived in the environment, suitability of the environment, alterations needed to accommodate disability needs
Current Support Networks	Formal supports may include DHB services, specialised services ACC, Justice, CYPF,SES, funded support *N.B.* Identify specialist services that may have relevant assessment information and seek disabled person's consent to access this if appropriate Informal support may include family/whanau, age specific organisations, disability providers, support groups service clubs The health and well-being of the family members supporting the disabled person should be noted.
Communication	Ability to express core needs Method Expressive and receptive communication Equipment used Support received e.g SLT
Sensory function	Is any provided equipment meeting the disabled person's needs?

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Mobility	Mobility inside-the disabled person's home Method of mobility-crawling, being carried, walking Equipment used-power chair, walking stick, walking frame Seating systems Safety Mobility outside Accessing the disabled person's section, back door steps To clothes line, mail box Mobility in the community Accessing local shops, library, GP, preschool, school Methods used Safety in the community Transport Driver Method of transportation Safety of disabled person and driver Adapted vehicle/seating system Transfers Ability to move to one surface to another Positioning Ability to get up after a fall Does the disabled person have a strategy Falls risk Why is the disabled person at risk, What factors contribute What is being done about this
Leisure	Opportunities to participate What does the disabled person like to do What would assist the disabled person to participate in these activities
Income support	Use check boxes to demonstrate what support the disabled person is receiving Need for ongoing referral
Household management	Shopping Disabled person's method of attending to daily shopping Assistance received Access to community services Meal preparation Safety How planned and managed Equipment used Participation of disabled person Housework Specify what parts of the activity the disabled person needs assistance with and why Laundry Consider all components Finances Day to day management i.e. ATM, paying bills Garden lawn What assistance is required Fire/Heating Method disabled person heats home and ability to manage Home safety Consider the use of heater, electric blankets Evacuation plan Smoke alarms Safety rails etc Home security Keeping safe at home i.e. ability to manage locks Neighbourhood watch

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Personal care	Bed mobility Ability to change position, respond to pressure, adjust bed clothes Bathing /showering Consider tasks that disabled person can safely undertake Note equipment used and effectiveness Grooming Hair, shaving , makeup Dental care Blocks to independence Foot care Include care of toenails and safety of procedures Fingernails Toileting Ability to express need to toilet Equipment used Continence bladder and bowel Describe difficulties and support received if any Times of incontinence Continence training programme in place Menstrual management Ability to manage Who is responsible for managing, if not the disabled person. Appropriateness Medication How does disabled person get and manage their medication Who monitors medications Eating Also consider diet, nutrition Swallowing safety Drinking Ability to manipulate a drinking vessel Sucking, swallowing Health management Disabled person's ability to respond to their health needs e.g. reporting pain and discomfort, when did they last visit their GP Night care sleep patterns Level of attention disabled person needs Effect on carer
Social	Relationships with others Isolated or integrated Effect of behaviours on others Peer group involvement Family friends and support Sexuality
Memory behaviours and cognition	State ownership of comments i.e. disabled person or other How does impairment affect disabled person's Effect on carer family others and their ability to cope Consider personal safety of disabled person Consider underlying reason, e.g. seizures, intractable epilepsy Behaviour Triggers for challenging behaviour Behaviour management plan and review date Who supports disabled person Dual diagnosis – known to Justice Department

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Educational vocational voluntary	<u>Educational</u> What and where Involvement of support e.g. SES, ORS Are disabled person's needs being met Integration of therapy programmes <u>Vocational</u> Opportunities to participate in meaningful activity Workbridge/ACC Long term goals for disabled person <u>Voluntary</u> Activities that the disabled person has /does participate in e.g. school, hospice
Cultural	Detail cultural perspectives that are important to the disabled person Determine blocks to participation
Spiritual	Detail spiritual perspectives that are important to the disabled person Determine blocks to participation
Disabled Person's goals	Goals, dreams, plans for the future Both short and long term Identify who the goals belong to
Other information	Anything the disabled person may wish to have added
Carer information	This section relates entirely to the disabled person's carer A carer is someone who has principal, active responsibility for the ongoing and frequent care of a person with a disability. A person is not paid by the MOH to carry out this role. The level of carer of support received and its utilisation needs to be explored. The reasons for the carer being unable to access an alternative carer must be determined.
All identified unmet support needs	All unmet needs and the disabled person's goals must be documented The disabled person has the opportunity to establish priority of need Responsibility of? Refers to the person who has agreed to work toward resolution of that particular need Urgency should only be used if the situation requires
Completing the assessment	The disabled person has opportunity to consider the assessment data. The disabled person may make amendments and corrections. The disabled person then signs off the assessment. No further data should be added after this point unless with the consent of the disabled person

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Are there any variations in the requirements for completing a needs assessment?

Central to the principle of assessment is the need for a person centred approach to be adopted by the assessor. An assessor who is skilled, and knowledgeable about the disabled person's particular disability or has experience in the lived world on disability must facilitate the support needs assessment.

These guidelines should be followed but some items

- will not apply to a disabled person's circumstances
- the disabled person may choose not to discuss some areas of their life. This should be respected and recorded and any consequences explained
- will require more detail e.g. with input from a specialised assessor or a significant family/whanau member who may not have been available at the time of assessment

Maintaining the boundary between needs assessment and service coordination

The disabled person's perception of their own needs and goals, combined with the specific knowledge and skills of the assessment facilitator are combined in the needs assessment.

The needs of the disabled person must be assessed away from consideration of the availability/constraints of resources. Any needs assessment reporting tool that relates to the funding level of services contravenes the principle of the boundary between needs assessment and service co-ordination.

Na/sc services are required to maintain and demonstrate a boundary between needs assessment and service co-ordination. Some will maintain the boundary by having two different people carry out the two functions. In all instances the principles for information reporting must be adhered to, meaning that information must be transferred well to ensure that the disabled person is not required to repeat information.

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Reassessment

The guidelines in this section have the following goals:

- To ensure the Na/sc provider understands and implements a consistent reassessment process
- To ensure the Na/sc provider understands the information requirements for reassessment

What is a Reassessment?

There are two scenarios where reassessment is required.

1. When there has been a significant change to the disabled person's needs and/or circumstances and the existing Support Plan no longer meets their needs.
2. The disabled person is unhappy with their assessment, has complained and requested or been offered a reassessment.

Requirements for Reassessment

A reassessment should follow the same process and reporting requirements as for a needs assessment.

Are there any variations in the requirements for completing a Reassessment?

Yes. Depending on the needs and circumstances of the disabled person, some information collected in the needs assessment may still be relevant and should not be duplicated.

Significant changes may have occurred in a limited number of need areas and these are the focus for the reassessment. Current specialist assessment information relating to these areas should be accessed or referrals made.

To assist in judging the scope of a Reassessment the Facilitator will need to be familiar with the disabled person's needs assessment and the Support Plan.

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Referral to other Agencies

The New Zealand Disability Strategy 2001 objective 7.3 states:
Investigate the development of a holistic approach to assessment and service provision that applies across agencies and funding sources

A Na/sc service cannot operate in isolation from other services that support the disabled person. It is essential that linkages are developed cross-sectorally with the DHBs, other government funded departments, and community organisations. The Na/sc service will need to have information on agencies and services funded by other government departments e.g. Child, Youth and Family Services, Department of Work and Income, Education Justice, ACC. In addition the Na/sc service will need information relating to community services.

It is likely that other agencies and services will have their own referral procedure. The Na/sc service should find out the procedure and follow it, as providing the right information will allow agencies and services to make an informed response to the referral.

Where the agency or service does not have a referral procedure then the guidelines for Specialised Assessments should be used as a model for referrals.

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Referral for Specialised Assessments

Goals of Guidelines

The guidelines in this section have the following goals:

- To ensure Na/sc providers understand the roles, functions and expertise of specialised assessors and the specialised clinical services they provide to the disabled person
- To promote effective professional relationships with an emphasis on disabled person centred communications between Na/sc services and specialised assessors
- To ensure that disabled persons who are identified as requiring specialised assessment are referred for that assessment in a timely manner
- To ensure that referrals are made in a manner acceptable to the disabled person and the specialised assessor.

When is a Specialised Assessment Required?

A specialised assessment is required when the disabled person's needs require further investigation and assessment by an assessor or service with particular skill and expertise in an area.

Reasons to make a specialised assessment referral include:

- Establishing a diagnosis
- Establishing eligibility
- Investigating the nature and extent of a disability
- Accessing treatments
- Accessing rehabilitation
- Accessing therapy services - assessment and interventions
- To assist in developing a Support Plan.

What is a Referral?

A referral is a documented request in relation to a disabled person with specific need who meets the eligibility criteria for assessment by the specialist service.

The New Zealand Disability Strategy 2001 Objective 7.2 states:

Ensure that government agencies, publicly funded services and publicly accountable bodies co-operate to ensure that the disabled person is at the centre of service delivery.

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It is the responsibility of the assessment facilitator to identify when a specialised clinical assessment is required and to make the appropriate referral. In some instances where the assessor is unable to make a referral directly to the specialised assessment service, it is their responsibility to link with the person who has authority to do so and discuss the need for referral. The Na/sc provider has a responsibility to ensure that assessors are knowledgeable about:

(a) all the specialised assessment services that may support the disabled person, and
(b) how to make referral to those services.

Na/sc services will have:

- written information about the specialised services available to the disabled person
- the entry criteria for specialised services
- guidelines on the referral processes for specialised services
- agreements with specialised services on information sharing e.g. feedback loops.

Guidelines and protocols should be developed in conjunction with the specialised service.

Should the Na/sc service be uncertain about the acceptability of a referral the specialised service should be consulted.

Consent to Referral

Referrals to a specialised service should be made after discussion and with the informed consent of the disabled person or their representative. Consent should be documented.

This involves the exchange and understanding of relevant information so that an informed, reasoned and unpressured decision can be made by someone who has the competence and legal capacity to make such choices.

This may mean providing the disabled person with both written and verbal information about the specialist service, the reason for the proposed referral, options to that referral, and what the process may involve.

Where the person does not agree to have information passed to Specialised Assessors and their safety is at risk, the Na/sc service might explore options for acting without the consent of the person e.g. discuss with Welfare Guardian or other legally acceptable representative.

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Are there any variations in the requirements for referral forms?

Yes. Most specialised assessment services will have their own referral procedure and form. These should be used as this will help provide the specialised service with the information needed to determine the most appropriate response.

Where a specialised assessment service does not have a referral procedure these guidelines should be followed. However, they are generic. Some items will not be relevant to a particular disabled person's circumstances. Others may require more detail.

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What Information needs to be recorded in the Referral to Specialised Assessors?

Heading	Content
Date of referral	Record the date
Referrer Name and Address	Record name and contact details of the referrer
Disabled Person's Details	Record the disabled person's: ▪ Name – as appears on birth certificate -preferred name ▪ Address –postal - actual ▪ Telephone ▪ Date of Birth ▪ Gender ▪ NHI ▪ Disability ▪ Ethnicity - ask the disabled person for their own description and record this ▪ Contact person's/ representatives details ▪ Communication method e.g. sign or other language. Is an interpreter required? ▪ GP ▪ Alerts e.g. dog at the disabled person's home
Reason for Referral	Detail: ▪ The reasons and purpose of the referral ▪ Key events or indicators that have led to the referral
Urgency	Is this referral urgent and if so why?
Does the disabled person agree to the referral?	Indicate the disabled person's consent to the referral. If this is not provided, give detail why not
Disabled person contact	Identify when, where and how to contact the disabled person. Indicate if a carer or representative is to be contacted. Provide contact details.
Timeframe	Indicate the timeframe for response to the referral

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Service Co-ordination

Goals of Guidelines

The guidelines in this section have the following goals:

- To ensure that disabled people have equitable access to support services to meet their prioritised needs
- To ensure that a transparent decision making process that promotes equity, fairness and equal access to services is implemented for eligible disabled person's by all Na/sc providers
- To ensure that service co-ordination only occurs after the completion of a holistic support needs assessment
- To ensure Na/sc providers understand and implement service co-ordination information requirements
- To promote a national framework which supports consistency between Na/sc providers.

What is Service Co-ordination?

Service co-ordination is the process of setting up flexible and responsive solutions to meet the prioritised needs and goals of the disabled person, as identified in the needs assessment, in a manner that makes sense to them. This is to be achieved within the funding guidelines. The support packages will be reviewed as required. Service co-ordination:

- explores all options for achieving desired outcomes
- may assist the disabled person to access support from other services
- may allocate DSS funding
- ensures services are in place and that agreed outcomes are being achieved.

It is important for successful service co-ordination that all options for achieving desired outcomes are explored. Good information sharing, knowledge of networks and resources are important, as is innovative thinking and creative problem solving.

Beginning Service Co-ordination

The needs assessment provides the service co-ordinator with information about the importance of each of the disabled person's assessed needs as agreed with the disabled person.

The delivery of service co-ordination will depend on the circumstances of the disabled person. For non-complex needs telephone contact may be sufficient for the development of the support plan. For complex needs multiple visits to the disabled person's home and with the disabled person and family/whanau, as well as support service providers may be required.

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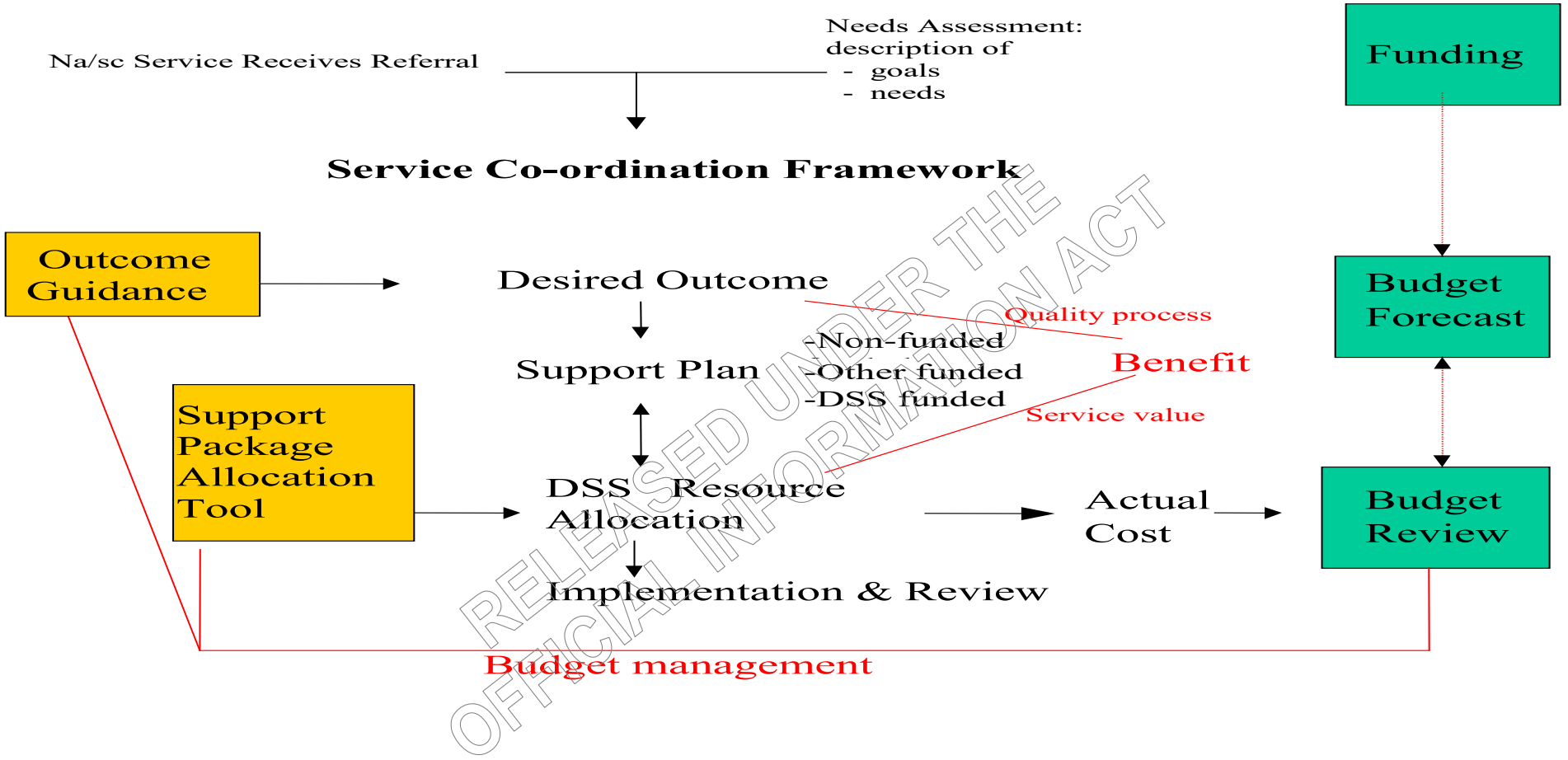

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Service Co-ordination Framework

The above model represents the key service co-ordination processes that are discussed in detail and identified as;-

1.Desired Outcome
2.Support Plan
3.DSS Resource Allocation
4.Management of DSS Resource
5.Implementation
6.Support Plan Check

Desired Outcome

The first task of the service co-ordinator is to identify and negotiate with the disabled person their desired outcomes. These outcomes are based on the disabled person's prioritised needs and goals as identified in the needs assessment. It is the service co-ordinator's role to achieve the best possible outcomes for the disabled person within the resources that are available.

This process requires:

- Clarification of needs with the disabled person
- Agreement of desired outcomes with the disabled person.

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2. Support Plan

The objective of the service co-ordinator is to develop a support plan that

- meets the needs as identified and prioritised by the disabled person in the process of needs assessment
- shows documented evidence that demonstrates consideration and evaluation of the worth of all options and solutions which may include:
  - informal support
  - recommendations from specialised assessors
  - making referrals to specialised services should this process have not been completed
  - accessing community support
  - DSS funded flexible support options.
- can be implemented
- will be checked to ensure outcomes are being meet
- is reviewed at least annually.

In developing the support plan the Service Co-ordinator must

- work in a collaborative manner with the disabled person
- identify if a key worker is required because of the complexity and number of services/resource being accessed to support the disabled person. If required, this person is responsible for ensuring support is delivered and the disabled person's outcomes are met. If the key worker is not the service co-ordinator, then the related role of the key worker is also identified
- integrate all activity that supports the disabled person to achieve their goals, both short and long term goals
- work through all options and solutions including those that are nonfunded, and those that require DSS and other government funded resources
- identify flexible funding options and how they will contribute to achieving the disabled person's desired outcomes (where relevant) and that the option will not put the disabled person or carer in any greater risk than other available support options
- ensure options and solutions are accepted within the Support Package Allocation Tool Guidelines or relevant criteria
- document any outcomes that cannot be met, including gaps arising from lack of service options acceptable to the disabled person.

The information-reporting requirement regarding the support plan is a standard procedure. All service co-ordinators must complete it fully and accurately.

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Information and the Support Plan

This documents the process for the service co-ordinator. The Na/sc service may choose to provide the disabled person with the completed Support Plan or a summary of the Support Plan. Guidelines related to providing service co-ordination information to the disabled person are outlined on the following page.

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Heading	Content
Needs and goals	Record prioritised needs and goals as identified in needs assessment
Outcomes	Alongside each need, identify the desired outcome i.e. what should be achieved.
Identify options	Identify and negotiate non-DSS funded options to meet the identified outcomes. Include: ▪ Informal supports including family, carers, church, volunteer, community ▪ Other supports e.g. education, vocational. Identify the agency and why they are involved.
	Identify the DSS funded support options required including: ▪ Environmental Support Services ▪ Specialist services e.g. AT&R, behaviour support ▪ Home support ▪ Carer support ▪ Respite care ▪ Residential care
	Flexible options: ▪ Identify the flexible funding options: ▪ Identify that the option will not put the disabled person or carer at risk and how those risks will be managed
Disabled person liaison	Record outcome of discussion with disabled person on service options. Record the rationale for choice i.e. why an option has been selected.
How will outcomes be achieved?	Negotiate solutions with providers: ▪ Role of proposed providers ▪ When support is to be provided ▪ The duration of the support ▪ The cost of the service
Action required	Record any action that may be required and timeframes e.g. ▪ Follow-up e.g. referrals to services, referrals to specialised services, resultant action of referrals etc
Action required from other (s)	Action agreed to others ▪ Identify the action ▪ Identify who is responsible for completing the action ▪ Timeframes
Unmet needs	Identify desired outcomes that could not be met ▪ Why? ▪ Options that have been explored
Progress statement	Comment on the effectiveness of the plan, are the desired outcomes being achieved: ▪ Were the actions completed? ▪ Is further work on the support plan required? ▪ Were the actions successful?
Review	Identify date for the review of the support plan
Key Worker	Identify the key worker:

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Disabled Person Information and the Support Plan

These guidelines summarise the activity undertaken during service co-ordination. The guidelines are minimum requirements for the information the disabled person receives.

Heading	Content
Outcomes	Record all outcomes of service co-ordination including: ▪ Non-DSS funded supports and services ▪ DSS funded services
Solutions	Record: ▪ Provider name and phone number ▪ Services to be delivered ▪ what the provider has agreed to do ▪ timeframes e.g. start date, review, finish ▪ specific arrangements e.g. transportation, meals
Unmet needs	Identify desired outcomes that could not be met ▪ Why ▪ Options that have been explored
Review	Identify date for the review of the support plan
Key Worker	❑ Identify the key worker i.e. person responsible for ensuring the plan is in place:

The Na/sc service must ensure the disabled person or their key worker knows how to contact the service in the event of a change in needs or circumstance.

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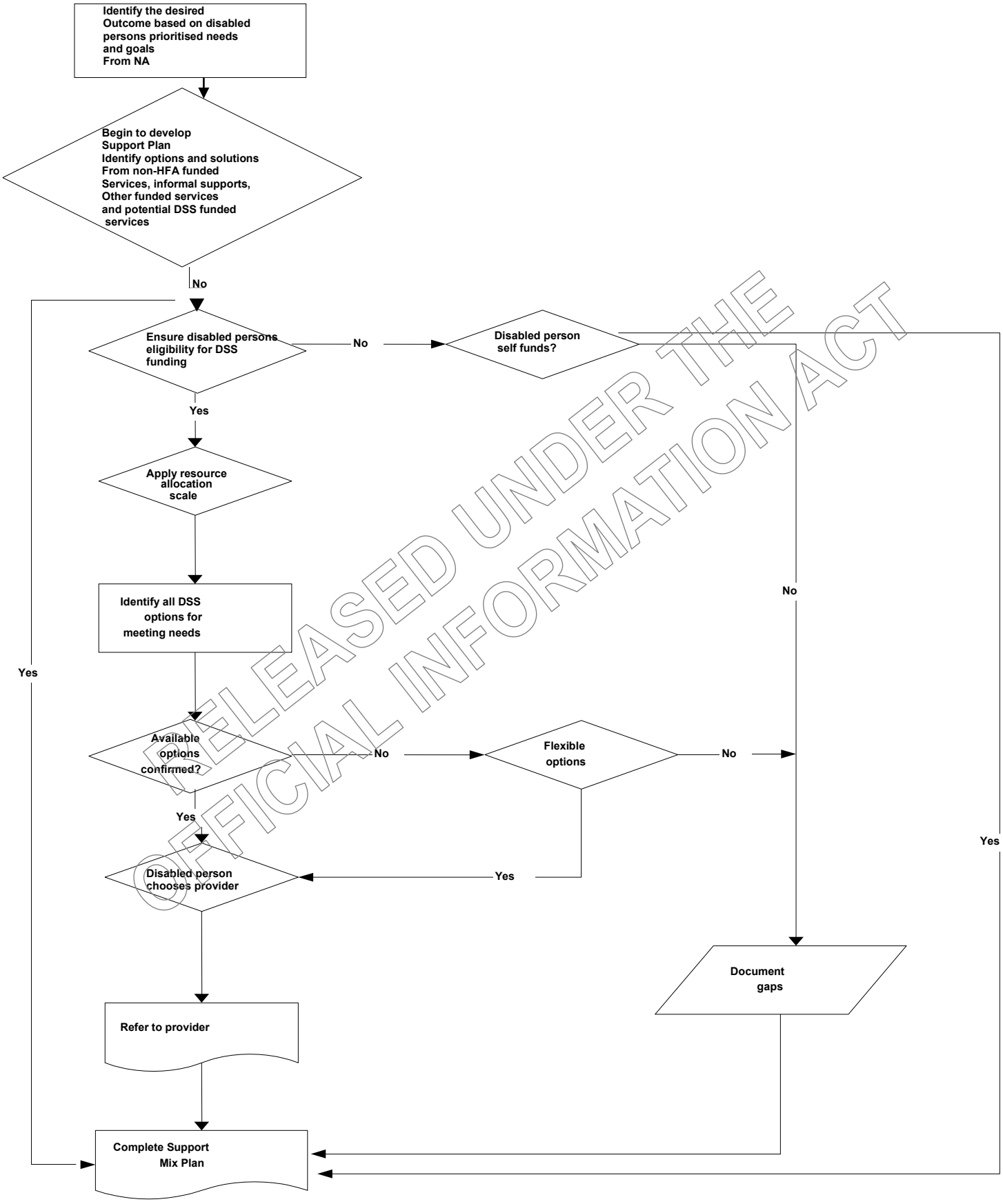
The Support Plan and Disability Support Services



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3. Resource Allocation

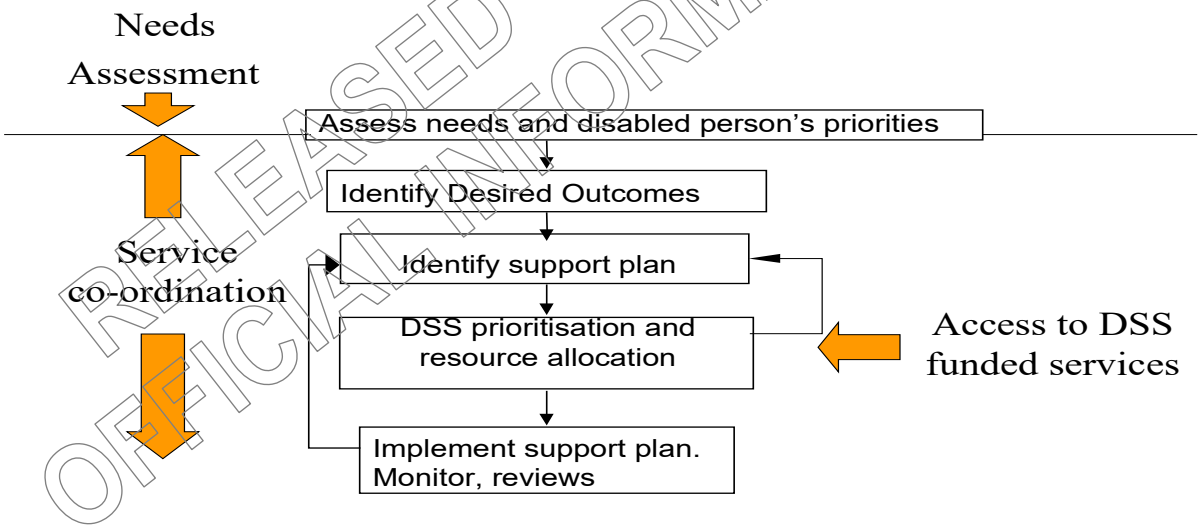
It is inevitable that there will be tension between the management of scarce resource and the realities of being of service to disabled people. Herein lies the challenge for service co-ordinators - to address this tension in a manner that reflects a true understanding of serving the disabled person in a manner that supports their common humanity.

Goals of DSS Resource Allocation

The guidelines in this section have the following goals

- To ensure Na/sc providers have a common understanding of "prioritisation" and "resource allocation" as it relates to service co-ordination
- To ensure Na/sc providers manage DSS resources effectively and efficiently guided by the Support Package Allocation tool.
- To ensure that Na/sc providers understand the information requirements related to the audit of the prioritisation and resource allocation process.

What is DSS Prioritisation and Resource Allocation?



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The DSS prioritisation and resource allocation process aims to provide disabled people with support solutions that meet their needs and result in the desired outcome. This must be achieved within the overall service budget and with due consideration given to ensuring that "the essential need" of other disabled people in the population receives equitable access to support solutions.

"Essential need" can be defined as the level of support that is expected to be met for all eligible disabled people. Safety and risk are the basis of essential need.

The development of the support plan and the prioritisation and resource allocation process will require negotiation with the disabled person, and should be the result of a collaborative process. The service co-ordinator must

acknowledge and document the link from the disabled person's needs and desired outcomes to the solutions and services to achieve those outcomes.

The total package is important, including non-funded and other funded solutions as well as DSS funded services.

DSS Resource Allocation

The service co-ordinator identifies which potential DSS support options provide the greatest benefit to a particular disabled person within the available budget for the population being served. To achieve this, the service co-ordinator will have considered:

- The likely scale of resources that may be available to develop and fund solutions for a particular disabled person (the resources will have included consideration of sources of funds or services other than DSS funding).
- What services and flexibly funded options are available from DSS funding and what the timeframes for response and start/completion will be.

DSS Prioritisation

The prioritisation process of allocating resources acknowledges:

- the relative priority of providing support solutions for a particular disabled person (compared with the rest of the population)
- the relative priority of the assessed needs and identified outcomes for a particular disabled person.

The objective of the prioritisation process is for the service co-ordinator to identify:

- which disabled people have the greatest urgency (e.g. for immediate attention)
- how a particular disabled person's desired outcomes and support requirement compares to the population being served
- how funding from sources other than DSS can support the disabled person
- how DSS funding can contribute to supporting the disabled person's desired outcomes.

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4. Support Package Allocation Tool for Na/sc Providers

INTRODUCTION

It is worthwhile reiterating some of the service co-ordinator's goals through the prioritisation and resource allocation process leading to the development of this Support Package Allocation tool.

The prioritisation and resource allocation process aims to:-

- Ensure Na/sc providers nationally have a consistent understanding of prioritisation and resource allocation as it relates to service co-ordination
- Ensure Na/sc providers manage resources through an effective and efficient process
- Ensure Na/sc providers understand the information requirements relating to the audit of the prioritisation and resource allocation process

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DEVELOPMENT OF THE SUPPORT PACKAGE ALLOCATION AND KEY POINTS TO NOTE

During the development of this support allocation process, the major aim is to provide disabled persons with support solutions that meet their needs and result in the desired outcomes. However, this must be balanced within the constraints of the overall service budget.

Management of available budgets within the proposed allocations below still remains the overall responsibility of the Na/sc service manager.

In most cases, the allocation amounts specified are the maximum amount for the particular scale of the disabled person's need level. In most instances, the average allocation amount will be well below the maximum amount and in practice, there will be a distribution of disabled people right through the allocation range.

Through each Na/sc service manager's experience and working within the budget constraints, each Na/sc service may wish to develop further "bands" within the scale for their own internal use with a specified proportion of disabled person's receiving packages of support for a specified amount of funding.

Management of DSS Resources

The MOH has responsibility for determining the available budget available for funding services. This information is made available to the Na/sc. Management of DSS resources for funded services then takes place at the disabled person level. Service co-ordination decides how DSS resources are spent through resource allocation for each disabled person. Na/sc services will be operating under allocation guidelines given to them by the MOH. It is the responsibility of the Na/sc to report regularly to the MOH to enable the MOH to assist with decision making regarding the management and allocation of DSS resource.

The MOH will provide the Na/sc service with information pertaining to funding available for disabled people of a region/area during the year. It is the responsibility of the Na/sc service to ensure relevant information is available for service coordination. Information that may be useful includes a common understanding of the scale of the budget available during the forecasted period for a particular level of need for disabled people, i.e. priority of need and desired outcome.

The role of the Na/sc service manager in providing the service co-ordinator with current budget updates and forecasts is crucial

Variations in Resource Allocation

There are inevitable idiosyncrasies, and isolated instances that will present as exceptions (i.e. cannot be benchmarked against the norm or average).

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For those disabled people that require an allocated resource that is above or below the criteria guidelines or require a unique support solution, the decision making process must be:

- transparent
- enable audit review of the process followed and decisions taken
- flag and take the service co-ordination decisions to a higher authority to sign-off for the management of DSS resources purposes and risk management.

There are two variation scenarios that the service co-ordination process must acknowledge:

i. The first type of variation scenario would be considered "tolerable". The deviation of resource allocation can be managed internally in the Na/sc. The service co-ordinator obtains sign-off from a higher authority within the Na/sc service.

ii. The second type of scenario would be considered "intolerable". The deviation of resource allocation has an external impact as well as the internal impact for the Na/sc service. The deviation has an overall budget impact and/or an element of involved risk. The sign-off authority must come from the MOH Locality.

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For example, within the “MEDIUM” scale in the 65 PLUS group, the recommended support package allocation ranges from $0 to $180 per week. Therefore a completely **hypothetical example** of this is that in practice, there may be a distribution such as:-

HYPOTHETICAL EXAMPLE ONLY

Amount	Percentage of clients
$ 100	60%
$ 160	30%
$ 180	10%
TOTAL	100%

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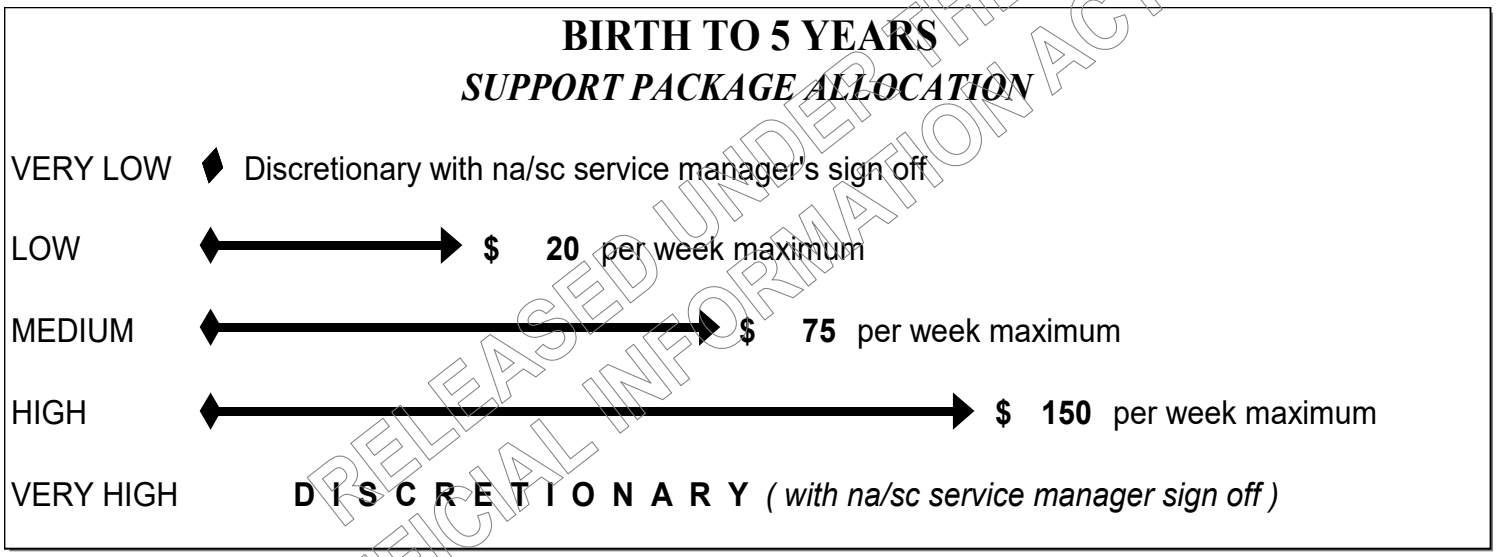
In the example above, only 10% of disabled people will be receiving packages of care of $180. Almost 90% of disabled people will be receiving packages of care up to $160.

Finally, it is important to note the following **key points** :-

1. The amounts listed are recommended amounts only, **NOT** automatic entitlements

2. There may be cases where the cost of packages of support may exceed these recommended amounts in the guidelines and in these instances, sign off from Na/sc service managers should be obtained

3. This tool will be further developed over time and the disabled person scale levels and allocation ranges may change with feedback and experience from Na/sc services.



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Scale	***Description***	***Outcome***	Support Package Allocations
Very Low	• Disabled person, family/whanau needs are minimal and the safety and wellbeing of both is not compromised	• The disabled person and family are supported through access to appropriate services • Family/ whanau have information on community services • Should the situation change they know how to access NASC services	**Discretionary with Na/sc service manager's sign off**
Low	• Although well supported the needs of the disabled person are increasing • Significant changes in need mean the level of support required must be considered • The disabled person is not achieving age appropriate milestones	• The disabled person has the opportunity to develop or maintain their level of functioning and participate in their community • Family/ whanau are effectively supported • Specialised assessment and treatment services are accessed	**$0 to $20/week**
Medium	• Opportunities and potential for development are limited or developed e.g. physical, cognitive, communication, behaviour • Family/ whanau are stressed and are not being effectively supported • The disabled person's disability is becoming more significant and the impact on the family/ whanau is constant • The disabled person's behaviour means that there is a risk of isolation from their community	• The disabled person has access to a comprehensive support package that encourages development and provides opportunity for participation • Family/ whanau has access to planned support • The child remains within their environment and community • Specialised assessment and treatment services are accessed	**$0 to $75/week**

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Scale	***Description***	***Outcome***	Support Package Allocations
High	• Disabled person's developmental milestones are severely delayed • Family/ whanau are unable to manage the disabled person's needs. These are likely to be either high medical or behavioural needs, or a combination • Family's integrity is threatened	• The child continues to have a meaningful relationship with their family/ whanau • The needs of the child are met in an environment that promotes growth, stability and community participation • Specialised assessment and treatment services are accessed	**$0 to $150/week**
Very High	• Disabled person's family/ whanau is experiencing very high levels of stress • Sustainability of the family is at risk • The child is at risk of abuse • There is a dramatic and unexpected change to the disabled person's disability status	• A time limited support package is developed that ensures the safety and wellbeing of the disabled person and family/ whanau • Planning is underway to meet the long-term needs of the child and family	**DISCRETIONARY** **With Na/sc service manager sign off**

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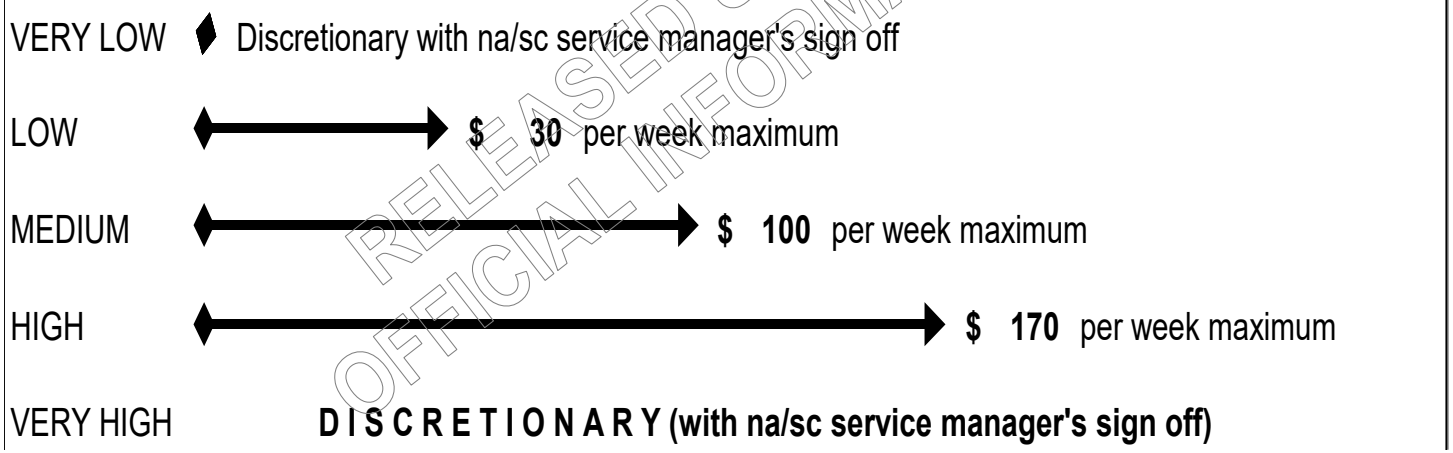
5 TO SCHOOL LEAVERS

SUPPORT PACKAGE ALLOCATION



Scale	***Description***	***Outcome***	***Support Package Allocations***
Very Low	• Disabled person is able to attend to daily living activities with existing support	• The disabled person and carers are provided with resources and information to continue to manage their disability needs • Community supports are accessed • Should the situation change they know how to access NASC services	**Discretionary with Na/sc service manager's sign off**
Low	• Although well supported the needs of the disabled person are increasing • Disabled person's not achieving age appropriate milestones	• Disabled person can participate in their environment and has maximum opportunity for developing independence and participation in their community • Carers receive effective support that enables them to carry out their role • Specialised assessment and treatment services are accessed	**$0 to $50/week**
Medium	• Disabled person's needs are changing but there are no significant concerns for the safety of the disabled person and their family / whanau • The disabled person has limited opportunity for personal growth and development • The carers capacity to carry out their role is compromised by the stress and tasks required to support the disabled person	• The disabled person is able to remain safely in their own environment • Disabled person can participate in their environment and has appropriate opportunity for developing optimum independence and participation • Carers are supported in a manner that considers both short term and long-term needs • Specialised assessment and treatment services are accessed	**$0 to $100/week**
High	• The disabled person's needs are significantly increasing and the current level of support is no longer enough to maintain them in the current environment • Carer is under considerable pressure	• The disabled person continues to have a meaningful relationship with their family/ whanau • The needs of the disabled person are met in an environment that promotes growth, stability and community participation	**$0 to $170/week** *Only in exceptional cases, consider residential services*

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Scale	***Description***	***Outcome***	***Support Package Allocations***
	• Disabled person's environment is becoming unsafe or unstable • Opportunities for personal growth and development are not being taken by the disabled person	• Disabled person participates in their environment and has maximum opportunity for developing independence and participation • Specialised assessment and treatment services are accessed	*– obtain Na/sc service manager's sign off*
Very High	• Disabled person experiences a significant change is their disability, this compromises their ability to remain in their current environment • Carer is no longer able to provide care for the disabled person (significant change in circumstance) • Sustainability of the family/ whanau is at risk as the disabled person's disability becomes more significant	• Support package is put in place that enables the disabled person to remain within their environment • Carers are valued and supported through a support package that addresses their needs • Planning is underway to address the long-term needs of the disabled person and their family/ whanau	**Discretionary** With Na/sc service manager's sign off

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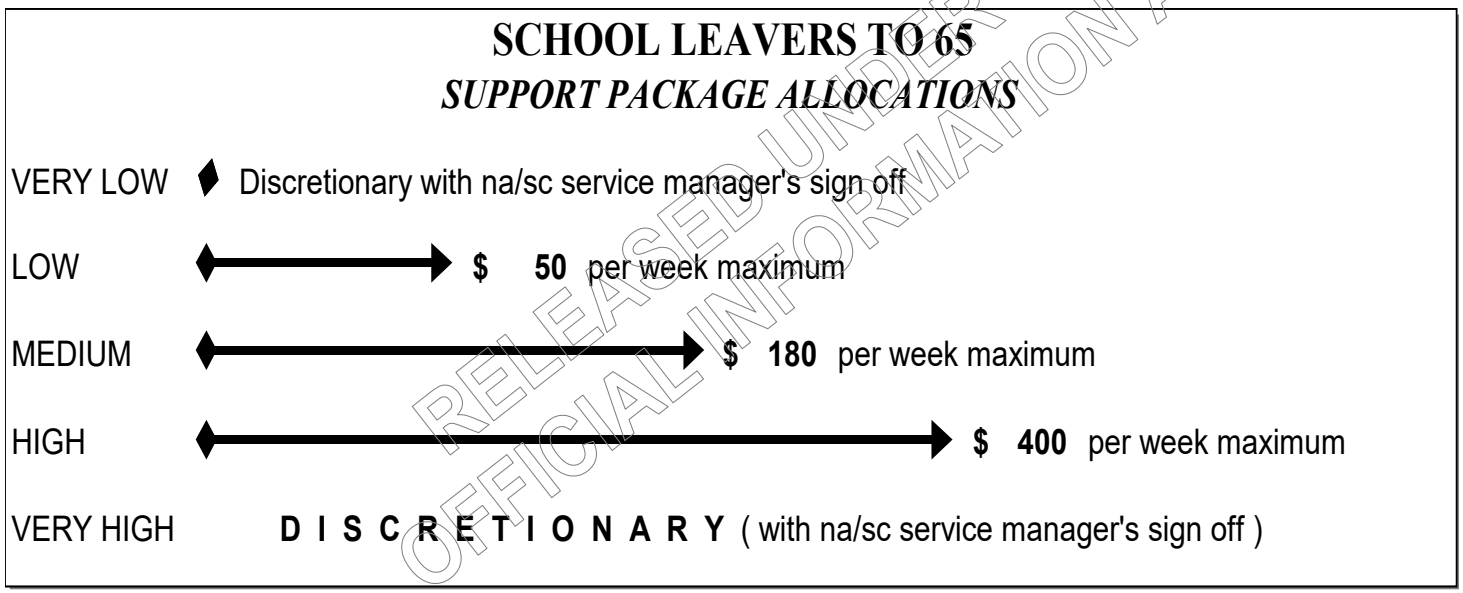

Scale	***Description***	***Outcome***	***Support Package Allocations***
Very Low	• Disabled person is able to live in their community and attend to daily living activities with existing support	• The disabled person and carers are provided with resources and information to continue to manage their disability needs • Community supports are accessed • Should the situation change they know how to access NASC services	**Discretionary with Na/sc service manager's sign off**
Low	• Although coping the disabled person's ability to participate in opportunities to develop life skills is compromised • The carers capacity to provide support has changed or is insufficient to meet the needs of the disabled person	• Disabled person has the opportunities and support required to maximise abilities and participate in their community Carers receive effective support that enables them to carry out their role • Specialised assessment and treatment services are accessed	**$0 to $50/week**
Medium	• Disabled person's well being and functional status is deteriorating and needs are increasing • Carer is under considerable pressure and their ability to support the disabled person is compromised • Disabled person is significantly compromised and issues of safety is becoming apparent • Disabled person has limited opportunity to participate in age appropriate activity	• The disabled person's support enables them to maximise their abilities and independence • Carer has access to meaningful and practical support, enabling them to maintain their own life roles • Specialised assessment and treatment services are accessed	**$0 to $180/week**
High	• The disabled person's ability to remain in their environment is compromised due to significant safety issues and complex support needs	• The disabled person has access to safe environment and effective support • Carer has access to meaningful and practical support, enabling them to maintain their life roles • Specialised assessment and treatment services	**$0 to $400/week[2]**

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[2] Note that price of residential care is dependant on the level of disabled person needs and contracted amount and therefore in some cases may exceed this amount.

Scale	***Description***	***Outcome***	***Support Package Allocations***
		are accessed	
Very High	• Disabled person experiences a significant alteration to their disability. Their ability to remain in their current environment is compromised. • Safety is paramount • Carer is no longer able to provide care for the disabled person (significant change in circumstance)	• Support enables the disabled person the opportunity to remain in the environment of their choice • Carers are valued and supported through a support package that addresses their needs • Disabled person's long-term needs are considered and incorporated into the package • Planning is underway to address the long-term needs of the disabled person and their family/ whanau	**Discretionary** with Na/sc service manager's sign off

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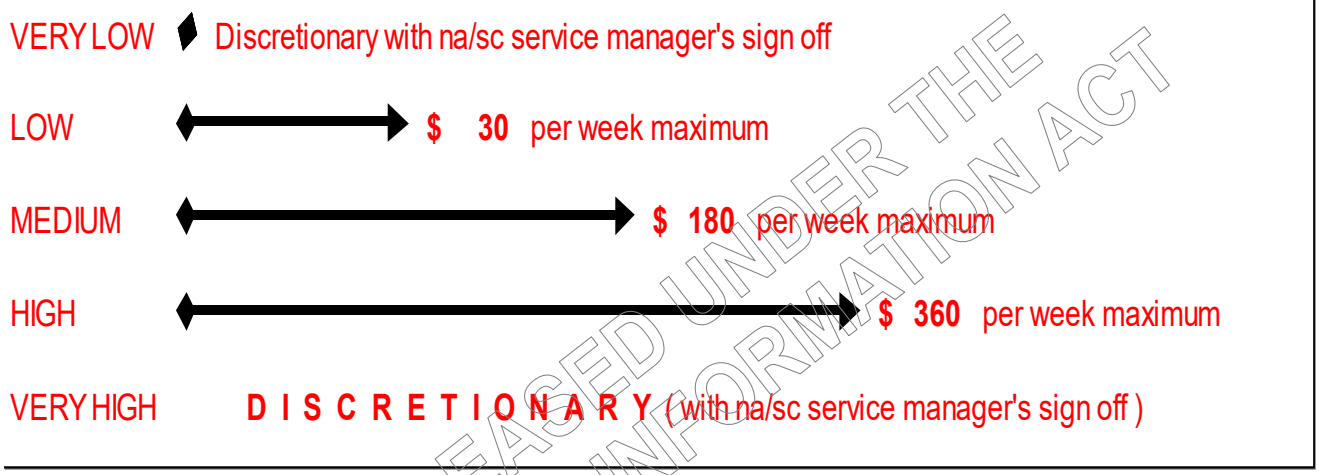
65 PLUS and AGE RELATED
SUPPORT PACKAGE ALLOCATIONS



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Scale	***Description***	***Outcome***	***Support Package Allocations***
Very Low	• Disabled person is able to live in their community and attend to daily living activities with existing support	• The disabled person and carers are provided with resources and information to continue to manage their disability needs • Community supports are accessed • Should the situation change they know how to access NASC services	**Discretionary with Na/sc service manager's sign off**
Low	• Although coping the disabled person's ability to participate in opportunities to maintain life skills and abilities are compromised • The carers capacity to provide support has changed or is insufficient to meet the needs of the disabled person	• Disabled person receives support that enables them to maintain / enhance their level of independence in the home • Areas requiring specialist attention are addressed i.e. assessed for reversibility and rehabilitation	**$0 to $50/week**
Medium	• Disabled person's wellbeing and functional status is deteriorating and needs are increasing • Carer is under considerable pressure and their ability to support the disabled person is compromised	• The disabled person's support enables them to maximise their abilities and independence • Carer has access to meaningful and practical support, enabling them to maintain their own life roles • The disabled person has the opportunity to remain in their own home • Specialised assessment and treatment services are accessed	**$0 to $180/week**
High	• The disabled person's ability to remain in their environment is compromised due to significant safety issues and complex support needs	• The disabled person has access to safe environment and effective support • Carer has access to meaningful and practical support, enabling them to maintain their life roles • Specialised assessment and treatment services are accessed	**$0 to $360[3]/week[4]**

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[3] This is based on resthome level care at say $71/day (excl GST) less disabled person contribution of $20/day = $51/day x 7 days = $357 (please refer also to the next footnote below)

[4] Note that price of residential care is **dependent on the level of disabled person needs** (eg. Dementia, Hospital long term care, etc) and contracted amount with the providers and therefore in some cases **may exceed this amount**.

Scale	***Description***	***Outcome***	***Support Package Allocations***
		• The carer is valued and supported	
Very High	• Due to rapid deterioration the disabled person's support needs have significantly increased • Current support are no longer effective • The safety of the disabled person and carer is at risk	• Disabled person is sustained by a support package • Carer is sustained by a support package • Areas requiring specialist attention are addressed i.e. reversibility and rehabilitation • Longer term planning is underway	**$0 to $600/week[5]**

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[5] Note that price of residential care is **dependent on the level of the disabled person's needs** (eg. Dementia, Hospital long term care, etc) and contracted amount with the providers and therefore in some cases **may exceed this amount**.

5. Implementation

The service co-ordinator is responsible for ensuring that the Support Plan is implemented to facilitate achievement of the disabled person's desired outcomes. This includes:

- Making referrals on behalf of the disabled person (see Referrals to Support Services). Additional referrals to Specialised Services may also be appropriate
- Following up referrals, ensuring that a response has been made
- Making inter-sectoral links e.g. education, vocational services etc
- Making links with other services e.g. church groups, voluntary organisations etc

It is the role of the service co-ordinator to ensure the Support Plan has been implemented and is effective.

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6. Support Plan Check

Service co-ordination is not complete until there is certainty that negotiated support and services are in place and the desired outcomes are being met. In order to close this episode of service co-ordination the service co-ordinator must check with the disabled person or key worker that this is so, or have in place another method of assurance. This assurance should be documented. In situations where outcomes are not being met, the service co-ordinator is responsible for identifying the blocks to support and service provision and negotiating a solution that the disabled person is satisfied with.

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Review

The guidelines in this section have the following goals:

- To ensure Na/sc providers understand the purpose of a review and its implementation
- To ensure Na/sc providers understand the information requirements for review.

What is a Review?

The purpose of the review is to ensure that the Support Plan is relevant and that the disabled person's desired outcomes are being achieved. The timeframe for the review is determined in the Support Plan and is indicated by the disabled person's needs, but generally would occur every 12 to 18 months.

Review periods for younger disabled people or those with high or complex needs or those in a crisis period may be considerably shorter and more frequent.

The size of the Review activity will depend on the needs and circumstances of the disabled person. In some instances it will be appropriate to conduct a review by telephone. In other instances the disabled person may need to be visited in their own environment to enable an accurate understanding of the suitability of the existing Support Plan.

Should the disabled person's needs or circumstances undergo significant change and the Support Plan no longer meets their needs, a reassessment will be required.

Beginning the Review

There are two key prompts to a review.

i. The time indicated for a review arrives
ii. The Na/sc is alerted to a potential or actual change in the disabled person's needs or circumstances by the disabled person, key worker or other source.

The Review requires existing assessment material and the current Support Plan to be accessed.

The disabled person should be contacted in the first instance to ascertain how extensive the review of the Support Plan should be e.g. telephone, face-to-face, or reassessment.

Are there any variations in the requirements Review?

Yes. These are generic guidelines and some areas may not be relevant to the disabled person or may need to be expanded.

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What information needs to be reported from a Review?

Heading	Content
Disabled Person's Details	Confirm all data is correct or make changes as required including; ▪ contact details ▪ nature of disabled person's disability ▪ Community Services Card details
Confirm Needs	Confirm the disabled person's needs. ***Where there is a significant change in needs and/ or circumstance and the Support Plan is no longer relevant, refer to Reassessment***
Outcomes	Comment on the effectiveness of non-DSS funded supports in meeting the needs and achieving the disabled person's goals and desired outcomes. Identify: ▪ Where outcomes have not been achieved ▪ Reasons ▪ When outcomes will be achieved
	Comment on the effectiveness of DSS funded supports in meeting the needs and achieving the goals and desired outcomes Identify: ▪ Where outcomes have not been achieved ▪ Reasons ▪ When outcomes will be achieved
	Comment on the effectiveness of flexible options in meeting the needs and achieving the goals and desired outcomes Identify: ▪ Where outcomes have not been achieved ▪ Reasons ▪ When outcomes will be achieved
Provider Actions	Identify the actions required to achieve outcomes ▪ Role of providers ▪ When support is to be provided
Other Action Required	Record any action that may be required and timeframes e.g. ▪ Follow-up e.g. referrals to services, referrals to specialised services, resultant action of referrals etc ▪ Who is responsible for the action? ▪ When will it occur?
Unmet needs	Identify desired outcomes that could not be met ▪ Why? ▪ Options that have been explored?
Review	Identify date for the review of the support plan
Confirm Key Worker	Identify the key worker:
Review date	Set next review date

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Service Requests to DSS Support Services

Goals of Guidelines

The guidelines in this section have the following goals:

- Minimise the need for the disabled person to repeat information to the Support Service Provider
- Ensure the co-ordinated implementation of the Support Plan
- Ensure Support Service Providers receive adequate information about the disabled person and their needs to enable them to provide the services that will meet the negotiated, contracted and funded outcomes for the disabled person
- Ensure providers inform the Na/sc provider of the status of Service Requests i.e. accepted or declined.

What is a Service Request?

A Service Request is a documented request for a specific service in relation to a disabled person deemed eligible for that service.

Who sends a Service Request?

The service co-ordinator sends the service request

- after discussing and agreeing the service options with the disabled person
- with the consent of the disabled person to approach and pass relevant information to the service provider – usually documented on the needs assessment form.

Where the disabled person does not agree to have information passed to Providers then:

- they may not be eligible for that service
- if their safety is at risk, the service co-ordinator might explore options for acting without the consent of the person e.g. discuss with Welfare Guardian or other legally acceptable representative.

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Are there any variations in the requirements for completing the Service Request?

These are generic guidelines that should be followed but some items will not be relevant. The service co-ordinator with the disabled person should determine what information is relevant.

They should keep in mind the goals of ensuring

- the provider has good knowledge of the needs of the disabled person
- that the disabled person should not be required to repeat information.

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What information needs to be in a Service Request?

Heading	Content
Date of referral	Record the date of referral to the Provider
Referrer Name and Address	Record name and contact details of the referring service co-ordinator
Disabled Person's Details	Record the disabled person's: ▪ Name – as appears on the birth certificate Preferred name ▪ Address-postal actual ▪ Telephone ▪ Date of Birth ▪ Gender ▪ NHI ▪ Ethnicity - ask the disabled person for their own description and record this ▪ Preferred language / method of communication ▪ Contact person's/ representatives details if other than the disabled person ▪ Alerts ▪ Relevant health information
Alternative contact details	Provide the daytime contact details of the carer or other alternative contact person.
GP name and phone number	Record name and contact details of GP
Disability information	Record the disabled person's disability and relevant specific abilities and impairments
Other services involved	Record other services involved that the support service provider should be aware of / consult with.
Support Needs	Specify ▪ The outcomes you seek for the disabled person ▪ The nature and extent of the disabled person's support needs ▪ What you wish to purchase from the Provider ▪ Cultural needs
Timeframe	Indicate the timeframe ▪ The service needs to commence by ▪ How long the service is required for
Review date	Record the Na/sc review date
Provider Accept/Decline	Provider to confirm if Request is accepted or declined

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Exit and Transfer

Goals of Guidelines

The guidelines in this section have the following goals:

- To ensure that exit or transfer of a disabled person from a Na/sc provider is a planned and managed process
- That the process is clear to the disabled person
- That the Na/sc provider understands the information requirements related to the exit or transfer of disabled people.

What is an Exit?

Usually an exit is the planned discharge of a disabled person from a Na/sc service. The disabled person or service may initiate it.

Examples of when an exit occurs are:

- A change in the need or circumstances of the disabled person means that the service is no longer required.
- The person is deceased

The temporary move of a disabled person to another region does not warrant an exit e.g. holiday.

There may not always be the opportunity to plan an exit. For tracking purposes the information requirements should still be completed to the best of your ability.

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Transfers

What is a Transfer?

A transfer is the planned permanent movement of a disabled person from one Na/sc service to another.

Where ever possible transfers should be planned and negotiated between Na/sc services to facilitate a smooth transfer of services for the disabled person. Na/sc services need to be mindful that services are not the same in all areas of New Zealand, which may well compromise the disabled person. The receiving Na/sc service must have opportunity to respond to the notice of intended transfer and to confirm acceptance of the referral and the availability of services to meet the disabled person's needs. Should the required services not be available the disabled person should be informed. Alternatives should be negotiated with the disabled person prior to transfer**.**

Where the disabled person has moved but is continuing to access DSS services in another region, with the disabled person's consent the Na/sc service must ensure that the disabled person's complete Na/sc file is transferred to the receiving Na/sc provider.

Are there any variations in the requirements for completing an Exit or Transfer?

These are generic guidelines that should be followed but some items will not be relevant to a particular disabled person's circumstances. This information relates to the records of the Na/sc service that was providing support for the disabled person

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What information should be recorded at exit or transfer?

Heading	Content
Disabled Person's Details	Confirm the disabled person's: ▪ Name – as appears on the birth certificate ▪ NHI ▪ New contact details
Request for Exit	Indicate where the disabled person has initiated the exit
Reason for Exit	Identify reasons for exit
Disabled person informed	According to the situation, indicate that the disabled person ▪ has been informed of exit, or that this has been confirmed ▪ knows how to contact Na/sc in the future (where appropriate)
DSS Providers	Indicate that DSS funded providers know last date of service
Transfer	Where the disabled person is transferring indicate ▪ the name of the receiving Na/sc provider ▪ date of transfer ▪ that the Na/sc provider has been informed ▪ that the disabled person's file has been forwarded to the new provider

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Flexible Options

Goals of Guidelines

The guidelines have the following goals:

- To ensure that flexible options are used well, implemented and aligned with the intent and responsibilities of the MOH
- To provide support to Na/sc providers in their use of flexible options
- To ensure Na/sc providers understand information requirements for flexible options

What are Flexible Options?

Service providers contracted with the MOH are able to contribute to the achievement of desired outcomes for most disabled people. Flexible options are used when this is not the case and the service co-ordinator is required to develop innovative and flexible solutions to achieve the desired outcomes of the disabled person.

There are two methods available for developing flexible options. These are:

1. Flexible funding
2. Direct Payment

Decision Making and Risk Management

Flexible options means that the service coordinator works with the disabled person to resource solutions for the disabled person that are outside the range of activities usually contracted by the MOH. It is therefore important that the service coordinators decision-making process is:

- transparent
- open to audit of the process followed and decisions taken, and
- taken to the Na/sc manager in the first instance for sign-off for the purpose of risk management. Where there are significant risks the MOH should be consulted.

Further policy development around Direct Payments is required. Without this the MOH cannot provide criteria for selecting disabled people for this option. Until government policy has been developed the Na/sc service and service coordinator need to manage this option well, as there are ethical concerns and risks associated with it.

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Some of the demand for Direct Payment is related to inflexible delivery of Home Based Support Services. A disabled person receiving Direct Payment assumes the responsibilities of an employer. This is a lot of work and may increase the personal risk to the disabled person. The service coordinator and Na/sc service should, in the first instance, seek to resolve the issue of inflexible service delivery.

A second example is anecdotal reports that some disabled people have been approached by support workers to take the Direct Payment option. There are a number of possible reasons, including that the support worker may understand that Direct Payments mean that they will be paid more, tensions with employers etc. When managing this the Na/sc service need to be mindful that their role is to facilitate support to the disabled person. Tacit involvement in the relationship between a Home Based Support Provider and their employees may be counter-productive e.g. the Provider may then be unwilling to provide back up support to the disabled person.

A final example relates to advanced personal care, an area currently undergoing further policy development. Advanced personal care involves the funded worker undertaking tasks some people regard as nursing activities. It is believed by some that these tasks should only be undertaken by registered practitioners with the relevant professional background, such as a nurse, who has professional indemnity. The service coordinator needs to be aware that there may be legal risks in allowing non-registered workers to carry out tasks of a medical nature. Therefore, in principle the MOH do not advise disabled person's needing advanced personal care be offered direct payment at this time.

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1. *Flexible Funding*

The guidelines in this section have the additional goals:

- to ensure that service co-ordinators and Na/sc providers are aware of the responsibilities of the MOH and how they impact on decisions
- to provide information that enables service co-ordinators and Na/sc providers to use flexible funding with confidence.

The MOH is sub-contracting with Na/sc services to provide flexible services to disabled people. Guidelines for sub-contracts between the Na/sc provider and service providers are in the Flexible Funded Support Options Schedule.

Responsibilities

There is a balance between managing responsibilities and creating an environment that enables service co-ordinators to be flexible and innovative in their use of resources. Where the Na/sc service is not sure that a solution is appropriate then they should contact the MOH for advice.

There are two key responsibilities that the MOH needs to consider as it carries out its business that are relevant to the Na/sc provider and service co-ordinator when using Flexible Funding.

The Funding Agreement between the MOH and Crown

The Disability Issues Directorate receives funds to purchase Disability Support Services to meet the needs of the eligible population. Other government departments, of course, receive funds to purchase and meet a range of other needs e.g. Vote Education, Vote Social Welfare. A Na/sc service is not expected to purchase solutions that are the responsibility of another funder, although solutions may complement the services of another funder e.g. after school care.

For most services there needs to be a level of prioritisation, with highest needs being met first. Flexible funding should not be used to avoid or shortcut processes and criteria for accessing existing disability-contracted services. However it may be used to purchase intermediate solutions e.g. while a disabled person waits for a residential support service.

The MOH is required to assure the quality of services provided. Where the Na/sc service is contracting directly for the provision of a specific service, then the contract should specify the quality requirements. In some circumstances the MOH may audit the quality of services.

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Using flexible funding to purchase disability support services that are outside the usual DSS quality frameworks should be avoided e.g. using flexible funding to purchase equipment that might ordinarily be purchased by Environmental Support Services will mean that the quality framework has been by-passed. Many possible solutions, however, will have a quality mechanism e.g. other quality processes will cover Master Tradesman or a season pass to a public swimming pool.

Commerce Act (1986)

The most significant requirements in the Commerce Act relate to the process of contracting for services e.g. contestability and fairness. This is why the size and volume of contracts possible with flexible funding is limited and is also why larger contracts should be managed by the MOH.

Process

The service co-ordinator is required to:

- determine that the flexible funded option(s) is the most appropriate option for the individual
- identify the solution, ensure that it is acceptable to the disabled person and will meet their desired outcomes
- ensure that the solution will not put the disabled person or carer in any greater risk than other available support options.
- ensure that the Na/sc service manager has signed-off the flexible funding proposal.
- 7omplete the Support Plan.

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2. *Direct Payment*

These guidelines in this section have the additional goals:

- to ensure that service co-ordinators are able to offer Direct Payment as an option to disabled people
- to ensure that service co-ordinators are able to appropriately support disabled people who choose to take this option
- to ensure that appropriate contracts between the Na/sc service and the disabled person receiving Direct Payment are established.

What is Direct Payment?

Direct Payment is defined as when the disabled person receives and manages funds instead of services. They are responsible for arranging their own supports and ensuring that their needs are met through this funding. The individual disabled person is required to invoice the Na/sc service or identified Payment Agency[6] who then makes a payment to the disabled person's bank account.

Objectives of Direct Payment

The benefits are to the disabled person and primarily qualitative. These include that the disabled person is able to:

- choose who comes into their house to provide support
- ensure their compatibility with the person providing support
- receive support in timeframes that suit
- ensure what tasks and how each task is performed without the addition of a third party supervising.

Responsibilities

Disabled person

Direct Payment means that the disabled person assumes a number of responsibilities including:

- administrative responsibilities
- employer responsibilities
- having and maintaining a bank account used only for Direct Payment i.e. for receiving payments from Na/sc service and for employee related expenses
- working with the Na/sc service to establish and review their Support Plan

[6] There is some in who has responsibility for payment across the Localities.

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- being accountable for the use of the funds and ensuring that their desired outcomes are achieved
- in the event of a change in needs, the disabled person is also responsible for notifying the Na/sc service.

Service Co-ordinator

The service co-ordinator is responsible for

- ensuring that the disabled person is able to manage their own funding and support services
- fully informing the disabled person of their responsibilities as an employer e.g. by supplying them with a 'Direct Payment Tool-kit'
- ensuring and supporting the disabled person to develop a crisis/risk management plan e.g. how needs will be meet in the event of a support worker being absent e.g. cover for sickness and other forms of leave
- developing and reviewing the Support Plan with the disabled person and ensuring that the desired outcomes are being achieved.

The review timeframes for Direct Payment will fit with the review of the Support Plan. The service co-ordinator must be mindful of the need to work with the disabled person to ensure safety and risk management when setting timeframes for review.

Na/sc service

The Na/sc service is responsible for:

- providing the disabled person with information about their responsibilities and how these can be met

Direct Payment Tool-kit

The objective of the tool-kit is to ensure that the disabled person has received information about their responsibilities and how they should be met. It is essential that the Na/sc service does not take on the role of providing specific information. Instead the information should be in the form of contacts for the below named services. In addition the Na/sc service may suggest that the disabled person seek legal assistance to help them through the process and therefore safeguard themself.

The Tool-kit may include information on:

- Inland Revenue requirements e.g. how to tax employees, wage books
- ACC
- Statutory employment provisions e.g. minimum wage, parental leave, Holiday Act
- Health and Safety Act
- Health and Sector Mediation Rules 1993

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- Examples of
  - Job descriptions
  - Contracts
- Invoicing – how to and specific requirements, e.g. forms

Other information that may be useful include options for training and back up support eg a Home Based Support Provider prepared to provide relief staff.

Direct Payment Contract

The MOH have developed a contract to be used for Direct Payments, see Appendix 2.

The Na/sc service may need to make some changes to reflect their particular requirements e.g. arrangements for payment.

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Appendices

Appendix 1 -
support needs assessment

Assessment Services _____

Date Referral Received _____

Date Assessment Completed _____

Date Assessment Received _____

First Contact Date _____

Community Services Card Holder ☐ **Yes** ☐ **No**

Number 00000 _____

Expiry Date _____

NHI No _____

Assessors' Name _____

SNL _____

Type of Assessment	Urgency of Assessment	Category of Disability	Cause of Disability	Place of Assessment	Usual Place of Residence
☐ initial assess ☐ early re-assess ☐ annual re-assess ☐ appeal	☐ within 24 hrs ☐ within 1 wk ☐ within 1-3 wks ☐ roll over ☐ other	☐ physical ☐ sensory ☐ intellectual ☐ psychiatric ☐ age related ☐ medical ☐ other	☐ congenital ☐ accident ☐ medical ☐ age related ☐ other	☐ own home ☐ rest home ☐ hospital ☐ day clinic ☐ other	☐ own home ☐ rest home ☐ hospital ☐ living with relatives/carers ☐ other

client details

Surname _____ Title _____ Sex ☐ Male ☐ Female

First Name(s) _____ Date of Birth _____

Address _____ GP _____

_____ GP Phone No. _____

Phone No. _____

Ethnicity _____

If the client's first language is not English, please specify _____

Disability / Diagnosis/Health & Wellbeing _____

_____

_____

_____

Events Leading to Assessment _____

_____

ACC claimant ☐ **Yes** ☐ **No** _____

Clients legal representative _____

_____

Correspondence to _____

_____

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consent for information

☐ to be collected, stored and used, for the purpose of identifying my support needs and for service coordination in that regard; ☐ **Yes** ☐ **No**

☐ **to be collected for those purposes including accessing relevant information held by other agencies (specify);**

_____ ☐ **Yes** ☐ **No**

☐ to be disclosed only to the parties who will be involved in my assessment of support needs and service coordination ☐ **Yes** ☐ **No**

I understand that failure to supply information or part of information requested in this form may result in my support needs not being identified or fully identified with consequent effect on any government funded assistance which may be available to meet those needs.

I understand that I have the right to access and correct any information collected pursuant to the Health Information Privacy Code 1994 made under the Privacy Act 1993 by contacting the Ministry of Health, PO Box 5013, Wellington.

☐ This information is not to be released to _____

_____ _____

Date Clients/Representatives signature

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contact

Surname _____

First Names _____

Address _____

_____

Phone No. _____

Relationship to client _____

alternative contact

Surname _____

First Names _____

Address _____

_____

Phone No. _____

Relationship to client _____

those present/those consulted

_____

_____

_____

_____

_____

background and present living situation

current support networks

Formal

Informal

communication

sensory function

Vision		Hearing	
Can see well enough to read with or without glasses	☐	No hearing deficit	☐
Reduced vision, but can read large print/watch TV	☐	Hears well with aids	☐
Very poor vision, may need guidance/assistance at times	☐	Hearing defecit	☐
Blind or nearly blind	☐	Severe deafness	☐

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mobility

	Ind.	Sup.	Ass.		Ind.	Sup.	Ass.
1. Mobility inside	☐	☐	☐	**5.** Transfers	☐	☐	☐
2. Mobility outside	☐	☐	☐	**6.** Ability to get up after fall	☐	☐	☐
3. Mobility in the community	☐	☐	☐	7.Falls risk?		☐ **Yes**	☐ **No**
4. Transport	☐	☐	☐				

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recreational

income support

Disabiility allowance	☐	Travel subsidy	☐	High user card	☐	Invalid benefit	☐
Child disabiility allowance	☐	Living Alone	☐	Accommodation Benefit	☐	Community Services	☐

household management

	Ind.	Sup.	Ass.		Ind.	Sup.	Ass.
1. Shopping	☐	☐	☐	**6.** Finances	☐	☐	☐
2. Meal preparation	☐	☐	☐	**7.** Garden / Lawn	☐	☐	☐
3. Housework	☐	☐	☐	**8.** Home safety	☐	☐	☐
4. Laundry	☐	☐	☐	**9.** Home security	☐	☐	☐
5. Heating	☐	☐	☐				

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personal care

	Ind.	Sup.	Ass.		Ind.	Sup.	Ass.
1. Bed mobility	☐	☐	☐	**8** Continence bladder	☐	☐	☐
2. Bathing/showering	☐	☐	☐	**9.** Continence bowel	☐	☐	☐
3. Dressing/undressing	☐	☐	☐	**10.** Menstrual management	☐	☐	☐
4. Grooming	☐	☐	☐	**11.** Medication	☐	☐	☐
5. Dental Care	☐	☐	☐	**12.** Eating	☐	☐	☐
6. Foot Care	☐	☐	☐	**13.** Drinking	☐	☐	☐
7. Toileting	☐	☐	☐	**14.** Health Management	☐	☐	☐
				15. Sleeping patterns	☐	☐	☐

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memory behaviour cognition

1. Memory	2. Orientation	3. Behaviour
☐ No noticeable memory deficit ☐ Mild loss of memory of recent events ☐ Fluctuating memory loss ☐ Moderate loss ☐ Severe loss of memory for recent events ☐ Severe loss of memory for both recent and remote events	☐ To familiar surroundings ☐ No evident difficulties finding way about ☐ Sometimes mistakes surroundings ☐ Frequently mistakes surroundings ☐ Totally confused as to surroundings	☐ Observes accepts social standards ☐ Some behaviour is unusual but does not offend ☐ Sometimes behaviour causes others actual distress or discomfort ☐ Behaviour often causes others actual distress or discomfort
4. Delusions/Hallucinations	**5. Motivation**	**6. Wandering**
☐ None ☐ Mild/occasional ☐ Moderate/frequent ☐ Severe (complete loss of contact with reality)	☐ Well motivated ☐ Motivated but can be unsafe ☐ Needs encouragement ☐ Unmotivated	☐ No wandering ☐ Occasional and brief bouts of wandering ☐ Persistent wandering - inside ☐ Persistent wandering - outside ☐ Unsafe wandering
7. Insight	**8. Anxiety**	**9. Night Behaviour**
☐ Good ☐ Some insight ☐ Little insight ☐ Totally lacks insight	☐ No anxiety ☐ Understandable anxiety ☐ Moderate ☐ Incapacitated by anxiety	☐ Settled ☐ Sometimes unsettled ☐ Disturbed/wandering
10. Supervision	**11. Mood**	**12. Specialist Care/Treatment**
☐ Independent ☐ Daily prompts ☐ Some for safety ☐ Cannot be left alone ☐ Length of time client can be safely left alone ?	☐ Usual H L ☐ ☐ At times but recovers ☐ ☐ For long periods - not treated ☐ ☐ Receiving treatment	☐ Needed ☐ Pending ☐ Receiving

Also consider: attention/concentration/planning/orientation to time & day

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educational vocational voluntary

cultural

spiritual

client goals

other information

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carer support information

consent for information

☐ to be collected, stored and used, for the purpose of identifying my support needs and for service coordination in that regard;

☐ Yes ☐ No

☐ to be collected for those purposes accessing including relevant information held by other agencies (specify);

_____

☐ Yes ☐ No

☐ to be disclosed only to the parties who will be involved in this assessment of support needs and service coordination

I understand that failure to supply information or part of information requested in this form may result in my support needs not being identified or fully identified with consequent effect on any government funded assistance which may be available to meet those needs.

I understand that I have the right to access and correct any information collected pursuant to the Health Information Privacy Code 1994 made under the Privacy Act 1993 by contacting the Ministry of Health, PO Box 5013, Wellington.

☐ This information is not to be released to _____

Carers signature Date

Carers Name _____ Relationship to client _____

Health/well-being of carer _____

_____

_____

Carers commitments _____

_____

_____

Carers concerns _____

_____

_____

What would contribute to making this caregiving situation sustainable? _____

_____

_____

Additional information _____

_____

_____

Level of carer support suggested by carer **Low** ☐ **Medium** ☐ **High** ☐

Current level of carer support and utilisation _____

_____

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all identified support needs

Client Priority	Identified Needs	By Whom	Urgency

completing the assessment

Client/Representative

I have read and discussed this assessment (and the appeal procedure) with the Assessment Facilitator. I understand the nature and effect of this assessment, including that the assessment will be used to provide for my disability related needs, and may be used to determine whether I will receive government funded assistance in respect of my disability and also the extent I will have to pay for my own needs, and I freely consent to this service being provided.

Clients/Representatives signature Date

Assessment Facilitator

I have discussed this assessment, the identified needs and appeal procedure with the client/representative.

Assessment Facilitators signature Date

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Notes

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Appendix 2 – Disability Support Services Direct Payment Agreement

This Agreement is between:

THE DISABLED PERSON:

Name:
Address:
Telephone:

AND;

THE AUTHORISING AGENCY:

Name:
Address:
Telephone:

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1. Purpose:
(Disabled person) is eligible for Disability Support Services. This agreement is to enable *(disabled person)* to receive funds to the provision of support services to meet the needs arising from his disability.

2. The relationship between *(Disabled person)* and *(Na/sc service)*
This is an agreement for the provision of Services between you and us. It is not a partnership agreement or a joint venture agreement. Under this contract you are a sub-contractor, not our agent or employee.

3. The duration of the Agreement:
This agreement commences in respect of the service on *(date)* and ends on *(date).* During this time you must ensure that you have services throughout the period of this agreement.

4 Payment
We will make payment to you by electronic funds transfer to your nominated bank account specifically established for the purpose of this contract, on the payment dates specified in the Payment Schedule (attached Schedule X), after receiving from you an invoice on the form supplied.

The supports and services you are expected to supply to achieve the outcomes are identified in the Support Plan (attached Schedule X).

Payments to a maximum of $XXX per payment period or $XXX (inclusive of GST) per annum.

This amount includes all costs associated with service provision and administration.

We will regard invoices as being late if they arrive more than three days from the fortnight end date as specified in the Payment Schedule (see attached Schedule 1). If an invoice arrives late, payment will occur within the following fortnightly period.

5 Responsibilities of *(Disabled person)*

5.1 To ensure that the outcomes identified in the Support Plan are achieved and that services are strictly managed within the annual allocation.

5.2 Ensuring that accurate auditable employment and accounts records are kept consistent with good business practice and which also meet all requirements of the Inland Revenue Department.

5.3 Send a detailed invoice to us for each fortnightly period, as specified in the payment schedule (see attached Schedule X).

5.4 Report to us in a manner agreed to by us on a monthly basis showing the hours worked by the personal caregivers, and the total payments made during the month broken down by person or activity.

5.5 By accepting this funding you are agreeing to and accepting responsibility for:

- Employment and recruitment of staff required.
- All employment issues such as taxation, ACC, and comply with all of the legal requirements under the relevant legislation that applies to employee terms and conditions.
- Where staff are self-employed obtaining a written statement from the support worker confirming that they are responsible for the payment of their own taxes.
- Training of all staff employed.
- Availability of relieving staff.
- Developing a risk management plan eg in the event of staff absences
- Invoicing for payment.

In particular you will comply, for all staff employed by you with the statutory minimum employment provisions for all people you employ including the Minimum Wage and Holidays Act.

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If a dispute arises with any person employed by you, and the dispute involves the employee initiating proceedings under the provisions of the Employment Contracts Act, and as a result of the complaint an award is made against you, you will be responsible for meeting all the costs, including, but not limited to, any legal costs and any form of compensation awarded against you as a result of any breach you are deemed to have committed.

5.6 Ensure the work environment and support worker meet the requirements of the Health & Safety Act.

5.7 Ensuring each support worker employed has a Job Description (see attached Schedule X), employment contract, and a copy of the expected Code of Conduct and a copy of the Complaints Procedure.

5.8 You must allow us access to your records for the purposes of quality audit.

6. Responsibilities of *(Na/sc service)*

6.1 Authorise the payment of funds for services identified in the Support Plan (see attached Schedule X)

6.2 Review the services at least on an annual basis and as indicated in the Support Plan (see attached Schedule X) to ensure they meet your personal and safety needs.

6.3 Provide advice and assistance to the disabled person as required under our contract with the Ministry of Health.

6.4 Report on the contract in our Quarterly Report to the Ministry of Health.

7. Disputes Between Parties Involved in this Contract:

7.1 If either of us has any dispute with the other in connection to this Agreement then both of us will use our best endeavours to settle the dispute by agreement between us. Both of us must always act in good faith and co-operate with each other to resolve disputes.

7.2 If the dispute cannot be resolved using Clause 7.1, then the matter will be dealt with in accordance with the Health and Sector Mediation Rules 1993 as amended or substituted from time to time.

7.3 Both of us will continue to comply with all our obligations in the Agreement until the dispute is resolved.

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8. General Provisions

8.1 Third party rights:

For the purposes of the Contract (Privacy) Act 1982 neither of us intends to confer a legally enforceable benefit under this contract on a person who is not a party to it.

8.2 Your indemnity to us:

You must indemnify us against any loss we, our employees or authorised agents, may incur or suffer because of a breach by you of this contract or because of a breach by you of the contract you have with a contractor or employee.

8.3 Our indemnity to you:

We must indemnify you against any loss you, your employees or authorised agents may incur or suffer because of a breach by us of this contract.

8.4 Amendments and Termination

Any amendments to this contract must be in writing and agreed to by signature of both parties. One month's notice in writing is required by either party to terminate this agreement.

(Disabled person) is most welcome to contact *(Na/sc service)* for clarification of this Agreement and in the event of a change of circumstances.

(Disabled person) will contact *(Na/sc service)* when there is a change in their needs.

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Signed for and on behalf of
(Na/sc service)

_____

(name)
Manager
(Na/sc service)

Date _____

Signed for and on behalf of

_____

(Disabled person)

Date_____

Witnessed by _____

Date: _____

Cultural Support Assessment for Mäori

The aim of this section is to develop a level of best practice throughout the entire needs assessment and service co-ordination process for disabled Mäori. It is important to ensure that tikanga and kaupapa Mäori perspectives permeate the assessment process. This will ensure that the cultural needs of the individual as Mäori are recognised and addressed during the needs assessment and service co-ordination process.

Acknowledgement of an individual's cultural identity and needs are important for a holistic assessment. The inclusion of a cultural dimension based on tikanga also offers Mäori an opportunity to be involved in an empowering process.

A cultural support assessment is carried out in conjunction with a support needs assessment. It is important that the cultural and support needs and any specialist assessments complement each other and have a clear focus on the best outcome for disabled Mäori and their whänau.

The Cultural Support Advisor/Kaiawhina:

- must have the skills to advise on the best support from a cultural perspective for the person
- must be able to recognise cross-cultural issues e.g. the Mäori and non-Mäori perspectives may be different for certain issues. This will reduce the possibility of cross-cultural misunderstandings and incorrect interpretations occurring during the assessment process.

Areas of cultural support assessment may include identifying with disabled Mäori:

- their needs, goals, priorities and areas of cultural importance
- cultural supports, including key people that need to be involved
- their whänau and turangawaewae
- cultural information, including the person's hapü and iwi, any information relating to whanau and whakapapa; tinana; hinengaro; wairua and mana.

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Cultural Support Assessment and The Treaty of Waitangi

The Treaty of Waitangi has a fundamental position in New Zealand society and this has been increasingly acknowledged in policy and service development and delivery.

The Treaty has a special relevance in the health and disability area because it is clear that the intention of the Treaty was to ensure the wellbeing of all residents and particularly that of tangata whenua. Processes of good government, self-determination and development of hapü and iwi resources as well as participation and equity are all identified.

As a treaty partner, Government recognises the special relationship between iwi and the Crown. The principles of the Treaty of Waitangi – *Partnership, Participation and Protection* – must therefore underpin the Maori Disability Action plan.

***Partnership**:* Working together with iwi, hapü, whanau and Mäori communities to develop strategies for Mäori health gain and appropriate health and disability services.

Participation: Involving Mäori at all levels of the sector in planning, development and delivery of services.

***Protection**:* Ensuring that Mäori experience at least the same level of health as non-Mäori and safeguarding Mäori cultural concepts, values and practices.

The Treaty of Waitangi will continue to be seen by tangata whenua as a suitable framework within which to consider health and disability issues, particularly in regard to the relationship between tangata whenua and the Crown as equal, sovereign signatories to the Treaty.

Mãori Cultural Values

The potential value to disabled Mäori of cultural matters such as land, whanau, hapü, iwi and participation in te Ao Mäori are important. The ability of disabled Mäori to participate in cultural activities and contribute where they can is also important.

A Cultural Support Advisor can advise where appropriate on the meaning of tikanga from a Mãori perspective and how this affects the person. Traditionally this is done through the whänau, marae and hapü. Also the importance of whakapapa, tikanga and te reo could be explained.

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Principles for Cultural Support Assessment

- The Treaty of Waitangi will be the overarching principle for cultural support assessments

- To provide a holistic picture of a person's needs

- To enhance the cultural perspective of the needs of the person and their whanau through appropriate assessment and service co-ordination

- To establish and maintain a culturally effective and safe service co-ordination and service delivery

- To ensure the involvement of Māori in the development and delivery of support services

Objectives of Cultural Support Assessment

The following objectives underpin the cultural support assessment process. Because of their broad nature these objectives are also applicable to the overall assessment process. These objectives will assist disability support services.

To acknowledge the mana whenua

It is important that the local iwi or mana whenua are acknowledged, their advice sought and the different kawa of each area must be recognised. The NASC Agency must consult with local iwi in order to get their support for the cultural assessment process. Kaumatua and kuia from local iwi may be included in the development of the process and have continual involvement in an advisory role. Their knowledge of tikanga, kawa and networks with other iwi will be invaluable to the disability support service in providing an effective cultural programme.

To establish and maintain kawa whakaruruhau

Kawa whakaruruhau or cultural safety is a necessary component of disability support services to assure Māori people that the needs assessment, service co-ordination and service delivery they receive is safe for a Māori person in a predominantly non - Māori environment. It is within a culturally safe service that a cultural assessment will take place. Once the assessment has been made, cultural safety is also inherently important in the summary of the individual's needs in order to provide a holistic picture. Key people such as Cultural Assessors must have extensive networks with the Māori community and be competent in the area of Māori disability to ensure culturally safe assessments.

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To ensure the spiritual wellbeing of disabled Mäori and their whänau or hapü (under Whare Tapa Wha – the four cornerstones of Mãori health)

"All things in nature cohere. It is wairua that is the cohesive element."

The spiritual dimension or wairua must be considered in the assessment process as this forms the basis and core of taha Mãori. Wairua consists of many aspects and components; the identification of those components gives insight and offers explanations for behaviour not only mentally and psychologically, but also physically. The wairua of an individual, their whänau, hapü, iwi and waka and all that these entail take precedence over all other considerations.

To promote the wellbeing of the individual and their whanau

Whanau is the nurturing environment in which a person feels they have support and aroha and will help them at all times. A whanau may be the immediate family, extended family, and in the social development of Aotearoa New Zealand, new forms of whanau for some people may be a residential support service, a support group or a group of friends whom the person has chosen to support them.

A whanau will ideally provide reassurance, aroha, confidence, warmth, empowerment and mana to the person that will sustain the person. It is appropriate for the whänau to be involved during the assessment and service planning and provision process.

The service must be careful not to alienate those Mãori people who choose not to have a cultural assessment or to participate in cultural activities. For these people, their choice must be respected and they must not be subject to harassment or coercion to try and change their mind. In the end it is the choice of the person to determine their involvement with tikanga Mãori and their whakapapa.

The Cultural Support Advisor must have a good understanding of the concepts of whakapapa or genealogy, mythology, kawa, te reo Mãori me ona tikanga because this is the context within which cultural support assessments take place. The assessor may not know specifics in relation to a particular person but when talking to the person, aspects of these concepts need to be considered to determine whether there are any cultural aspects to the person's needs. It should be noted that certain cultural constructs might cause certain behaviours.

The Needs Assessment and Service Co-ordination process can also include traditional Mãori healing methodologies, such as karakia, rongoa, mirimiri, tohunga, whanaungatanga, awhi and manaaki.

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Process of a Cultural Support Assessment

An important feature of the cultural support assessment process is that it must be flexible enough to be able to accommodate the needs of the individual and their whanau.

Having a cultural support assessment should always be a choice for a Mãori person as part of identifying care and support needed. If a cultural support assessment is refused then the assessor must respect the person's choice. However, because an individual may have decreased ability to give informed consent to participate in a compulsory assessment, their wishes should be balanced with those of the whänau/hapü and iwi.

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Glossary

Aroha	Love
Cultural Support Assessment	A cultural support assessment is the process of ensuring that the person's cultural background and preferences are taken into account when determining their needs.
Hapü	Sub-tribe
Hinengaro	Emotions and mental state
Kuia	Elderly woman
Iwi	Tribe
Karakia or whakamoemiti	Prayer
Kaumatua	Elderly men and women
Koroua	Elderly man
Mana	Respect
Mana Whenua	People of the land
Mihimihi	Reciprocal greeting
Powhiri	Welcome
Taonga	Treasure
Tikanga	Customs and cultural values
Tinana	The physical body
Te Reo	Mãori language
Turangawaewae	A place to stand
Wairua	Spiritual essence/wellbeing
Waka	Canoe
Whakapapa	Family Tree/genealogy
Whanau	Family/extended family

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Guide to eligibility for public health services

Choose the option that matches your situation.

On this page

↓ Choose the option that matches your situation
↓ Eligibility for a limited range of publicly funded health services

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Choose the option that matches your situation

Is your situation different to those listed below?

If your situation does **not** match any of the options listed below, you may still be eligible.

New Zealand Resident Class Visa Holders

Eligibility criteria:

A New Zealand resident who has:

- a resident visa, or
- a permanent resident visa,

is eligible for publicly funded health and disability services.

This includes people who were granted residency before 29 November 2010, who still hold valid residence permits (these are deemed "residence class visas" along with the two listed above).

Other people, including people who arrived in New Zealand before 2 April 1974 and have been in New Zealand continuously from that date, may also be permanent residents. They need to contact Immigration New Zealand to get proof of their residence status.

Criteria: B3, Health and Disability Services Eligibility Direction 2011

Proof of eligibility:

You will need to show your health service provider:

- your valid passport with a Resident Visa (or Residence Permit if issued before 29 November 2010) or Permanent Resident Visa OR

- your Certificate of Identity issued under the Immigration Act 2009 OR
- evidence you are currently getting a social security benefit (except Emergency Benefit) AND two forms of supporting identity documentation – one needs to have a photograph of you.

Examples of identity documents include:

- a driver license
- an 18+ card,
- a community services card or SuperGold Card,
- a school/tertiary ID card,
- an employment contract, a rental agreement, or
- letters addressed to you at your current address.

Requirements for these documents are waived for children.

Note: Children aged 17 years or younger, in the care and control of a parent or legal guardian who is a New Zealand resident, are eligible for the same publicly funded health and disability services as that parent or guardian. The same applies if the adult is applying to be their adopted parent or legal guardian.

Except for maternity services, partners of people eligible for publicly funded health services must themselves meet the eligibility criteria.

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New Zealand citizens (including those from the Cook Islands, Niue or Tokelau)

Eligibility:

A New Zealand citizen (a person who has New Zealand citizenship under the Citizenship Act 1977 or the Citizenship (Western Samoa) Act 1982) is eligible for publicly funded health and disability services.

Criteria: B2, Health and Disability Services Eligibility Direction 2011

Proof of eligibility:

You will need to show your health service provider:

- your New Zealand passport OR
- your New Zealand Birth Certificate (or Cook Island, Niue or Tokelau birth certificate) AND two forms of proof that you are the person on the birth certificate OR
- your New Zealand Certificate of Citizenship AND two forms of supporting identity documentation – one needs to have a photograph of you OR

- your Descent Registration Certificate AND two forms of supporting identity documentation – one needs to have a photograph of you OR
- evidence you are currently getting a social security benefit (except emergency benefit) AND two forms of supporting identity documentation – one needs to have a photograph of you.

Examples of identity documents include:

- a driver licence
- an 18+ card
- an employment contract, a rental agreement, or
- letters addressed to you at your current address.

The following cards may also be used for proof of identity (but not proof of eligibility)

- a Community Services Card or SuperGold Card
- a school/tertiary ID card

Requirements for these documents are waived for children.

Note: Time spent overseas does not affect New Zealand citizens' eligibility. However, if only temporarily in New Zealand, they may not meet the requirements for primary health organisation enrolment.

Children aged 17 years or younger, in the care and control of a parent or guardian who is a New Zealand citizen, are eligible for the same publicly funded health and disability services as their parent or guardian. Children aged 17 years or younger, in the care and control of a person applying to legally adopt them, or become their legal guardian, are also eligible.

Except for maternity services, partners of people eligible for publicly funded health and disability services must themselves meet the eligibility criteria.

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Australian citizen or permanent resident who has lived, or intends to live, in NZ for two years or more

If you're **not** eligible under the criteria below, read information about the reciprocal health cover for Australian residents temporarily in New Zealand. (/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services/reciprocal-health-agreements)

Eligibility:

Australian citizens and permanent residents who live, or are intending to live in New Zealand for two years or more are eligible for publicly funded health services. The two years is a consecutive period, counted from your first day in New Zealand.

(Note: Australian visitors to New Zealand are not entitled to publicly funded emergency transport by ambulance. This includes both non-injury and emergency transport. Similarly, New Zealand visitors to Australia are not entitled to publicly funded emergency transport by ambulance.)

Proof of eligibility:

You will need to show your health service provider:

- your valid Passport of your own nationality with a current resident visa (including a resident return visa) issued by the Government of Australia. (Criteria: B6 and B7, Health and Disability Services Eligibility Direction 2011.)
- proof that New Zealand will be your principal place of residence for two years or more (eg, work contract, house long-term lease, ownership, or mortgage). The two years is counted from the date you migrated to New Zealand AND
- either:
    - your Australian passport OR
    - your valid Passport of your own nationality with a current resident visa (including a resident return visa) issued by the Government of Australia.

Criteria: B6 and B7, Health and Disability Services Eligibility Direction 2011.

Note: Australian citizens and Australian permanent residents not intending to stay for at least two years may be eligible for immediately necessary hospital and maternity services and pharmaceuticals. Go to Reciprocal health agreements (https://www.tewhatuora.govt.nz/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services/reciprocal-health-agreements/) to find out more.

Children aged 17 years or younger, whose parent, legal guardian or person applying to be their legal guardian or adoptive parent, are also eligible for publicly funded health and disability services (relevant to children whose own citizenship or immigration status does not meet the criteria).

Except for maternity services, partners of people eligible for publicly funded health and disability services must themselves meet the eligibility criteria.

Work visa holder eligible to be in NZ for two years or more

Eligibility:

A person who holds a work visa that either:

- entitles them to remain in New Zealand for two years or more (work visas start on the person's first day in New Zealand) OR

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- entitles them to remain in New Zealand for a period of time which, together with the time that person has already been lawfully in New Zealand immediately prior to obtaining the visa, equals or exceeds two years

is eligible for publicly funded health and disability services.

Criteria: B5, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility:

You will need to show your health service provider your valid passport endorsed (stamped) with a current work visa (or work permit), that:

- entitles you to remain in New Zealand for a period that equals or exceeds two years (work visas start on the person's first day in New Zealand) OR
- entitles you to remain in New Zealand for a specified period of time which, together with the period of time you have already been lawfully in New Zealand (ie. on other visas/permits), allows for a total continuous stay of at least two years.

Note: Time spent lawfully in New Zealand immediately prior to the current work visa/permit counts towards the two years (ie. on a visitor or student visa/permit or another work visa/permit).

Except for maternity services, partners of people eligible for publicly funded health and disability services must themselves meet the eligibility criteria.

For more information about these eligibility criteria, go to the main Guide to eligibility page (/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services/guide-to-eligibility-for-public-health-services).

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Recent change to calculation of visa duration

The Ministry of Health previously calculated the duration of a person's visa exclusive of the date the visa expires. Following consideration of a complaint to the Ombudsman, this was reviewed by the Ministry and the Ministry has accepted that it was incorrect.

Any person who considers that they would have been eligible for publicly funded services if the final date of their work visa was counted towards the two-year visa requirement under clause B5 is entitled to seek a review of the previous eligibility decision by emailing eligibility@health.govt.nz (mailto:eligibility@health.govt.nz).

In future, the date of the visa's expiry will be included when calculating the duration of a work visa.

People aged 17 years or younger

Eligibility:

People aged 17 years or younger are eligible for publicly funded health services if they are in the care and control of a: parent, or legal guardian, or person in the process of legally adopting them or becoming their legal guardian, who is eligible as a:

- a New Zealand citizen or permanent resident (B2 and B3)
- an Australian citizen or Australian permanent resident living or planning to live in New Zealand for two years or more (B6, B7)
- an interim visa holder (B4)
- an work visa holder (B5)
- refugee, protected person or victim of people trafficking (B10, B11, B12),
- a New Zealand Aid Programme student (B13) OR
- is in the care and control of the Chief Executive of Oranga Tamariki - Ministry for Children.

Criteria: B16, Health and Disability Services Eligibility Direction 2011.
Note: Refer to the clauses above for the conditions of the relevant criteria for parents/guardians.

Proof of eligibility:

You will need to show your health service provider:

- proof that you are in the care and control of a parent, or guardian, or person who is in the process of legally adopting you or becoming your legal guardian, AND
- proof that your parent or guardian or adopting parent is an eligible person AND
    - your passport AND proof of relationship to your parent or guardian or adopting parent OR
    - your birth certificate (to prove your age and relationship to your parent) AND supporting identity documentation to show that you are the person on that birth certificate OR
    - your birth certificate (to prove your age) and proof of guardianship or that adoption is in process AND supporting identity documentation to show that you are the person on that birth certificate.

Examples of identity documentation include:

- a driver licence
- a school/tertiary ID card
- an employment contract, a rental agreement, or
- letters addressed to you at your current address.

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Note: Except for maternity services, partners of people eligible for publicly funded health and disability services must themselves meet the eligibility criteria.

Interim visa

Eligibility:

Interim visa holders are eligible if, immediately prior to their interim visa, they were eligible for publicly funded health and disability services (ie. under other criteria).

Criteria: B4, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility:

You will need to show your health service provider:

- your interim visa letter AND
- an immigration history from Immigration NZ detailing the visas/permits you have been issued and the time you have spent in NZ on those visas/permits AND
- supporting identity documentation to prove that you are the person on those letters.

Examples of identity documents include:

- a driver's licence
- a school/tertiary ID card
- an employment contract, a rental agreement, or
- letters addressed to you at your current address.

Requirements for these identity documents can be waived for young children.

Note: Dependent children (aged 17 years or younger) of eligible interim visa holders are eligible for publicly funded health and disability services, provided they can show that it is their parent, legal guardian, adopting parent, or person applying to become their legal guardian who is the eligible interim visa holder.

Partners of eligible interim visa holders must themselves meet the eligibility criteria to be eligible for publicly funded health and disability services.

Pregnant partners of eligible interim visa holders may be eligible for maternity-related services (only), if not already eligible in their own right. They must be able to provide proof of their partnership with the eligible person. For more information, go to maternity services.

NZ Aid Programme student receiving Official Development Assistance funding

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Eligibility

Students:

Students are eligible for publicly funded health and disability services if they are studying in New Zealand under the Manaaki New Zealand Aid Programme (previously New Zealand Aid Programme), and receiving Official Development Assistance funding via a New Zealand Government Scholarship from Education New Zealand.

Criteria: B13, Health and Disability Services Eligibility Direction 2011.

Family members:

Children in the care and control of a parent or guardian who meets the criteria above (clause B13, Health and Disability Services Eligibility Direction 2011) are also eligible for publicly funded health and disability services.

Criteria: B16, Health and Disability Services Eligibility Direction 2011.

Partners of people who meet the criteria above (clause B13, Health and Disability Services Eligibility Direction 2011) are also eligible for publicly funded health and disability services.

Criteria: B20, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility

()Students:

If you are the recipient of the New Zealand Government Scholarship, you will need to show your health service provider:

- your valid passport with current student permit and
- a letter of scholarship offer from Education New Zealand, signed by you.

Family members:

To prove eligibility of a child or partner of the recipient of the New Zealand Government Scholarship, you will need to show your health service provider:

- proof of the scholarship recipient's eligibility (https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services/nz-aid-programme-student-receiving-official-development-assistance-funding#student) and
- the approval letter received from Immigration New Zealand, confirming the family member's application for a visa as a dependent of a recipient of a New Zealand Government Scholarship through Education New Zealand.

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Commonwealth scholarship student

Eligibility

Students who are studying in New Zealand under the Commonwealth Scholarship and Fellowship Plan, funded by a New Zealand university, are eligible for publicly funded health and disability services.

Criteria: B14, Health and Disability Services Eligibility Direction 2011.

Students who are studying in New Zealand under a Commonwealth Scholarship, funded by Education New Zealand through the Manaaki New Zealand Aid Programme, are eligible for publicly funded health and disability services.

Criteria: B13 and B14, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility

Students:

You will need to show your health service provider:

- your valid passport with a student permit **and**
- documents that indicate that you are studying in New Zealand on the Commonwealth Scholarship and Fellowship Plan **or**
- a letter of scholarship offer from Education New Zealand, signed by you.

Family members:

Partners and children of students studying under the Commonwealth Scholarship and Fellowship Plan, funded by a New Zealand university, are not eligible unless they meet the eligibility criteria in their own right.

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Foreign language teaching assistant

Eligibility:

Foreign language teaching assistants funded by the Ministry of Education's Foreign Language Teaching Assistantship Scheme are eligible for publicly funded health and disability services.

Criteria: B15, Health and Disability Services Eligibility Direction 2011

Proof of eligibility:

You will need to show your health service provider:

- your valid Passport with a work visa AND

- a letter from Tui Tuia | Learning Circle / Auckland UniServices Ltd confirming you are participating on this scheme. If you are participating in this scheme and do not yet have the required letter please email tuituia.languages@auckland.ac.nz. (mailto:tuituia.languages@auckland.ac.nz)

Refugees and protected persons

Eligibility:

Refugees and protected persons, applicants for refugee and protection status, and people appealing against refusal of refugee or protection status are eligible for publicly funded health and disability services. Victims and suspected victims of people trafficking offences are also eligible for publicly funded health and disability services.

The person must have:

- applied for refugee or protection status and be awaiting a decision, OR
- been granted refugee or protection status, OR
- appealed to the Immigration and Protection Tribunal against refusal of refugee status and be awaiting a decision OR
- be a victim or a suspected victim of a people trafficking offence.

Criteria: B10, B11 and B12, Health and Disability Services Eligibility Direction 2011.

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Proof of eligibility:

You will need to show your health service provider proof of your refugee or protection status. This will be:

- a letter from Immigration New Zealand confirming that you have been recognised as a refugee or protected person, OR
- a recent letter from Immigration New Zealand confirming that you have a current application for refugee or protection status, OR
- a recent letter from Immigration New Zealand confirming that you have an appeal before the Immigration and Protection Tribunal for refugee or protection status OR
- confirmation from the Police stating that the person is a victim or a suspected victim of a people trafficking offence.

You will also need to show proof that you are the person in the letter. This might be:

- your Refugee Travel Document issued under the Passport Act 1992, OR
- your Certificate of Identity issued under the Immigration Act 1987.

Note: The type or length of visa held is not relevant to these criteria.

A person whose appeal against refusal of refugee status has been declined by the Immigration and Protection Tribunal is not eligible for publicly funded health and disability services. Appeals to the Immigration and Protection Tribunal for other reasons (eg, removal from New Zealand) do not satisfy the eligibility criteria.

Children in the care and control of people in this category are dealt with under People aged 17 years or younger.

Except for maternity services, partners of people eligible for publicly funded health and disability services must themselves meet the eligibility criteria.

The Refugee Status Branch (https://www.immigration.govt.nz/new-zealand-visas/preparing-a-visa-application/living-in-new-zealand-permanently/information-for-refugees-and-asylum-seekers/asylum-seekers) **decision times increased to over a year for most asylum seekers and has limited resources to issue updated claim letters to clients every three months so they will accept claim letters as is.**

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Eligibility for a limited range of publicly funded health services

Accidents and personal injuries

Eligibility:

People needing treatment for personal injuries can be covered by ACC, regardless of their residential status.

You'll need to complete a claim form at the time of treatment. The health service provider decides whether a claim should be lodged. The claim must be accepted by ACC before it will contribute to ongoing funding.

ACC does provide cover for accidents that occur overseas but only to people ordinarily resident in New Zealand, and only in limited situations.

Criteria: B26, Health and Disability Services Eligibility Direction 2011

Proof of eligibility:

At the initial consultation, the health service provider decides if an ACC claim should be lodged. If the treatment does not meet the ACC criteria, eligibility for publicly funded care must be determined, and you should be told of the expected cost, if any.

When ACC accepts a claim for cover, you will need to provide details of this cover to any subsequent health service providers.

For more information on ACC, visit the ACC website (http://www.acc.co.nz/).

Australian resident on a temporary visit to New Zealand

Eligibility:

Australian residents are covered by the New Zealand/Australia Reciprocal Health Agreement if they:

- are on a temporary visit (up to two years) to New Zealand AND
- in the opinion of the provider of medical treatment, they need immediately necessary medical treatment while in New Zealand.

Their medical treatment may be publicly funded as it would be for a New Zealand citizen:

- IF that treatment is clinically necessary for the diagnosis, alleviation or care of the condition requiring attention
- for pharmaceutical benefits, hospital services, and maternity services.

(Note: Australian visitors to New Zealand are not entitled to publicly funded emergency transport by ambulance. This includes both non-injury and emergency transport. Similarly, New Zealand visitors to Australia are not entitled to publicly funded emergency transport by ambulance.)

Criteria: B8, Health and Disability Services Eligibility Direction 2011.

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Proof of eligibility:

You will need to show your health service provider:

- your Australian passport OR
- your passport of other nationality with a current resident visa (including a resident return visa) issued by the Government of Australia OR
- your Medicare Australia card, and your passport to prove that you are the holder of that card.

Definition of Australian resident:

"Australian resident" is defined by the Australian Health Insurance Act 1973 (s3 Interpretation) as people who reside in Australia and includes:

- Australian citizens
- Australian permanent visa and resident return visa holders
- Australian temporary visa holders who are waiting for their permanent residency application to be processed.

Those listed are eligible to enrol in the Australian Medicare scheme – refer to the Health Insurance Act (http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/cth/consol_act/hia1973164/) for a full list. "Australia" means the Commonwealth of Australia, and includes the territories of Coco (Keeling) Islands, Norfolk and Christmas Island.

PHO enrolment:

- A person who is only eligible for services under the reciprocal agreement may not enrol with a Primary Health Organisation (PHO) and is not entitled to free or subsidised care by a primary health provider/general practitioner. The ineligible person may register with a General Practice as a private patient, and should be allocated a NHI number if they do not already have one.

Eligibility under other criteria:

- An Australian citizen or permanent resident who has been in New Zealand for a period of two years or more, or can demonstrate reasonable intention to remain in New Zealand for two years or more, is eligible for all publicly funded services, and can enrol with a PHO and get the same health subsidies as a New Zealand citizen.
- Other Australian residents may also be eligible for other publicly funded services, under other criteria. For example, they may be fully eligible if they have a New Zealand work visa that, together with time spent on visas immediately prior, allows them to be continuously in New Zealand for two years or more. Or they may be eligible for maternity-related services funded to the same extent as for a New Zealand citizen if their partner is eligible for the full range of publicly funded health and disability services.

Insurance recommended:

- The Government strongly recommends that people in New Zealand who are not eligible for publicly funded health and disability services should hold comprehensive travel insurance, including health insurance. The reciprocal agreement does not cover non-urgent treatment, rehabilitation or repatriation, and some services to New Zealanders such as doctors visits and pharmaceuticals are subject to part charges.

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Compulsory treatment

Eligibility:

People who are eligible to receive or are receiving compulsory health services under the following Acts are eligible for those services to be publicly funded.

- Alcoholism and Drug Addiction Act 1966
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

- Mental Health (Compulsory Assessment and Treatment) Act 1992.

In the case of people receiving services that would be prescribed under the Alcoholism and Drug Addiction Act or the Mental Health (Compulsory Assessment and Treatment) Act, the health service provider will provide:

- diagnostic services or assessments to determine whether further compulsory services are required
- inpatient or outpatient care for the illness, including medications, while the person continues to meet the criteria for requiring compulsory treatment
- other follow up such as counseling, during the time that the person meets the criteria for requiring compulsory treatment.

Citizenship and immigration status are not relevant; length of stay is not relevant.

Criteria: B25, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility:

If there is doubt about whether the Alcoholism and Drug Addiction Act 1966; or Mental Health (Compulsory Assessment and Treatment) Act 1992 provisions apply in a particular case, it should be referred to the District Inspector who will consult the Ministry of Health where necessary.

If there is doubt about whether the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 or Criminal Procedure (Mentally Impaired Persons) Act 2003 provisions apply in any particular case, queries should be referred to the Director (IDCC&R), Ministry of Health.

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Emergency services

Eligibility:

Anyone may receive publicly funded services during or as the result of an emergency (eg, natural disaster, act of terrorism), if:

- the services are required as the result of an emergency, AND
- the services are necessary to address health risks to the person or other persons.

"Emergency" has the same meaning as in section 4 of the Civil Defence Emergency Management Act 2002.

Criteria: B24, Health and Disability Services Eligibility Direction 2011.

Note: The Government strongly recommends that people in New Zealand who are not eligible for publicly funded health services hold comprehensive travel insurance, including health insurance.

Foreign diplomats and their family

Eligibility:

Foreign diplomats and their family members are **not** eligible for publicly funded health and disability services unless injured in an accident.

The Government they're representing is responsible for covering their health costs. They may receive medical care in the public health system but must pay for all medical and associated costs.

Foreign diplomats and their family members requiring acute care will receive it, and will later be invoiced for the services received.

Foreign diplomats and their family members seeking elective services through the public health system will be treated only where there is capacity beyond meeting the needs of the eligible population. Provision of treatment is decided on a case-by-case basis, by the treating District Health Board. In some cases, payment may be sought in advance.

Foreign diplomats and their family members are covered under the accident compensation scheme and may receive medical treatment under the public system as the result of an accident, including motor vehicle accidents. Foreign diplomats may be eligible for publicly funded health care in situations where they otherwise meet the eligibility requirements of the 2011 Direction. This also applies to Consular and Official staff, and their family members.

Please refer any queries to Protocol Division of the Ministry of Foreign Affairs and Trade, Wellington.

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Immunisation and Well Child/Tamariki Ora

Eligibility:

Regardless of their citizenship or immigration status, children are eligible for publicly funded vaccinations on the Immunisation Schedule, and WellChild/Tamariki Ora services.

Criteria: B17, B18, Health and Disability Services Eligibility Direction 2011.

Note: Children may be eligible for other services to be funded, under other criteria. For example, if they are a UK citizen who ordinarily resides in New Zealand, they would be eligible for certain publicly funded services under a reciprocal agreement. If they are under 18 and have an eligible parent, they may be eligible for the full range of publicly funded health and disability services (return to the beginning of the Guide for further information).

The Government strongly recommends that people in New Zealand who are not eligible for publicly funded health services hold comprehensive travel insurance, including health insurance.

People receiving treatment for infectious diseases

Eligibility:

People who have or who are suspected of having an infectious and/or quarantinable disease are eligible for publicly funded health services to address the risks to other people.

Infectious and quarantinable diseases are those listed in the Schedule to the Health Act 1956 and tuberculosis.

The services must relate only to all or any of the following:

- the surveillance of persons who are liable to quarantine under the Health Act 1956 or the Tuberculosis Act 1948
- diagnosis
- treatment of the person's infectious or quarantinable disease
- follow-up services and
- contact tracing services.

for the person's infectious or quarantinable disease, to the extent appropriate in the circumstances to address risks to other persons, as determined by a clinician.

Citizenship and immigration status are not relevant; length of stay is not relevant.

Criteria: B23, Health and Disability Services Eligibility Direction 2011

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Proof of eligibility:

If there is doubt about whether the Tuberculosis Act 1948; or Health Act 1956 provisions apply in a particular case, it should be determined on the judgment of the Medical Officer of Health.

Pregnant wife or partner of an eligible person

Eligibility:

Pregnant partners of:

- New Zealand citizens
- New Zealand resident visa (including residence permit) and permanent resident visa holders

- Australian citizens or permanent residents who have or intend to live in New Zealand for two years or longer
- refugees, or people whose application to become a refugee has been accepted by Immigration NZ, or people who are in the process of having an appeal for refugee status determined by the Immigration and Protection Tribunal
- people with protection status, people applying to Immigration NZ for protection status or people appealing against refusal of protection status
- children aged under 18 who are in the care and control of a parent or guardian (or a person in the process of legally adopting them or becoming their legal guardian) and that person is:
    - a New Zealand citizen or permanent resident, OR
    - an Australian citizen or permanent resident who has been living, or who intends to live, in New Zealand for two years or longer, OR
    - a Work Visa holder whose visa is for two years or more, or who has a current work visa which, together with previous visas, allows them to be continuously in New Zealand for two years or more (work visas start on the person's first day in New Zealand)
- Work Visa holders whose visa is for two years or more, or who have a current work visa which, together with previous visas, allows them to be continuously in New Zealand for two years or more (work visas start on the person's first day in New Zealand)

who are not eligible for publicly funded health and disability services in their own right, are eligible for the same maternity-related services as New Zealand citizens.

Maternity-related services include all services included in the section 88 Maternity Notice, and any other treatment for a condition determined by a clinician that would adversely impact on the survival of the mother or the baby.

Criteria: B21, Health and Disability Services Eligibility Direction 2011.

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Criteria:

The pregnant wife or partner of an eligible person.

Proof of eligibility:

You will need to show your health service provider:

- your partner's proof of eligibility e.g. a valid New Zealand Passport, Passport with a current Work Visa AND
- proof of being the wife or partner of an eligible person

Examples of proof include:

- a partner's Passport AND a marriage or civil union certificate OR
- a Visa or Permit granted by Immigration New Zealand on the basis of the relationship OR
- a statutory declaration from both partners, detailing how they meet the definition of "de-facto partner".

Pregnant woman infected with the HIV virus

Eligibility:

Pregnant women who have been infected with the HIV virus are eligible for specific maternity services to reduce the risk of mother to child transmission.

Any pregnant woman who is infected with HIV has free access to:

- a hospital based lead maternity carer
- blood tests to determine HIV viral load in the pregnant woman
- a funded course of antiretroviral drug(s), noting that there is no entitlement to ongoing antiretroviral treatment for the mother
- information around safe alternatives to breastfeeding
- a caesarean section for those cases where specialist medical opinion considers that a caesarean section is required for delivery to effectively limit the HIV transmission risk to the child
- post caesarean section hospitalisation (approximately one week)
- postnatal hospital visits for the child for the purpose of disease exclusion, that is, to determine the HIV status of the child.

Criteria: B22, Health and Disability Services Eligibility Direction 2011.

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Proof of eligibility:

You will need to show your health service provider:

- your Passport (only to prove your identity) AND
- proof of your being infected with the HIV virus (eg. a referral letter from your GP).

A pregnant woman infected with the HIV virus is eligible for the specified maternity services while she is in New Zealand, irrespective of her immigration status.

People in prison or on remand in prison custody

Eligibility:

Prison inmates and people on remand are eligible for publicly funded health and disability services that are not provided by the prison health system.

Criteria: B27, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility:

You (or the person acting on your behalf) will need to show the health service provider proof that you/the person is a prison inmate or an individual on remand.

Citizenship and immigration status are not relevant; length of stay is not relevant.

UK citizen ordinarily resident in the UK, on a temporary stay in NZ

Eligibility:

Under a reciprocal agreement, a United Kingdom (UK) citizen (passport holder) is eligible for treatment (medical, hospital and related) on the same basis as a New Zealand citizen if they:

- are ordinarily resident in the UK (including England, Scotland, Wales, Northern Ireland, the Isle of Man, the Island of Jersey and the Balliwick of Guernsey, comprising the islands of Guernsey, Alderney, Herm, Jethou and Sark) AND
- are on a temporary stay in New Zealand (a temporary stay would be any stay that was not permanent, and to become permanent they would need to have a residence visa or NZ citizenship) AND
- require medical treatment which:
    - in the opinion of a medical practitioner (or dentist for people 19 years or younger)
    - needs prompt attention
    - for a condition that arose after arrival into New Zealand, OR became, OR without treatment would have become, acutely exacerbated after arrival.

Criteria: B5, Health and Disability Services Eligibility Direction 2011.

Proof of eligibility:

You will need to show your health service provider:

- your valid UK Passport with a Visitor Visa OR a Student Visa OR a Work Visa for less than two years AND
- proof of being ordinarily resident in the UK (eg. return ticket, property lease or ownership papers, proof of employment in the UK)

Note:

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Permanent residency in New Zealand or other countries:

- The UK Reciprocal Health Agreement does not cover UK permanent residents.
- A UK passport holder who is not ordinarily resident in the UK is not eligible for coverage under the New Zealand/UK reciprocal health agreement.
- A UK citizen who held a residence visa for any other country prior to arriving in New Zealand would not be covered by this agreement. Applying for permanent residency in New Zealand does not exclude the applicant from coverage under this agreement. If New Zealand residency is not granted, the person may still be considered ordinarily resident in the United Kingdom.

PHO enrolment:

- When receiving services under the reciprocal agreement, a person may not enrol with a Primary Health Organisation (PHO). They should get the same health subsidies as a New Zealand citizen visiting a general practitioner as a casual patient, if the medical practitioner has decided the condition needs prompt attention. They may register with a GP, and should be allocated a NHI number if they do not already have one.

Eligibility under other criteria:

- UK citizens may also be eligible for other publicly funded services, under other criteria. For example, they may be fully eligible if they have a work visa that, together with time spent on visas immediately prior, allows them to be continuously in New Zealand for two years or more. Or they may be eligible for maternity-related services funded to the same extent as for a New Zealand citizen if they have a partner who is fully eligible.

Insurance recommended:

- The Government strongly recommends that people in New Zealand who are not eligible for publicly funded health and disability services should hold comprehensive travel insurance, including health insurance. The reciprocal agreement does not cover non-urgent treatment, rehabilitation or repatriation, and some services to New Zealanders such as doctors visits and pharmaceuticals are subject to part charges.

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Not eligible?

The government strongly recommends that people in New Zealand who are not eligible for publicly funded health services hold comprehensive **travel insurance, including health insurance**.

Also in this section

Corporate information (/corporate-information)

About us (/corporate-information/about-us)

Contact and engagement (/corporate-information/contact-and-engagement)

News and updates (/corporate-information/news-and-updates)

Our health system (/corporate-information/our-health-system)

Eligibility for publicly funded health services (/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services)

Health targets and mental health and addiction targets (/corporate-information/planning-and-performance/health-targets)

Health sector organisations (/corporate-information/our-health-system/health-sector-organisations)

National Operating Model and Structure (/corporate-information/our-health-system/national-operating-model-and-structure)

Organisational overview (/corporate-information/our-health-system/organisational-overview)

Strategic initiatives in health research and innovation (/corporate-information/our-health-system/strategic-initiatives-in-health-research-and-innovation)

Supporting healthcare in your region (/corporate-information/our-health-system/supporting-healthcare-in-your-region)

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Sustainable and resilient (/corporate-information/our-health-system/sustainable-and-resilient)

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Volunteer at a hospital or health facility (/corporate-information/our-health-system/volunteer-at-a-hospital-or-health-facility)

Consumer representatives (/corporate-information/our-health-system/consumer-representatives)

Planning and performance (/corporate-information/planning-and-performance)

Procurement (/corporate-information/procurement)

Publications (/publications)

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Agreement

Between

HER MAJESTY THE QUEEN IN RIGHT OF HER GOVERNMENT IN NEW ZEALAND
(acting by and through the Ministry of Health)

MINISTRY OF HEALTH
MANATŪ HAUORA

650 Great South Road
Private Bag 92-522
Auckland
Ph: 09-580 9000
Fax: 09-580 9001

354 Victoria Street
PO Box 1031
Hamilton
Ph: 07-858 7000
Fax: 07-858 7001

133 Molesworth St
PO Box 5013
Wellington
Ph: 04-496 2000
Fax: 04-496 2340

250 Oxford Terrace
PO Box 3877
Christchurch
Ph: 03-372 1000
Fax: 03-372 1015

229 Moray Place
PO Box 5849
Dunedin
Ph: 03-474 8040
Fax: 03-474 8582

Contact: **Doug Funnell (Dunedin)**

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and

Compensation Advisory Services Ltd - LifeLinks

Needs Assessment and Service Coordination

PO Box 2379
Christchurch
Ph: 03-365 9593
Fax: 03-365 5244

Contact: **Craig Hutchison**

for Health and Disability Services

You, as the Provider, agree to provide the Services on the terms of this agreement.

Signed for and on behalf of
HER MAJESTY THE QUEEN IN RIGHT OF HER GOVERNMENT IN NEW ZEALAND (acting by and through the Ministry of Health) *by:*

Authorised Signatory

Name .....

Position ..... Mark Powell Manager - Service Access Team Disability Support Services

Date 22/10/2010

Signed for and on behalf of
COMPENSATION ADVISORY SERVICES LTD - LIFELINKS *by:*

Authorised Signatory

Name ..... C. HUTCHISON

Position ..... DIRECTOR

Date 8-10-10

HEAD AGREEMENT – SUMMARY TABLE

This section lists all documents included in The Agreement. The Agreement comes into effect from the commencement date identified in Part 1 below. The following summary table will be updated, in an agreement variation, whenever there is a change to this list.

Part 1 – The Head Agreement

Document	Commencement Date
This Document	1 October 2010

Part 2 – The Service Schedules

Service Schedule(s)	Reference/ Version No	Commencement Date	End Date
DSS1040 DSD NASC Management	1.0	1 October 2010	30 September 2012
DSS1039D DSD Discretionary Funding	1.0	1 October 2010	30 September 2012
DSS1039D Historic Individualised Funding	1.0	1 October 2010	30 September 2012

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PART 1 HEAD AGREEMENT

SECTION A: GENERAL TERMS AND CONDITIONS

A1 AGREEMENT

A1.1 We agree to purchase and you agree to provide Services on the terms and conditions set out in the Agreement, which you and we enter into under section 10 of the New Zealand Public Health and Disability Act 2000.

A1.2 The Agreement means Part 1 (this document, to be referred to as the Head Agreement), together with Part 2 (the documents listed in the Agreement Summary).

A1.3 Expressions used in this Agreement are defined in clauses A30.11 and A30.12

A1.4 If there is any conflict between the terms of Part 1 and Part 2, the terms of Part 2 will prevail.

A1.5 Both of us acknowledge that both of us expect that Part 1 will not normally be amended and that any such amendment will usually be expressly provided for in Part 2.

A1.6 The Agreement will commence on the Commencement Date and, subject to any rights of review, amendment, variation or termination, will apply until the End Date.

A2 RELATIONSHIP AND REVIEW PRINCIPLES

A2.1 Relationships

Both of us acknowledge that the relationship between each of us is fundamental in achieving our respective objectives in entering into the Agreement. Both of us therefore agree and commit, to address and develop relationship principles, which will guide both of us in our dealings with each other in the operation of this Agreement.

A2.2 Review

Both of us acknowledge the ongoing nature of this Agreement and the need for and commitment to continuous improvement in service delivery and health outcomes within available funding. Both of us agree that this includes such support as we may agree from time to time, for a streamlined purchase framework and service reviews, which address areas of poor health status and/or inadequate service delivery.

A3 MÄORI DISABILITY AND HEALTH SERVICES

A3.1 Treaty of Waitangi and Mäori Disability and Health Statement

The Treaty of Waitangi establishes the unique and special relationship between iwi Mäori and the Crown. As a Crown organisation we consider the Treaty of Waitangi principles of partnership, participation and proactive protection of Mäori disability and health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which our organisation responds to Mäori disability and health issues.

Equally we require that these principles shall be explicitly expressed in agreements between contracted Service providers and us. Therefore all contracted providers, whose clientele may include Mäori, shall demonstrate how the policies and practices of their provider organisation and Service delivery shall benefit that Mäori clientele. This reflects Objective 11 of the New Zealand Disability Strategy, which is to ensure that mainstream providers of disability

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services are accessible to and culturally appropriate for disabled Mäori and their whänau. This will include:

- developing the capacity of disabled Mäori through the equitable allocation of resources within the context of Mäori development frameworks;
- the provision of appropriate training for Mäori disability service provider professionals; and
- increasing the advisory capacity of Mäori.

A3.2 Mäori Health Priority

Where the Services contain a specific Mäori Health component the following will apply:

a. You agree that Mäori health is a specifically identified health gain priority area. You must therefore establish and implement a Mäori health policy that reflects that fact. In developing this policy, and without limitation, you must take into account our strategic direction for Mäori health in terms of minimum requirements for Mäori health based on the Treaty of Waitangi, Crown objectives for Mäori health and specific requirements negotiated from time to time with us.

b. You must specify how you intend to implement this policy. Together, we will identify those services you will deliver as explicit contributions to Mäori health gain priorities, how these services will be measured to ascertain what benefit is evident and other additional opportunities that may exist for furthering Mäori health gain. We will agree any additional services we may need to purchase to implement this policy.

c. On commencement of the Agreement, you must develop your Mäori health policy and operational plans after consultation with us, subject to agreement between both of us as to our respective responsibilities for ensuring that the plans, policy and services are adequately resourced within the current levels of funding.

A4 SERVICE PROVISION

A4.1 Provision of Services

You must provide the Services and conduct your practice or business:

a. in a prompt, efficient, professional and ethical manner; and

b. in accordance with all relevant law; and

c. in accordance with Our Objectives;

from the Commencement Date and then without material interruption until the End Date of the relevant Services or until the Agreement or the relevant Services end in accordance with the terms of the Agreement.

A5 PAYMENTS

A5.1 We will pay you in accordance with the terms of the Agreement.

A5.2 You may only claim payments under this Agreement in respect of Services provided to Eligible Persons unless you are a Disability Information and Advisory Services (DIAS) agency and a set amount of funding is to be provided for Services provided under this Agreement. If there is any conflict between this clause and the Service Specification set out in Part 2 Section C, Part 2 Section C will prevail in determining the payments that you may claim.

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A5.3 Subject to clause A5.5 below, if we do not pay any amount due to you within three (3) days of the agreed payment date, then you may charge us Default Interest from the agreed payment date.

A5.4 Subject to any existing arrangements between both of us, no Default Interest is payable with respect to invoices received by us prior to the agreement being signed by both of us.

A5.5 You must first have given us an invoice completed in the agreed format and we must have received it 10 Working Days before the agreed payment date which must be specified in that invoice.

A5.6 If you invoice us for Services not covered by this Agreement, we may recoup any payment made in respect of such invoice and charge you Default Interest on such payment from the date paid until recoupment is made.

A6 WITHHOLDING OF PAYMENTS

A6.1 Where you:

a. Breach clause A11.2, or clause A11.6; or

b. Have not completed a compliance requirement contained in a notice of default given under clause A12.3(b) or in a notice given under clause A12.4; or

c. Fail to meet your obligations in terms of clause A23,

we may withhold some or all of the next payment or payments due until you have remedied the breach, or otherwise complied with the relevant obligation, or until any costs incurred by us have been met, whichever is later.

A6.2 Where you have failed to comply with any obligations under this Agreement not referred to in clause A6.1, and that failure is material, we may withhold 5% of the next payment or payments due until you comply with the relevant obligation or until any costs incurred by us have been met, whichever is later.

A6.3 A6.3 We will give 20 Working Days notice of our intention to withhold payments under clause A6.1 and/or A6.2, during which notice period you may remedy your non-compliance.

A7 INSPECTION OF RECORDS UNDER HEALTH ACT 1956

A7.1 Where we exercise powers under section 22G of the Health Act 1956, or any enactment that replaces that section and, following inspection under that section, we are unable to verify any of the your claims for payment under this Agreement, we may:

a. Require you to report at such intervals and on such financial matters as we may specify;

b. Withhold payments under this Agreement from you until satisfied of the veracity of any of your claims for payment; and

c. Take such further action, as we consider necessary in the circumstances.

A8 CHARGES TO SERVICE USERS

A8.1 Subject to your right to charge Service Users User Part Charges for certain Services as detailed in the Agreement, you will not charge Eligible People for Services funded by us under the Agreement.

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A8.2 If and when you provide Services to persons who are not Eligible Persons, you will use your best endeavours to charge and recover from that person at least the full cost to you of providing that Service. You will record details of Services provided to such persons, the costs of such Services and the extent to which these costs are recovered.

A9 COST SHIFTING

You must not knowingly be party to any arrangement, which results in

a. our effectively having to pay more than once; or

b. you effectively receiving separate payments, whether from us or any other Person

for the supply of the same Services or any component of them.

A10 OTHER ARRANGEMENTS

A10.1 You must not enter into any other agreement or arrangement, which would prejudice your ability to meet your obligations in the Agreement.

A10.2 You may (subject to your obligations in the Agreement) agree to provide Services for any other person.

A10.3 You may assign your right to receive payment under this Agreement to another party providing finance to you for the sole purpose of obtaining such finance.

A10.4 Except as provided in clause A10.3, you must not transfer any part of your rights or obligations under the Agreement without our prior written consent, and such consent is not to be unreasonably withheld.

A11 QUALITY ASSURANCE

A11.1 Record keeping

a. You must keep and preserve Records and protect the security of them in accordance with your statutory obligations and make them available to us in accordance with our reasonable instructions and our rights to access such Records.

b. In the event of your ceasing to provide the Services you must:

i. transfer Records relating to Service Users to the new provider of services to those Service Users; and

ii. preserve Records not transferred to another provider.

A11.2 Access for Quality Audit

a. You must co-operate with us fully and allow us, or our authorised agents, access to:

i. your premises;

ii. all premises where your Records are kept;

iii. Service Users and their families and nominated representatives;

iv. staff, sub-contractors or other personnel used by you in providing the Services,

for the purposes of and during the course of carrying out:

v any Quality Audit of your Services at your Premises; or

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vi. any Quality Audit of your agents or subcontractors who provided services to Service Users to whom you provide Services, or in respect of whom you hold relevant Records.

b. You must ensure that any sub-contracting or agency agreements you may enter into in relation to the Services include a provision to the effect that the sub-contractor or agent must co-operate fully with us.

c. You must ensure that the people appointed by us to carry out the Quality Audit have the access referred to in this clause A11.2, during the hours they are entitled to audit.

d. For the purposes of clause 11.2(a)(iii), within 3 Working Days after receiving notice of a Quality Audit under clause A11.3(a), or immediately in the case of a Quality Audit under clause A11.3(b), you must, as far as practicable, provide to us, in writing, the names and addresses of all Service Users' families and nominated representatives or a sample of the names and addresses of Service User's families and nominated representatives, depending on our request.

e. We will ensure that the exercise of access under this clause will not unreasonably disrupt the provision of the Services to Service Users.

A11.3 Notice of Quality Audits

a. Subject to clause A11.3(b), we will give you 10 Working Days prior notice of any Quality Audit unless we agree to greater notice.

b. If we believe that delay will prejudice the interests of any Person, we may carry out a Quality Audit without prior warning. If we exercise our rights under this clause, we will give you notice on our arrival at your premises of the scope of and reasons for the Quality Audit to be carried out.

c. We may also, during the course of a Quality Audit commenced under clause A11.3(b), expand the scope of the Quality Audit to matters not referred to in the notice if desirable, in the opinion of the Quality Auditor carrying out the Quality Audit, to assess whether you comply with your obligations under this Agreement.

A11.4 Times for Quality Audits

a. Subject to clause A11.4(b), a Quality Audit may be carried out between 9 am and 5 pm on any Working Day and at any other time by agreement.

b. We may carry out a Quality Audit under clause A11.3(b) at any time on any day where reasonably necessary having regard to the scope of that Quality Audit.

A11.5 Appointment of Quality Auditors

a. We may appoint our staff or third parties to audit, on our behalf, and at our cost, in relation to any of the matters contained in the Agreement. Each Person so appointed is a Quality Auditor.

b. We will give you prior written notice of the names of the people to be appointed.

c. You may object to such appointments where any or all of those people appointed (whether our staff or third parties) have a demonstrable conflict of interest, by advising us of the claimed conflict of interest and providing the evidence which supports your claim.

d. If we receive advice from you under clause A11.5(c) not less than 5 Working Days before a Quality Audit is to be conducted under clause A11.3(a), we will review the information provided and, if we agree that there is a conflict of interest, the Quality Audit will not proceed until we have appointed a replacement Quality Auditor.

e. If we receive advice from you under clause A11.5(c) either:

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i. less than 5 Working Days before a Quality Audit under clause A11.3(a); or

ii. in relation to a Quality Audit under clause A11.3(b),

we may conduct the Quality Audit up to and including the preparation of the Draft Findings Report while we review the information provided. If we agree that there is a conflict of interest, we will appoint a replacement Quality Auditor to verify the Draft Findings Report before we prepare the Final Audit Report.

A11.6 Quality Audit process

a. In carrying out any Quality Audit we may:

i. have access to Health Information about any past or current Service User;

ii. observe the provision or delivery of the Services;

iii. interview and/or survey Service Users and/or their families (including, without limitation, either in writing or by way of an interview); and

iv. interview and/or survey any staff, sub-contractors or other personnel used by you in providing the Services (including, without limitation, either in writing or by way of an interview),

in accordance with the Privacy Act 1993 and any code of practice issued under that Act covering Health Information held by health providers.

b. Each Quality Auditor may take copies of any parts of the Records for the purposes of the Quality Audit in accordance with the Privacy Act 1993, and any code of practice issued under that Act covering Health Information held by health providers.

c. You must allow each Quality Auditor to use any photocopier at your Premises, but you are not required to supply paper. If there is no photocopier at your Premises, we may remove the relevant Records from your Premises for the purposes of copying such Records, and we will return those Records on the same day or, if that is not practicable, within 24 hours or a timeframe agreed between both of us.

d. For the purposes of clause A11.6(a)(iv), during the course of a Quality Audit you must provide opportunities for the Quality Auditors to interview staff, sub-contractors or other personnel used by you in providing the Services, in private, without you or your Manager being present. At the request of a staff member, sub-contractor or other Person being interviewed, a support person (excluding you or your Manager) may be present at any interview.

e. On the completion of the Site Visit, the Quality Auditor must discuss the preliminary findings of the Quality Audit with you.

A12 QUALITY ASSURANCE – REPORTING AND COMPLETION

A12.1 Draft Findings Report

a. We will submit a Draft Findings Report to you within 5 Working Days of the Site Visit.

b. To the extent that we wish to incorporate in the Draft Findings Report any information provided in interviews conducted under clause A11.2(a)(iii) and (iv) and identify the Person or Persons who provided that information, we will do so only with the prior consent of the Persons concerned.

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c. We will include a fair and reasonable summary of the information provided under clause A11.6(a)(iii) and (iv) as an appendix to the Draft Findings Report.

d. If you disagree with any of the findings in the Draft Findings Report, you may respond to us within 5 Working Days of receipt of the Draft Findings Report, indicating why you do not agree with the findings.

A12.2 Final Audit Report

a. We must prepare a Final Audit Report that takes into account your comments on the Draft Findings Report.

b. The Final Audit Report must include:

i. a summary of your comments, if any, on the Draft Findings Report;

ii. the Final Findings Report, including a statement as to whether or not you are compliant with your obligations under this Agreement;

iii. actions that you must take, if any, to become compliant with your obligations under this Agreement ("compliance requirements");

iv. the timeframe within which you must complete the compliance requirements;

v. the actions required to verify that you have met the compliance requirements. This may include a follow up visit by the Quality Auditor.

c. The Final Audit Report will be sent to you within 20 Working Days of the Site Visit.

A12.3 Provider in default

a. You are in default if you have not completed a compliance requirement specified in the Final Audit Report within the timeframe set in accordance with clause A12.2(b).

b. Where you are in default, we may give you notice of default, and such notice shall state:

i. where the compliance requirement was to be completed within 2 Working Days, that you have a further period of not less than 2 Working Days from the date of notice of the default to comply with the relevant compliance requirement;

ii. where the compliance requirement was to be completed within 2 to 10 Working Days, that you have a further period of not less than 10 Working Days from the date of the notice of default to comply with the relevant compliance requirement; or

iii. in all other cases, that you have a further 20 Working Days from the date of the notice of default to comply with the compliance requirements.

c. If, by the end of any period stated under clause A12.3(b), you have not completed the compliance requirement(s) in question, we may:

i. vary the compliance requirement;

ii. extend the timeframe to complete the compliance requirement;

iii. withhold payment in accordance with clause A6; or.

iv. terminate this Agreement in accordance with clause A27.

d. When we are satisfied that you have completed all compliance requirements, we will notify you in writing that you are compliant.

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A12.4 Material or repeated failure

If in our opinion, based on reasonable grounds:

a. Your non compliance with your obligations under this Agreement, as stated in a Final Audit Report, is material; or

b. On the basis of a Final Audit Report and any previous Final Audit Report relating to any previous Quality Audit of your Premises, you have repeatedly failed to comply with your obligations under this Agreement,

we may give you a single period of not less than 20 Working Days to complete any or all compliance requirements specified under clause A12.2(b)(iii), and if by the end of that period, you have not completed the relevant compliance requirements, clause A12.3 shall not apply and, despite clause A13.4, we may terminate this Agreement under clause A27.

A12.5 Advice to Family Members

We may advise a Service User's family or nominated representative about the progress of a Quality Audit at any time during the course of or following the Quality Audit where we have serious concerns (based on reasonable grounds) about the health and safety of that Service User.

A12.6 A Quality Audit is completed when we notify you that you are compliant.

A12.7 Publication of Final Audit Report

a. Subject to clause A12.7(b), we may publish the Final Audit Report on our website and in any other medium.

b. A Final Audit Report will not be published while that Final Audit Report is being reviewed under clause A13 or is the subject of dispute resolution under clause A25.

c. Subject to the Privacy Act 1993 and any code of practice issued under that Act, you must make the Final Audit Report available to any Person for reading on request.

d. If a Person requests a copy of the Final Audit Report, you may require that Person to pay reasonable costs for copying.

A12.8 We retain the right to conduct a Quality Audit after this Agreement ends, but only in respect of Services provided prior to termination, or following termination under clause A29.

A13 QUALITY AUDIT REVIEW

A13.1 If you dispute any element of the Final Audit Report, you may apply to us for a review of the Quality Audit.

A13.2 We will review the Quality Audit only if we receive an application for review under clause A13.1 no later than 10 Working Days after the Final Audit Report is sent to you.

A13.3 Quality Audit Review Process

a. We will notify you that the application for review has been received.

b. We will request information in relation to the issues raised by you from the Quality Auditors who carried out the Quality Audit.

c. Our Chief Internal Auditor, or a Person responsible for this function within the Ministry, will review all information relating to the Quality Audit.

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d. Following our Chief Internal Auditor's review, we will discuss our response to the issues raised with you.

e. Both of us must use our best endeavours to resolve the issues raised by you.

f. If we agree with any issues raised by you, we will amend the Final Audit Report accordingly.

g. If you and we are unable to resolve any issue raised within 20 Working Days from the date that we receive your application for review, then either of us may require mediation under clause A25.1(b) and clause A25 will apply accordingly.

A13.4 You must comply with all your obligations, including any compliance requirements issued under clause A12.2(b), while the review process is carried out, but we will not terminate the Agreement under clause A12.3(c) until the review is complete.

A13.5 Where you have complied with any compliance requirements in the Final Audit Report issued under clause A12.2(b) ("the original requirements"), which are amended or removed under clause A13.3(f) ("the amended requirements"), we will reimburse you an amount equal to our assessment of the difference between the reasonable costs of complying with the original requirements and the amended requirements.

A14 FINANCIAL MANAGEMENT AND AUDIT

A14.1 You must operate sound financial management systems and procedures in relation to

a. the Services;

b. your premises; and

c. Service Users where you are maintaining or managing Service User personal funds.

A14.2 If you receive moneys from other sources on behalf of a Service User (except payments for the Services) these moneys shall be noted in a separate accounting record held on behalf of the client, and you will keep full records of all such moneys for inspection by either the Service User on whose behalf such funds are being held or his/her authorised agent or by us or our authorised agent. You shall make these funds available to the Service User as requested or needed by that Service User or his/her legal representative.

A14.3 Where we have serious concerns (based on reasonable grounds) that you are not operating sound financial management systems and procedures, without limiting any of our other rights in this Agreement, we may:

a. request that you provide, to an independent auditor appointed by us at our cost, within 30 days of our request:

i. a copy of your most recent accounts, including accounts relating to individual or all Service Users personal funds;

ii. any previous year's accounts (audited or otherwise, as required by us); and/or

iii. a solvency certificate from an appropriately qualified Person; and

b. arrange for that independent auditor to audit:

i. the correctness of the information you give us under clause A14.2(a);

ii. your calculations of the cost of providing the Services; and

iii. your financial position.

A14.4 The independent auditor:

a. must not disclose details of your costs of providing the Services; but

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b. may advise us if he or she considers that your financial position may prejudice, or otherwise affect, your ability to carry out your obligations under the Agreement; and

c. may advise us if he or she considers that you are not appropriately managing Service Users personal funds.

A14.5 If the independent auditor so advises us under clause A14.4 (b), we may carry out a Quality Audit.

A15 INSURANCE

A15.1 You must have reasonable comprehensive insurance covering your business throughout the term of the Agreement or so long thereafter as required for the purposes of the Agreement. You must notify us on request of the insurance cover you have put in place. You may self-insure where you consider it to be appropriate.

A16 INDEMNITY

A16.1 You must indemnify us for all claims, damages, penalties or losses including reasonable costs (but excluding indirect or consequential losses) caused by:

a. a failure by you to comply with obligations in the Agreement; or

b. any act or omission by either of you or by any person for whom you are responsible, where that act or omission occurs in the course you performing (or failing to perform) an obligation in the Agreement.

A16.2 Clause A16.1 does not mean that you are responsible for legal liabilities caused by us, or our servants or agents, actions or omissions. Where there is joint responsibility, each of us will bear their own proportion of the liability according to the degree of responsibility involved.

A17 COMPLAINTS

A17.1 Complaints Procedure

You will enable Service Users/families/whanau and other people to make complaints through a procedure for the identification and management of complaints. This procedure will meet the Health and Disability Commissioner's Code requirements and will also ensure that:

a. the complaints procedure itself is made known to and easily understandable by consumers/families/whanau

b. all parties have the right to be heard

c. the person handling the complaint is impartial and acts fairly

d. complaints are handled at the level appropriate to the complexity or gravity of the complaint

e. any corrective action required following a complaint is undertaken

f. it sets out the various Complaints Bodies to whom complaints may be made including the Complaints Body referred to in the Agreement, and the process for doing so. Service Users/families/whanau will further be advised of their right to direct their complaint to the H&D Commissioner and to us, particularly in the event of non-resolution of a complaint

g. complaints are handled sensitively with due consideration of cultural or other values

h. Mäori Service Users and their whanau will have access to a Mäori advocate to support them during the complaints process

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i. Service Users who complain, or on whose behalf families/whanau complain, shall continue to receive Services which meet all contractual requirements

j. complaints are regularly monitored by the management of the Services and trends identified in order to improve service delivery

k. it is consistent with any complaints policy as notified by us from time to time.

A17.2 If we wish to initiate a quality audit based on any complaints we have received, we will inform you of the substance of that complaint in the notice required under clause A11.3(b).

A17.3 We will give you reasonable assistance in respect of any complaints made to any Commissioner appointed by statute, which involve both of us.

A18 WARRANTY

Each of us warrants that all material information given to the other is correct, to the best of our respective knowledge and belief.

A19 DEALING WITH ISSUES AND RISKS

A19.1 Notification of issues and risks

a. Upon becoming aware of any:

i. significant risks,

ii. significant issues (including those that could reasonably be considered to have high media or public interest), or

which materially reduce or affect, or are most likely to materially reduce or affect, the ability of either of us to meet our obligations under the Agreement, each of us will notify the other.

b. We must discuss with each other possible ways of remedying the matters notified. Discussion or attempted discussions will not limit any of either party's rights under the Agreement.

c. You will notify us in writing if an event occurs that results in the death of, or significant injury or harm to, a Service User or Service Users with your Services. Such notification will include a full description of the incident, its consequences, the remedial action taken and any further action required. You will notify us within two working days in the case of a death and within seven working days of significant injury or harm.

A20 VARIATIONS TO THE AGREEMENT

A20.1 This Agreement may be varied at any time by agreement between both of us and also on the occurrence of any of the following Variation Events:

a. Where either of us consider that changes occurring as a result of:

i. any change in law;

ii. any change in the definition of Eligible Person arising from a change in the law after the date on which this Agreement commences;

iii. requirements under the Service Agreement;

iv. significant changes in the health sector environment or costs that are beyond the control of either of us,

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will have a material impact on the provision of Services including the costs of providing Services.

b. Where an Uncontrollable Event occurs. In that case clause A21 will apply in addition to provisions of this clause.

A20.2 On the occurrence of a Variation Event, we will both identify and quantify the impact of the Variation Event and will seek expert advice, if necessary, to assist us in doing so.

A20.3 Where we both agree there is a material impact resulting from the Variation Event, both of us will then seek to agree a variation to this Agreement, which may include, without limitation:

a. Reconfiguration of any Services; or

b. Adjustment to costs of or payments in respect of any Services.

A20.4 Where both of us are unable to agree that there is a material impact, or potential material impact resulting from the Variation Event, then the matter may be referred to dispute resolution under clause A25. Where it is determined through the dispute resolution procedure that there is a material impact, or potential material impact, resulting from the Variation Event, the parties shall seek to agree a variation to the Agreement in accordance with clause A20.3.

A20.5 Each of us must negotiate in good faith to reach prompt agreement on any issues, proposed amendments or any alternative proposal.

A20.6 If neither of us can agree on any variation to the Agreement in accordance with clause A20.3 or A20.4 within 2 months of agreement under clause A20.3, or determination under clause A20.4, then either of us may terminate this Agreement by giving 6 months written notice.

A20.7 Despite anything in this Agreement to the contrary, we may vary this Agreement, on written notice, in order to give effect to a change in law or in the definition of Eligible Person arising from a change in the law from the date that change has effect.

A20.8 Any variation to this Agreement must be in writing and, except for a variation made under clause A20.7, signed by both of us.

A21 UNCONTROLLABLE EVENTS

A21.1 The person affected by an Uncontrollable Event will not be in default under the terms of the Agreement if that Uncontrollable Event causes the default. The person affected must:

a. promptly give written notice to the other specifying:

i. the cause and extent of that person's inability to perform any of the person's obligations; and

ii. the likely duration of the non-performance;

b. in the meantime take all reasonable steps to remedy or reduce the impact of the Uncontrollable Event.

A21.2 Neither of us is obliged to settle any strike, lock out or other industrial disturbance.

A21.3 Performance of any obligation affected by an Uncontrollable Event must be resumed as soon as is reasonably possible after the Uncontrollable Event ends or its impact is reduced.

A21.4 If you are unable to provide any Services as the result of an Uncontrollable Event we may make alternative arrangements suitable to us for the supply of those Services during the period that you are unable to supply them after we consult with you.

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A22 REVIEW

A22.1 A review initiated under this clause A22 must relate solely to matters applicable to the provision of disability support services nationally for the purpose of ensuring nationally consistent and nationally applicable provisions.

A22.2 Subject to compliance with clause A22.3, we may, including on your request, at any time initiate a review, for whatever reason, of:

a. the whole or any part of the Agreement 9 months from the Commencement Date of the Agreement; and/or

b. the whole or any part of a Service Schedule that forms part of this Agreement before the End Date of that Service Schedule;

by giving you 10 Working Days written notice.

A22.3 The written notice initiating a review under clause A22.2 must describe the purpose for the review, issues to be addressed and any proposals in existence at the time of the notice. Any proposals developed subsequent to the Commencement Date will be communicated to you in writing as soon as possible after they have been developed.

A22.4 Following a review initiated under this clause A22, we may propose amendments to the whole or part of the Agreement or Service Schedule. Both of us will then, in good faith, seek to agree on what amendments, if any, will be made to the Agreement or relevant Service Schedule. This clause A22.4 does not require either of us to withdraw from or compromise what either of us considers to be fundamental policy, principles, objectives or requirements arising from the Services Agreement.

A22.5 To assist us to reach such agreement, we may both agree to appoint an independent person with relevant expertise to analyse the impact, financial or otherwise, of any proposed amendment. The independent expert is to act as an expert and not as an arbitrator and their advice will not be binding. All costs associated with the appointment of the independent expert are to be shared equally between both of us or otherwise as determined by the independent expert.

A22.6 Any amendments to the Agreement or a Service Schedule that are specific to you are to be made by agreement between us. For the purposes of this clause A22, "amendments" includes, without limitation, the addition of a new provision or Service Schedule to this Agreement or the deletion of an existing provision or Service Schedule to this Agreement.

A22.7 If both of us are unable to agree on any such amendment within 3 months of the date of the written notice of the review under clause A22.2, both of us will then refer the matter in writing to our respective chief executives for discussion.

A22.8 If our respective chief executives are unable to agree on what amendments, if any, should be made to the whole or part of the Agreement or a Service Schedule within one month of the matter being referred to them, then the matter will be referred in writing to the Minister for determination. Any determination by the Minister under this clause A22.8 will be binding on both parties.

A22.9 Any amendments agreed under clauses A22.4 or A22.7 will take effect under this Agreement from a date agreed to by both of us. Any amendments determined by the Minister under clause A22.8 will take effect from the date specified by the Minister.

A22.10 Any review of the Agreement or any Service Schedule initiated by us before the Commencement Date of this Agreement will be deemed to have been initiated in accordance with clauses A22.2 and A22.3.

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A23 WE MAY REMEDY YOUR FAILURE TO MEET YOUR OBLIGATIONS

A23.1 A23.1 Where you have, in our opinion (such opinion based on reasonable grounds), committed a breach of your obligations under this Agreement you have an obligation to remedy such breach.

If such a breach, in our opinion, requires urgent action to protect the health and safety of Service Users,

we may, unless such breach is due to an Uncontrollable Event:

c. Withhold some or all of our payments to you in accordance with clause A6 until you have remedied the breach or until we are satisfied on reasonable grounds that you have taken appropriate steps to ensure that a breach of that nature will not happen again; and

d. Ourselves take action to remedy the breach, and recover the reasonable costs (including reasonable legal expenses if any) from you, including by deducting such costs and expenses from payments due under this Agreement in accordance with clause A6.1.

A23.2 You may initiate dispute resolution under clause A25 in respect of any action taken by us under this clause A23, but we are not required to delay or suspend any such action while dispute resolution is proceeding.

A24 PUBLIC STATEMENTS, ISSUES AND ADVERTISING

A24.1 Neither of us may directly or indirectly criticise the other publicly, without first discussing the matters of concern with the other.

A24.2 The discussion referred to in clause A24.1 must be carried out in good faith and in a co-operative and constructive manner.

A24.3 Nothing in this clause A24 prevents either of us from discussing any matters of concern with our respective staff, subcontractors, agents, advisers or persons to whom we are responsible.

A24.4 Neither of us may use the name or logo of the other without the prior written consent of the other.

A24.5 The provisions of this clause A24 will remain in force after the Agreement ends.

A25 DISPUTE RESOLUTION

A25.1 If either of us has any dispute with the other under this Agreement then:

a. Both of us will use our best endeavours and act in good faith to settle the dispute by agreement; and

b. If the dispute is not settled by agreement within 20 Working Days, then, unless both of us agree otherwise, either of us may (by written notice to the other) require that the dispute be submitted for mediation by a single mediator agreed by both of us, or if both of us cannot agree on a mediator, a mediator nominated by LEADR or if LEADR no longer exists or is unable to nominate a mediator, the President for the time being of the New Zealand Law Society. In the event of any such submission to mediation:

i. the mediator will not be deemed to be acting as an expert or an arbitrator;

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ii. the mediator will determine the procedure and timetable for the mediation;

iii. the cost of the mediation will be shared equally between both of us (unless otherwise agreed).

c. Subject to clause A25.3 if the dispute is not settled by mediation in accordance with clause A25.1(b), then either of us may initiate proceedings in the District Court.

A25.2 Neither of us will initiate any court proceedings during this dispute resolution process, unless proceedings are necessary for preserving the party's rights.

A25.3 Both of us will continue to comply with all our obligations in the Agreement until the dispute is resolved.

A25.4 Except where expressly provided for, this clause A25 will not apply to any dispute concerning:

a. any variation or review of any part of this Agreement; or

b. whether or not any Person is an Eligible Person.

A26 NOTICE OF FUTURE INTENTIONS

A26.1 Before the End Date of any Service Schedule if:

a. one of us does not wish to enter into a new Service Schedule for those Services when the Service Schedule ends; or

b. one of us wishes to enter into a new Service Schedule for those Services when the Service Schedule ends but on materially different terms,

that party must give a minimum of 6 months notice. Provided that if Management of Change Protocols apply in these circumstances and such protocols specify a different period, the notice period in any event shall not be less than 6 months.

A26.2 This clause does not mean either of us must enter into a contract with the other when the Agreement ends.

A27 TERMINATION OF THIS AGREEMENT

A27.1 We may terminate this Agreement by giving you notice in writing if any of the following events occur:

a. You are convicted of any dishonesty offence relating to any claim for payment from any party (not limited to us or our predecessors) whether claimed pursuant to this Agreement or otherwise; or

b. You have failed to carry out any of your obligations under this Agreement and the failure is material; or

c. You have failed to carry out any of your obligations under this Agreement, other than in relation to the completion of compliance requirements, and you do not remedy the failure within 20 Working Days of receiving notice of default from us; or

d. Clause A12.3(c) applies (which relates to non completion of compliance requirements); or

e. Clause A12.4 applies (which relates to material or repeated failure); or

f. You are placed in liquidation or a receiver is appointed.

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A27.2 For the purposes of clause A27.1(b), a material failure includes, but is not limited to, a breach of any of the following clauses:

a. Clause A11.2 (Access for Quality Audit); or

b. Clause A11.6 (Quality Audit Process).

A27.3 Termination under clause A27.1 takes effect on the day that we give you notice under that clause, or any later date specified in that notice.

A27.4 Either of us may terminate this Agreement by giving 12 weeks notice in writing to the other, unless a shorter notice period is agreed by both of us.

A27.5 If we default in any of our obligations and we fail to remedy the default within 20 Working Days of your giving us written notice of the default you may do any one or more of the following:

a. seek specific performance of the Agreement; or

b. seek damages from us; or

c. seek default interest (calculated at the bill rate plus 2 percent per annum. The bill rate means the average rate per annum (expressed as a percentage) as quoted on Reuters page BKBM (or any successor page displaying substantially the same information) under the heading "FRA" for bank accepted bills having a term of three months as fixed at 10.45 am on the date the default interest under this clause A27.5 is first payable).

A27.6 Nothing in clause A27.5 above affects any other rights you may have against us in law or equity.

A28 EFFECT OF TERMINATING THE AGREEMENT

A28.1 Immediately following termination of the Agreement:

a. We will:

i. continue making further payments to you under this Agreement in relation to services provided under clause A28.1(b)(i), except where you do not comply with your obligations under clause A28.1(b)(ii), but otherwise we will cease making payments to you under this Agreement;

ii. inform the affected Service Users and, as far as practicable, each affected Service User's family of the termination of this Agreement;

iii. where necessary, make alternative arrangements with another provider or providers to commence the provision of Services to Service Users as soon as practicable; and

b. You will:

i. continue to provide Services to each affected Service User under the terms and conditions of this Agreement until such times as the alternative arrangements we have made with another provider or providers for the provision of Services to Service Users commence;

ii. co-operate with us and our agents accordingly, including allowing us to access your Records, communicate with Service Users and, as far as practicable, supplying us with contact details for such Service Users' families.

A28.2 Where either of us has given notice in writing under clause A27.4, both of us will use our best endeavours to ensure that, where necessary, both of us have facilitated the smooth

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transition of Services to Service Users in accordance with clause A28.1(a)(ii) prior to the expiry of the 12 week period specified in the notice or as otherwise agreed between both of us.

A28.3 Any termination of this Agreement will not affect:

a. The rights or obligations of either of us that arose before this Agreement was terminated; or

b. The operation of any clauses in this Agreement that are expressed or implied to have effect after this Agreement ends.

A29 CONFIDENTIALITY

a. Except as otherwise provided in the Agreement, neither of us may disclose any Confidential Information to any other person.

b. Both of us acknowledge that the Agreement, but not any Confidential Information, may be publicly released by us through any media including electronically via the Internet.

c. Neither of us will disclose to any third party, information which will identify any individual (as defined in the Privacy Act 1993):

i. without that person's informed consent; or

ii. unless authorised by statute, or by a Code of Practice under the Privacy Act 1993 covering Health Information held by Health Agencies.

d. This clause does not apply:

i. to Confidential Information which is or becomes generally available to the public except as the result of a breach of this clause; or

ii. to Confidential Information which either of us considers, in good faith it is required by law to supply to any person but only to the extent so required; or

iii. to Confidential Information disclosed to the professional advisers of either of us, or to those involved in a Service User's clinical or care management where disclosure is reasonably necessary for that clinical or care management; or

iv. to information which either of us are required by the Agreement to disclose or forward to any person.

v. to any terms or information, which we disclose in accordance with any Services Agreement, or Crown Direction.

e. Each of us will ensure all Confidential Information is kept secure and is subject to appropriate security and user authorisation procedures and audits.

A30 MISCELLANEOUS

A30.1 Entire Agreement

The Agreement sets out the entire agreement and understanding between us and supersedes all prior oral or written agreements or arrangements relating to its subject matter.

A30.2 Governing Law

New Zealand law governs the Agreement.

A30.3 Contracts (Privity) Act 1982

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No non-party may enforce any of the provisions in the Agreement.

A30.4 Waiver

a. Any waiver by either of us must be in writing duly signed. Each waiver may only be relied on for the specific purpose for which it is given.

b. A failure of either one of us to exercise, or a delay by either one of us in exercising, any right given to it under the Agreement does not of itself mean that the right has been waived.

A30.5 Enforceability of the Agreement, and its component parts

If any provision in any of the documents listed in the Agreement Summary is lawfully held to be illegal, unenforceable or invalid, the determination will not affect the remainder of the relevant document or the Agreement, which will remain in force.

If an entire document listed in the Agreement Summary is lawfully held to be illegal, unenforceable or invalid, the determination will not affect any other documents listed in the summary or the Agreement, which will remain in force.

If any provision in any of the documents or an entire document listed in the Agreement Summary is held to be illegal, unenforceable or invalid, then we agree to take such reasonable steps or make such reasonable modifications to the provision or document as are necessary to ensure that it is made legal, enforceable or valid.

The above provisions with respect to illegality, unenforceability or invalidity are not to affect any rights validly to terminate any of the documents in the above schedule or the Agreement as a whole in accordance with the terms of the Agreement or otherwise.

A30.6 Notices

Any notice must be in writing and may be served personally or sent by security or registered mail or by facsimile transmission. All notices are to have endorsed on them the agreement reference number given to the Agreement.

A30.7 Notices given:

a. personally are served upon delivery;

b. by fastpost (other than airmail) are served three days after posting;

c. by airmail are served two days after posting;

d. by facsimile are served upon receipt of the correct answer back or receipt code.

A30.8 A notice may be given by an authorised officer, employee or agent of the party giving the notice.

A30.9 The address and facsimile number for each of us shall be as specified in the Agreement or such other address or number as is from time to time notified in writing to the other party.

A30.10 Relationship of Both of Us

Nothing in the Agreement constitutes a partnership or joint venture between both of us or makes you an employee, agent or trustee of ourselves.

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A30.11 Construction

In the Agreement:

a. "we", "us" and "our", "MoH" means HER MAJESTY THE QUEEN IN RIGHT OF HER GOVERNMENT IN NEW ZEALAND (acting by and through the Ministry of Health) including its permitted consultants, subcontractors, agents, employees and assignees (as the context permits).

b. "you" and "your" means the provider named in this agreement, including its permitted subcontractors, agents, employees and assignees (as the context permits).

c. "both of us", "each of us", "either of us" and "neither of us" refers to the parties.

d. a reference to a person includes any other entity or association recognised by law and the reverse;

e. words referring to the singular include the plural and the reverse;

f. any reference to any of the parties includes that party's executors, administrators or permitted assigns, or if a company, its successors or permitted assigns or both;

g. every thing expressed or implied in the Agreement which involves more than one person binds and benefits those people jointly and severally;

h. clause headings are for reference purposes only;

i. a reference to a statute includes:

- all regulations under that statute; and
- all amendments to that statute; and
- any statute substituting for it which incorporates any of its provisions

j. all periods of time or notice exclude the days on which they are given and include the days on which they expire;

k. Working Days – Anything required by the Agreement to be done on a day which is not a Working Day may be done on the next Working Day.

A30.12 Definitions

In this Agreement the following expressions shall have the following meanings:

Expression	Meaning
Act	The New Zealand Public Health and Disability Act 2000 .
Agreement	This Agreement including Part 1 between both of us for the provision of any Services and each schedule to that agreement or arrangement.
Agreement Summary	The summary table set out at the front of the Agreement.
Audit Protocols	Protocols that may be agreed between both of us in relation to audit of the quality of Services.
Bill Rate	The average rate per annum (expressed as a percentage) as quoted on Reuters page BKBM (or any successor page displaying substantially the same information) under the heading "FRA" for bank accepted bills having a term of three months as fixed at 10.45 am on the date Default Interest is first payable.
Commencement Date	The date the Agreement or the respective parts thereof commence as set out in the Agreement Summary.

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Commissioner	Any commissioner or ombudsman appointed by statute and having authority to deal with any complaints arising from this Agreement.
Complaints Body	Any organisation appointed: a. under the Agreement; or b. by both of us by mutual agreement; or c. by a Health Professional Authority; or d. by law to deal with complaints relating to the Services.
Confidential Information	Any information, data or know-how disclosed by us to you or vice versa, either before or during the course of the Agreement, or arising out of the operation of the Agreement: a. that is agreed by both of us as being confidential; or b. that may reasonably be considered to be confidential taking into account all the circumstances, including without limitation, the manner of and circumstances in which disclosure occurred. but excluding the terms of the Agreement.
Consult	means to comply with the following: a. Each of us must state our proposals and views to the other and carefully consider each response to them. b. Each of us must act in good faith and not predetermine any matter. c. Each of us must give the other adequate opportunity to consult any other interested party. d. The obligation of either of us to Consult will be discharged if the other refuses or fails to participate in the consultation in accordance with these requirements. e. Such consultation must take place within a reasonable time frame.
Crown	The meaning given in the Act.
Crown Direction	means any direction given under sections 32 or 33 of the Act or any regulations made thereunder.
Default Interest	means interest calculated at the Bill Rate plus two per cent per annum.
DHB	Means a District Health Board established under section 19 of the Act.
Eligible Person	Any individual who: a. is in need of the Services as determined by a DHB or DHB/Ministry of Health authorised Needs Assessment Co-ordination Service; and b. meets the essential eligibility criteria and other criteria, terms or conditions which, in accordance with the Health and Disability Services Eligibility Direction current at any time, or any other Crown Direction must

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	be satisfied before that individual may receive any Services purchased by us. The Minister will determine whether an individual is an Eligible Person if there is any dispute. "Eligible People" has a corresponding meaning.
End Date	means the date on which a Service Schedule ends as set out in the Agreement Summary.
GST	Goods and Services Tax under the Goods and Services Tax Act 1985.
Ministry of Health	Includes any of its legal successors.
Health Professional Authority	Any authority or body that is empowered under and by virtue of any enactment of law, or the rules of any body or organisation, to exercise disciplinary powers in respect of any person who is involved in the supply of Health or Disability Services, or both.
Management of Change Protocols	Such protocols as may be agreed between us relating to the management of change.
Mäori Participation	Includes the development of a relationship with local tangata whenua and if appropriate, regional tangata whenua, Mäori staff, Mäori providers, and Mäori community organisations to achieve the required Mäori input.
Minister	The Minister of Health.
Ministry	The Ministry of Health (by whatever name known) and any successor department of state and includes the Minister of Health and the Director-General of Health and any delegates of such person.
Part of a Service	means the part of a service defined by a purchase unit, or a number of purchase units, and the associated volume of services that we purchase from you, where the part of a service is substantively less than the whole service.
Part of Part 1	means other than the whole or substantively the whole of Part 1 of the Agreement.
Our Objectives	Include: a. The objectives specified in the New Zealand Disability Strategy b. To promote: i. the personal health of Eligible Persons; and ii. the care or support for those Eligible Persons who are in need of personal health services or disability support services (each as defined by the Act); and iii. the independence of those Eligible Persons with disabilities. c. To meet the relevant health strategy, disability strategy and any strategy for the development and use of nationally consistent standards, quality assurance programmes and performance monitoring

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	determined by the Minister under section 8 or section 9 of the Act.
Person	Includes a corporation, incorporated society or other body corporate, firm, government authority, partnership, trust, joint venture, association, state or agency of a state, department or Ministry of Government and a body or other organisation, in each case whether or not having a separate legal identity.
Population Served	Means communities or targeted populations of Eligible People, for whom Services are or may be provided.
Quality Audit	Audit, inspection, investigation, evaluation or review of: a. quality, b. service delivery, c. performance requirements, d. organisational quality standards, e. information standards f. organisational reporting requirements g. safety standards h. clinical standards i. standard of care Service Users receive j. compliance with any of your obligations in relation to the provision of the Services by you.
Quality Auditor	Means any person appointed by us in accordance with clause A11.5 and includes a. any person appointed by us to carry out a Quality Audit. b. any person appointed by us to investigate complaints relating to the quality of care Service Users are receiving.
Records	a. all written and electronically stored material; and b. all records and information held by you or on your behalf or by your employees, subcontractors, or agents, which are relevant to the provision of the Services.
Service Agreement	The relevant agreement within the meaning of section 25 of the Act, entered into by us.
Services	The services defined by each of the service specifications in Part 2 of this Agreement.
Service Schedules	The schedules to this Agreement.
Service Users	Users of any of the Services.
Site Visit	Attendance by a Quality Auditor at your premises.
Uncontrollable Event	An event, which is beyond the reasonable control of one of us but does not include:

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a. any risk or event which the person claiming could have prevented or overcome by taking reasonable care including having in place a reasonable risk management process; or

b. a lack of funds for any reason (other than where we have failed to make due payment).

User Part Charges	The user part charges as set out in the Service Agreement.
Variation Event	An event as set out in clause A20.1.
Washup	A funding adjustment made in terms of this Agreement, as a result of reconciliation between what is contracted for in this Agreement and what is actually provided.
Whole Service or Whole of a Service	means the whole or substantively the whole of a Service defined in each Service Schedule.
Working Day	In respect of payment due by us, means a day on which our Bank at our principal office of payment is open for business but otherwise any day other than Saturday and Sunday or a public holiday where that public holiday is relevant to the application of the particular notice or other action required.

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SECTION B: PROVIDER QUALITY SPECIFICATIONS

B1 PROVIDER QUALITY SPECIFICATIONS APPLY TO ALL SERVICES

B1.1 All Services provided by you must comply with:

a. requirements of MoH Mäori Health Policy and Strategies

b. identified needs of consumers, carers and families

c. service goals and objectives

d. parameters of activities

e. management of risks

f. any good practice guidelines endorsed by the MoH

g. professional standards and codes relevant to your service

B1.2 Non-compliance with PQS

a. If you are unable to provide any Services in accordance with these PQS you must notify us and identify the reasons for this non-compliance.

b. We may allow you to provide any Services to differing standards proposed by you where you can provide evidence to show that the safety and treatment of consumers, visitors and staff will not be materially adversely affected or materially compromised by the application of such different standards.

c. In permitting you to provide any Services in accordance with different standards, you must embark on a programme which will ensure that you comply with the PQS within a reasonable timeframe set by us.

B2 WRITTEN POLICY, PROCEDURES, PROGRAMME, PROTOCOL, GUIDELINE, INFORMATION, SYSTEM OR PLAN

Where you are required to develop a written policy, procedure, programme, protocol, guideline, information, system or plan in order to meet any specification under the Agreement, you will:

a. develop such a document

b. demonstrate systems for reviewing and updating all such documents regularly and as required by current performance or risks

c. demonstrate implementation, through documentation supported as requested through interviews with staff, consumers, and Mäori

d. demonstrate that staff are adequately informed of the content and the intent of these written documents

e. provide us with a copy of the document on request.

Any reference to written policies and procedures throughout the rest of these Provider Quality Specifications shall include the above.

B3 ALL STAFF INFORMED

You will ensure that:

a. these PQS are attached to each and every service specification contracted by us and delivered by you

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b. employees and sub-contractors are aware of your and their responsibilities for these PQS and relevant Service Specifications as they relate to services provided.

B4 QUALITY REQUIREMENTS FOR MÄORI

B4.1 Mäori Participation

To enable your Services to meet the diverse need of Mäori, you must ensure that Mäori participate in decision making at governance, management and service delivery levels and that such participation will be integrated at all levels of strategic and service planning, development and implementation within your organisation.

This will include:

a. consultation with, and involvement of, Mäori in your strategic, operational and service processes

b. development of a monitoring strategy in partnership with Mäori that reviews and evaluates whether Mäori needs are being met by your organisation, including:

i. removal of barriers to accessing your services,

ii. facilitation of the involvement of whanau and others,

iii. integration of Mäori values and beliefs, and cultural practices,

iv. availability of Mäori staff to reflect the consumer population,

v. existence, knowledge and use of referral protocols with Mäori service providers in your locality

vi. education and training of staff in the requirements of the MoH Mäori Health Policy and Strategies. Implementation of their expectations could be stated in employment contracts.

vii. education and training of staff in Mäori values and beliefs and cultural practices.

viii. support and development of a Mäori workforce.

B5 QUALITY MANAGEMENT

You are required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for consumers.

B5.1 Quality Plan

You will have a written, implemented and at least annually reviewed Quality Plan designed to improve outcomes for consumers. This plan may be integrated into your business plan. 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 your organisation and Services, and will at least include:

a. an explicit quality philosophy

b. clear quality objectives

c. quality improvement and risk management systems

d. systems for monitoring and Quality Audit compliance

e. designated organisational and staff responsibilities

f. consumer input into services and into development of the Quality Plan

g. how you will address Mäori issues including recognition of:

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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 MoH Mäori Health Policy and Strategies, and the Mäori Health Clause in the Standard Terms & Conditions

v. Mäori specific quality specifications, monitoring requirements and service specific requirements

B5.2 Employees Registration, Education and Training

a. Employees will be, where relevant, registered with the appropriate statutory body, and will hold a current statutory certificate.

b. Employees will have 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.

c. Your employment policies and practices will support professional career pathway development for Mäori health workers; Mäori service advisory positions; Mäori change management positions, and the recruitment and retention of Mäori employees at all levels of the organisation to reflect the consumer population

B5.3 Training and Supervision of Assistants and Volunteers

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

B5.4 Supervision of Trainees

Trainees will be identified and will provide services only under the supervision and direction of appropriately qualified staff.

B5.5 Service Audit

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

B5.6 Access

All eligible people will have fair, reasonable and timely access to effective Services within the terms of the Agreement. You will define and apply criteria for providing Services, including any priority or eligibility criteria agreed between us. You will manage access to services within available resources and according to those criteria. You will maintain records of people who receive services and those who do not, and the criteria by which these decisions are made.

B5.7 Service Information

Potential and current consumers, and referrers, will have access to appropriately presented information in order for eligible people to access your services. This information must be made available before any person is offered the option of private treatment. Service information may be in the form of a brochure and will include at least the following:

a. the services you offer

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b. the location of those services

c. the hours the service is available

d. when the service may be available to the person

e. how to access the service (e.g. whether a referral is required)

f. consumer rights and responsibilities including copy of H&DC Code of Rights, and Complaints Procedure

g. availability of cultural support

h. after hours or emergency contact if necessary or appropriate

i. any other important information in order for people to access your services.

This information will be presented in a manner appropriate to the communication needs of consumers and communities.

B5.8 Support for Mäori

You will facilitate support from whanau/hapu/iwi; kuia/kaumatua; rongoa practitioners; spiritual advisors; Mäori staff and others as appropriate for Mäori accessing your service.

B6 ACCEPTABILITY

B6.1 Cultural Values

You will deliver services in a culturally appropriate and competent manner, ensuring that the integrity of each consumer's culture is acknowledged and respected. You will take account of the particular needs within the community served in order that there are no barriers to access or communication, and that your services are safe for all people. You will include significant local or service specific ethnic and other cultural groups in assessing satisfaction with services. You will incorporate Mäori principles/tikanga into your organisation. These are explained further in B10.

B6.2 Services to People from Pacific Islands.

Services to people from Pacific Islands are to recognise differences especially as they relate to linguistic, cultural, social and religious practices. You must develop and maintain linkages with such key groups in your locality in order to facilitate consultation and involvement of them in planning, implementation and monitoring and review services.

B6.3 Consumer Advocates

You will inform consumers, in a manner appropriate to their communication needs, of their right to have an advocate, including to support the resolution of any complaint. You will allow advocates reasonable access to facilities, consumers, employees and information to enable them to carry out their role as an advocate. You will know of and be able to facilitate access to a Mäori advocate for consumers who require this service.

B6.4 Consumer/Family/Whanau and Referrer Input

a. You will regularly offer consumers/families/whanau and referrers the opportunity to provide feedback as a means of improving the outcomes for consumers. When you obtain feedback from consumers by means of written surveys, you will comply with the MoH Guidelines for Consumer Surveys. When requested you will make available to us the results of such surveys.

c. Consumer input will be reflected in the maintenance and improvement of quality of service, both for the individual

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consumer and across the service as a whole. You will actively seek feedback from Mäori by appropriate methods to improve organisation responsiveness to Mäori

B6.5 Consumer rights

You will comply with all aspects of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and will:

a. ensure that each consumer will receive services in a manner that complies with the code

b. make the code known and available to consumers and visitors to the Service

c. ensure staff are familiar with and observe their obligations under this Code.

B6.6 Complaints Procedure

You will enable consumers/families/whanau and other people to make complaints through a procedure for the identification and management of complaints. This procedure will meet the Health and Disability Commissioner's Code requirements and will also ensure that:

a. the complaints procedure itself is made known to and easily understandable by consumers/families/whanau

b. all parties have the right to be heard

c. the person handling the complaint is impartial and acts fairly

d. complaints are handled at the level appropriate to the complexity or gravity of the complaint

e. any corrective action required following a complaint is undertaken

f. it sets out the various Complaints Bodies to whom complaints may be made including the Complaints Body referred to in the Agreement, and the process for doing so. Consumers/families/whanau will further be advised of their right to direct their complaint to the H&D Commissioner and to the MoH, particularly in the event of non-resolution of a complaint

g. complaints are handled sensitively with due consideration of cultural or other values

h. Mäori consumers and their whanau will have access to a Mäori advocate to support them during the complaints process

i. consumers who complain, or on whose behalf families/whanau complain, shall continue to receive services which meet all contractual requirements

j. complaints are regularly monitored by the management of the service and trends identified in order to improve service delivery

k. it is consistent with any MoH complaints policy as notified from time to time.

B6.7 Personnel identification

Employees, volunteers, students or sub-contractors undertaking or observing service delivery will identify themselves to all consumers and family/whanau.

B6.8 Ethical Review

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a. You will obtain ethical review as necessary. If you conduct research and innovative procedures or treatments you will have written and implemented policies and procedures for seeking ethical review and advice from an accredited Ethics Committee in accordance with the current "National Standard for Ethics Committees".

b. You will consult with and receive approval from Mäori for any research or innovative procedures or treatments that will impact on Mäori.

B7 SAFETY AND EFFICIENCY

B7.1 General Safety Obligation

You will protect consumers, visitors and staff from exposure to avoidable/preventable risk and harm.

B7.2 Risk Management

a. You will have policies, processes and procedures for:

i. identifying key risks including risks to health and safety

ii. evaluating and prioritising those risks based on their severity, the effectiveness of any controls you have and the probability of occurrence,

iii. dealing with those risks and where possible reducing them.

iv. minimising the adverse impact of internal emergencies and external or environmental disasters on your consumers, staff and visitors.

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

vi. accident and hazard management that safeguard consumers, staff and visitors from avoidable incidents, accidents and hazards.

b. These will include definitions of incidents and accidents and will clearly outline the responsibilities of all employees, including:

i. taking immediate action

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

iii. debriefing and staff support as necessary.

B7.3 Equipment Maintained

You will ensure that equipment used is safe and maintained to comply with safety and use standards.

B7.4 Infection Control/Environmental and Hygiene Management

You will safeguard consumers, staff and visitors from infection. You will have environmental and hygiene management/infection control policies and procedures which minimise the likelihood of adverse health outcomes arising from infection for consumers, staff and visitors. These will meet any relevant profession-specific requirements and the requirements of Standard Universal Precautions Guidelines. They will include definitions and will clearly outline the responsibilities of all employees, including immediate action, reporting, monitoring, corrective action, and staff training to meet these responsibilities.

B7.5 Security

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You will safeguard consumers, employees and visitors from intrusion and associated risks. You will have written, implemented and reviewed policies and practices relating to security to ensure that buildings, equipment and drugs are secure.

B7.6 Prevention of Abuse and/or Neglect

a. You will safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment or neglect. You will have policies and procedures on preventing, detecting and removing abuse and/or neglect. These will include definitions of abuse and neglect and 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.

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

B8 EFFECTIVENESS

B8.1 Entry to service

You will manage consumer entry to your service in a timely, equitable and efficient manner, to meet assessed need.

B8.2 Care/Lifestyle Plan

You will develop for each consumer a written, up to date plan of care/lifestyle plan and/or record of treatment which:

a. is based on assessment of his/her individual needs, including cultural needs

b. includes consultation with the consumer, and,

c. where appropriate, and with the consent of the consumer, includes consultation with the consumer's family/whanau and/or caregivers

d. contains detail appropriate to the impact of the service on the consumer

e. facilitates the achievement of appropriate outcomes as defined with the consumer

f. includes plans for discharge/transfer

g. provides for referral to and co-ordination with other medical services and links with community, iwi, Mäori and other services as necessary.

B8.3 Service Provision

You will deliver to consumers services that meet their individual assessed needs, reflect current good practice, and are co-ordinated to minimise potentially harmful breaks in provision.

B8.4 Planning Discharge from the Service OR Transfer between Services

a. You will collaborate with other services to ensure consumers access all necessary services. When a consumer is transferred or discharged from your services and accesses other appropriate services they will do so without avoidable delay or interruption.

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

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i. defined employees' responsibilities for discharge planning

ii. incorporating discharge planning into the consumer's plan of care/service plan, where appropriate from or before admission

iii. full involvement of the consumer in planning discharge

iv. involvement of family/whanau, including advising them of discharge, as appropriate

v. assessment and management of any risks associated with the discharge

vi. informing the consumer on their condition, possible future course of this, any risks, emergency contacts, and how to access future treatment, care or support services

vii. where appropriate involving the original referrer and the health professional having ongoing responsibility for the consumer in planning discharge and informing them of confirmed discharge arrangements

viii. a process for monitoring that discharge planning does take place, which includes assessment of the effectiveness of the discharge planning programme.

B8.5 Where services are declined

You will have policies and procedures to manage the immediate safety of the consumer for whom entry to the service is declined and, where necessary, the safety of their immediate family/whanau and the wider community. These include:

a. applying agreed criteria for providing services

b. ensuring all diagnostic steps have been taken to identify serious problems which may require your service

c. advising the consumer and/or their family/whanau of appropriate alternative services

d. where appropriate advising the family/whanau or other current services that you have declined service

e. recording that entry has been declined, giving reasons and other relevant information

f. having in place processes for providing this information to us.

B8.6 Death/Tangihanga

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

a. immediate action

b. appropriate and culturally sensitive procedures for notification of next of kin

c. any necessary certification and documentation

d. appropriate and culturally competent arrangements, particularly to meet the special needs of Mäori, are taken into account in the care of the deceased, until responsibility is accepted by the family or a duly authorised person.

B8.7 Health Education, Disease Prevention and health advice/counselling

You will incorporate within your services, where appropriate, an emphasis on health education, disease prevention and health advice/counselling, and support the goals of The Ministry of Health Strategy "Strengthening Public Health Action" June 1997 or subsequent publications.

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B9 FACILITIES

B9.1 Accessible

You will support consumers in accessing your services by the physical design of your facilities. You will make specific provision for consumers with a mobility, sensory or communication disability available and known to consumer. You will make services available to deaf people through the provision of interpreters and devices to assist communication.

B9.2 Facilities, Maintained

You will provide services from safe, well-designed, well-equipped, hygienic and well-maintained premises.

B10 EXPLANATION OF MÄORI PRINCIPLES / TIKANGA

Wairua	**Spirit or spirituality**	A recognition that the Mäori view of spirituality is inextricably related to the wellbeing of the Mäori consumer
Aroha	**Compassionate love**	The unconditional acceptance which is the heart of care and support
Turangawaewae	**A place to stand**	The place the person calls home, where their origins are. Must be identified for all Mäori consumers who wish it
Whanaungatanga	**The extended family**	Which takes responsibility for its members and must be informed of where its member is
Tapu/Noa	**Sacred/profane**	The recognition of the cultural means of social control envisaged in tapu and noa including its implications for practices in working with Mäori consumers
Mana	**Authority, standing**	Services must recognise the mana of Mäori consumers
Manaaki	**To care for and show respect to**	Services show respect for Mäori values, traditions and aspirations
Kawa	**Protocol of the marae, land, iwi**	Determines how things are done in various circumstances. Respect for kawa is very important. If the kawa is not known the tangata whenua should be consulted

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SECTION C: INFORMATION AND REPORTING STANDARDS

C1 FORWARDING YOUR COMPLETED REPORT

C1.1 You will forward all reports as required by us under this agreement to:

The Performance Reporting Team
Sector Services
Ministry of Health
Private Bag 1942
Dunedin 9054

Ph: 03-474 8040
Fax: 03-474 8582

C2 QUALITY OF INFORMATION

You must put in place adequate numbers of trained personnel and sufficient information technology resources to meet the following quality standards with regards to the provisioning of information under this agreement.

C3 ACCURACY, CONSISTENCY AND COMPLETENESS

C3.1 The information you provide should, in all cases, be an accurate, consistent and complete representation of the facts. The information will identify any material inaccuracies or inconsistencies you know about.

C4 INFORMATION ACTION PLANS

C4.1 You will develop an agreed information action plan for your services. The information action plan will include your plans for achieving any information requirements as set out in the Service Schedules. The information action plan may be included as part of your quality plan, as required in your quality specification.

C4.2 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 NHI/ethnicity;

b. information required as a result of ACC legislation.

C4.3 You will assess your performance against the key targets and against your action plan, and report your progress to us at appropriate intervals.

C5 TIMELINESS

C5.1 Unless stated otherwise in the Service Schedule, information to be provided to us is to be provided at three monthly intervals in accordance with the timetable below.

Quarters for Reporting	Due Date for reports
1 January to 31 March	20 April
1 April to 30 June	20 July
1 July to 30 September	20 October
1 October to 31 December	20 January

C5.2 Where the Agreement begins or ends part way through a quarter, the report will be for that part of the quarter which falls within the term of the Agreement.

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C5.3 Any delays will be notified to us.

C6 READABILITY AND AVAILABILITY

C6.1 The information you provide must be made available to us in a readable format. With each information requirement for a specific piece of information, we will provide you with a template, which describes the method, medium and format must comply with.

C6.2 If no specific template is supplied by us, you will provide the information on paper as typed text or in an electronic format using file formats supported by the Microsoft Office (Word, Excel, Access) suite of desktop tools.

C6.3 Both of us may mutually agree to alternative solutions during the term of this Agreement. Such an agreement will be confirmed in writing at least one month before the alternative arrangement is implemented.

C7 DOCUMENTATION OR AUDITABILITY

C7.1 Information you provide to us must be auditable. All information you provide to us or other agencies under this agreement, must therefore be produced through a documented (information) process. This documentation will include:

a. Definition of data needed to provide information.

b. Source of the data needed to provide information.

c. Person(s) responsible for the capture of this data.

d. Description of manual and automated procedures and processes used to transform this data into the information the Provider provides.

e. Procedures that describe how the Provider accurately records client ethnicity.

f. Procedures that describe how the Provider ensures the security of information according to the Privacy Act 1993 and The Health Information Privacy Code.

C7.2 You must provide us with access to this documentation, if so requested by us.

C8 AUTHENTICITY

You must provide sufficient identification with the information sent to us, to satisfy us, or other agency receiving information from you under the Agreement, that the information received was sent by you. Unless stated differently in this agreement, this identification should as a minimum include:

a. Agreement number of the agreement the information relates to.

b. Service specification the information relates to (if applicable).

c. Identification details of the Provider contracted to provide this information.

d. Date or period the information relates to.

e. Date the information was provided.

f. Size (number of records or number of pages) of the complete report including headers and title pages.

C9 AGGREGATION

The Information you provide should comply with the detail (aggregation) requirements as specified in the service specifications. Unless agreed differently in the Agreement, we will

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require transaction details, that are event based. Each event will be represented by a combination of:

a. Date of the event

b. Subject (or patient) of the event

c. Health care provider involved in the event

d. Type of event

C10 CONTINUITY

You must take all due care to ensure that in the event of ceasing to provide the Services, your records are properly preserved and accessible by us.

C10.1 The Costs Associated with the Provision of Information

The costs associated with the provision of information under the Agreement are to be paid for by you. Unless agreed differently in the Agreement, reimbursement for these costs by us to the you is deemed to be included in the Service pricing as agreed under the Agreement.

C10.2 Ad-hoc Information requirements

a. We may request additional information from you in relation to you in general or the Services specified in the Agreement. In the request, we will detail the reasons for the request and the intended usage of the required information.

b. You will endeavour to provide us with every reasonable assistance in obtaining the required information. Both of us will agree to conditions and specifications of Ad-hoc Information Requirements in writing.

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PART 2 SERVICE SCHEDULES

This Part 2 contains each of the Service Schedules listed in the Head Agreement (Agreement Summary).

Each of the Service Schedules in Part 2 form part of the Agreement between us, as defined in the Head Agreement or in a subsequent Variation to the Head Agreement, as applicable.

Each Service Schedule contains DSS Service Type Terms and Conditions, Service Specifications, and Provider Specific Terms and Conditions associated with the Service.

The DSS Service Type Terms and Conditions set out the terms and conditions not outlined in Part 1 of the Agreement that apply to the specific type of service being purchased.

Service Specifications describe the Service, and set out quality and information reporting requirements additional to those specified in Part 1 (the Head Agreement). Note that nationally standard service descriptions may contain details (particularly Purchase Units and Reporting Requirements) which do not apply to all agreements.

The Provider Specific Terms and Conditions detail those elements of the Agreement that are unique to you. These include payment terms, term of the Service Schedule, any details which differ from Part 2 (the General Terms) and/or standard Service Specification/s (including detailed clarification of any parts of the nationally standard service description that do not apply to your agreement and a full list of relevant purchase units, volumes, prices, and reporting requirements).

Contents of each Service Schedule within Part 2

Section A DSS Service Type Terms and Conditions

Section B. Provider Specific Terms and Conditions

- B.1 Introduction
- B.2 Standard Documentation
- B.3 Purchase Units
- B.4 Payment Details.

Section C. Service Specifications

- Standard national specifications
- Additional specifications (if appropriate)

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SECTION A: DSS SERVICE TYPE TERMS AND CONDITIONS

Nil.

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SECTION B: PROVIDER SPECIFIC TERMS & CONDITIONS

B1 SERVICE DETAILS

B1.1 It is agreed that the following details apply to this Service Schedule.

Legal Entity Name	Compensation Advisory Services Ltd - LifeLinks
Legal Entity Number	230284
Agreement Number	334906/00
Agreement Commencement Date	1 October 2010
Agreement End Date	30 September 2012

B2 STANDARD DOCUMENTATION

B2.1 It is agreed that the Service Schedule includes the standard documentation in Part 2 (the General Terms), and the standard service specifications included in this Service Schedule, as amended by any changes (if any) identified below.

B2.2 It is agreed that the services will be paid for in accordance with the details given in the Payment Details below.

B3 DETAILS OF ALL PURCHASE UNITS WHICH APPLY TO THIS SERVICE SCHEDULE 1 OCTOBER 2010-30 SEPTEMBER 2012

Purchase Unit (PU ID)	Total Price excl. GST	GST Rate (%)	Payment Type
DSS1040 DSD NASC Management	$3,895,197.60	15.0	CMS
DSS1039D DSD Discretionary Funding	$474,240.00	15.0	CMS
DSS1039D Historic Individualised Funding	$220,800.00	15.0	CMS
Total price for the Service Schedule	**$4,590,237.60**		

B3.1 DETAILS OF ALL PURCHASE UNITS WHICH APPLY TO THIS SERVICE SCHEDULE 1 OCTOBER 2010-31 OCTOBER 2010

Purchase Unit (PU ID)	Total Price excl. GST	GST Rate (%)	Payment Type
DSS1040 DSD NASC Management One-off backdate July/September 2010	$4,820.79	15.0	CMS
Total price for the Service Schedule	**$4,820.79**		

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B4 PAYMENT DETAILS (CMS)

B4.1 Price

The price we will pay for the Service you provide is specified above. Note that all prices are exclusive of GST.

B4.2 Invoicing

We will pay you on the dates set out in the Payment Schedule below for the services you provide in each invoice period so long as we receive a valid GST tax invoice from you. The invoice must meet all legal requirements and must contain the following information:

a. provider name (legal entity name)

b. provider number (legal entity number)

c. provider invoice number

d. agreement number

e. purchase unit number or a description of the service being provided

f. date the invoice is due to be paid/date payment expected

g. dollar amount to be paid

h. period the service was provided

i. volume, if applicable

j. GST rate

k. GST number

If we do not receive an invoice from you by the date specified in the payment schedule below, then we will pay you within 20 days after we receive the invoice.

B4.3 Payment Schedule DSS1040 DSD NASC Management

Payments will be made by us on these dates:	On invoices received by us on or before:	For services supplied in the period:	Amount (excl GST)
22 November 2010	31 October 2010	October 2010	$162,299.90
20 December 2010	30 November 2010	November 2010	$162,299.90
20 January 2011	31 December 2010	December 2010	$162,299.90
21 February 2011	31 January 2011	January 2011	$162,299.90
21 March 2011	28 February 2011	February 2011	$162,299.90
20 April 2011	31 March 2011	March 2011	$162,299.90
20 May 2011	30 April 2011	April 2011	$162,299.90
20 June 2011	31 May 2011	May 2011	$162,299.90
20 July 2011	30 June 2011	June 2011	$162,299.90
22 August 2011	31 July 2011	July 2011	$162,299.90
20 September 2011	31 August 2011	August 2011	$162,299.90
20 October 2011	30 September 2011	September 2011	$162,299.90
21 November 2011	31 October 2011	October 2011	$162,299.90
20 December 2011	30 November 2011	November 2011	$162,299.90
20 January 2012	31 December 2011	December 2011	$162,299.90
20 February 2012	31 January 2012	January 2012	$162,299.90
20 March 2012	29 February 2012	February 2012	$162,299.90
20 April 2012	31 March 2012	March 2012	$162,299.90
21 May 2012	30 April 2012	April 2012	$162,299.90
20 June 2012	31 May 2012	May 2012	$162,299.90

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20 July 2012	30 June 2012	June 2012	$162,299.90
20 August 2012	31 July 2012	July 2012	$162,299.90
20 September 2012	31 August 2012	August 2012	$162,299.90
23 October 2012	30 September 2012	September 2012	$162,299.90
Total			**$3,895,197.60**

B4.4 Payment Schedule DSS1040 One-off payment

Payments will be made by us on these dates:	On invoices received by us on or before:	For services supplied in the period:	Amount (excl GST)
20 October 2010	10 October 2010	October 2010	$4,820.79
Total			**$4,820.79**

B4.5 Payment Schedule DSS1039D DSD Discretionary Funding

Payments will be made by us on hese dates:	On invoices received by us on or before:	For services supplied in the period:
22 November 2010	31 October 2010	October 2010
20 December 2010	30 November 2010	November 2010
20 January 2011	31 December 2010	December 2010
21 February 2011	31 January 2011	January 2011
21 March 2011	28 February 2011	February 2011
20 April 2011	31 March 2011	March 2011
20 May 2011	30 April 2011	April 2011
20 June 2011	31 May 2011	May 2011
20 July 2011	30 June 2011	June 2011
22 August 2011	31 July 2011	July 2011
20 September 2011	31 August 2011	August 2011
20 October 2011	30 September 2011	September 2011
21 November 2011	31 October 2011	October 2011
20 December 2011	30 November 2011	November 2011
20 January 2012	31 December 2011	December 2011
20 February 2012	31 January 2012	January 2012
20 March 2012	29 February 2012	February 2012
20 April 2012	31 March 2012	March 2012
21 May 2012	30 April 2012	April 2012
20 June 2012	31 May 2012	May 2012
20 July 2012	30 June 2012	June 2012
20 August 2012	31 July 2012	July 2012
20 September 2012	31 August 2012	August 2012
23 October 2012	30 September 2012	September 2012

B4.6 Payment Schedule DSS1039D Historic Individualised Funding

Payments will be made by us on hese dates:	On invoices received by us on or before:	For services supplied in the period:
27 October 2010	13 October 2010	01 October-14 October 2010
10 November 2010	27 October 2010	15 October-28 October 2010
24 November 2010	10 November 2010	29 October-11 November 2010
08 December 2010	24 November 2010	12 November-25 November 2010
22 December 2010	08 December 2010	26 November-09 December 2010
5 January 2011	20 December 2010	10 December-23 December 2010
19 January 2011	10 January 2011	24 December 2010-06 January 2011

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02 February 2011	19 January 2011	07 January-20 January 2011
16 February 2011	02 February 2011	21 January-03 February 2011
02 March 2011	16 February 2011	04 February-17 February 2011
16 March 2011	02 March 2011	18 February-03 March 2011
30 March 2011	16 March 2011	04 March-17 March 2011
13 April 2011	30 March 2011	18 March-31 March 2011
27 April 2011	13 April 2011	01 April-14 April 2011
11 May 2011	27 April 2011	15 April-28 April 2011
25 May 2011	11 May 2011	29 April-12 May 2011
08 June 2011	25 May 2011	13 May-26 May 2011
22 June 2011	08 June 2011	27 May-09 June 2011
06 July 2011	22 June 2011	10 June -23 June 2011
20 July 2011	10 July 2011	24 June-07 July 2011
04 August 2011	21 July 2011	08 July-21 July 2011
18 August 2011	03 August 2011	22 July-04 August 2011
01 September 2011	17 August 2011	05 August-18 August 2011
19 September 2011	31 August 2011	19 August-01 September 2011
29 September 2011	14 September 2011	02 September-15 September 2011
13 October 2011	28 September 2011	16 September-29 September 2011
27 October 2011	14 October 2011	30 September-13 October 2011
10 November 2011	26 October 2011	14 October-27 October 2011
21 November 2011	09 November 2011	28 October-10 November 2011
08 December 2011	23 November 2011	11 November-24 November 2011
22 December 2011	07 December 2011	25 November-08 December 2011
09 January 2012	21 December 2011	09 December-22 December 2011
19 January 2012	09 January 2012	23 December 2011-05 January 2012
02 February 2012	18 January 2012	06 January-19 January 2012
16 February 2012	01 February 2012	20 January-02 February 2012
01 March 2012	15 February 2012	03 February-16 February 2012
15 March 2012	28 February 2012	17 February-01 March 2012
29 March 2012	14 March 2012	02 March-15 March 2012
12 April 2012	28 March 2012	16 March-29 March 2012
26 April 2012	11 April 2012	30 March-12 April 2012
10 May 2012	25 April 2012	13 April-26 April 2012
24 May 2012	09 May 2012	27 April -10 May 2012
07 June 2012	23 May 2012	11 May-24 May 2012
21 June 2012	06 June 2012	25 May-07 June 2012
02 July 2012	20 June 2012	08 June-21 June 2012
19 July 2012	04 July 2012	22 June-05 July 2012
02 August 2012	18 July 2012	06 July-19 July 2012
16 August 2012	01 August 2012	20 July-02 August 2012
30 August 2012	15 August 2012	03 August-16 August 2012
13 September 2012	28 August 2012	17 August-30 August 2012
01 October 2012	12 September 2012	31 August-13 September 2012
15 October 2012	05 October 2012	14 September-30 September 2012

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SERVICE SPECIFICATION v1.1

SERVICE DESCRIPTION AND PURCHASE UNIT CODES:
DSS Needs Assessment and Service Co-ordination (DSS1040)
including Discretionary Funding (DSS1039D)

DSD PHILOSOPHY

The aim of Disability Services Directorate (DSD) of the Ministry of Health (the Ministry) is to build on the vision contained in the New Zealand Disability Strategy (NZDS) of a fully inclusive society. New Zealand will be inclusive when people with disabilities can say they live in:

'A society that highly values our lives and continually enhances our full participation.'

With this vision in mind, DSD aims to promote a person's quality of life and enable community participation and maximum independence. Services should create linkages that allow a person's needs to be addressed holistically, in an environment most appropriate to the person with disability.

Disability support services should ensure that people with disabilities have control over their own lives. Support options must be flexible, responsive and needs based. They must focus on the person and where relevant, their family and whānau, and enable people to make real decisions about their own lives.

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1. DEFINITIONS

Disabled person/ person with disability

NASC should ensure services are provided only to those disabled people who are eligible to receive them, as required by the Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand. For the purposes of this service specification a person with a disability is someone who has been identified as having a physical, intellectual, sensory disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.

Note: Subsequent references in this document to "the person" or "people" should be understood as referring to a disabled person/person with disability.

Throughout this document the term "person" is taken to include, where appropriate, family/ whānau/ aiga and/or full-time carer. When the NASC is working with a child, that child is always considered within the context of the family/whānau/ aiga.

Carer

For the purposes of this specification, a full-time carer is someone who has principle, active responsibility for the ongoing and frequent care of a person, usually on an unpaid basis and according to the above definitions.

For the purposes of this specification needs assessment or service coordination is a process provided by a Needs Assessment Service Coordination (NASC) on behalf of the Ministry of Health. This process is based on *The New Zealand Framework for Disability Service Delivery,* Ministry of Health, August 1994. Needs assessment and service coordination provides the means for a person to identify their prioritised disability support needs within the context of their own natural resources and existing supports, receive information on support options, including those which are government funded, and receive assistance with coordination of support services. NASC also manage DSS budgets for the funder.

The three key functions of NASC are:

Facilitated Needs Assessment

Needs assessment is a process of determining the current abilities, resources, goals and needs of a person and identifying which of those needs are the most important. The purpose of the process is to decide what is needed to maximise a person's independence so that they can participate as fully as possible in society, in accordance with their abilities, resources, culture and goals. A person's needs will also include, where appropriate, the needs of their family/whänau and carers; their recreational, social and personal development needs; their training and education needs; and their vocational and employment needs. This does not assume Ministry responsibility for funding of supports in relation to all of these needs, and particularly when they are the funding responsibility of other agencies.

Service Co-ordination

Service co-ordination is a process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the person and, where appropriate, their family/whänau and carers. Service co-ordination also determines which of the assessed needs can be met by government funded services and which can be met by other services, and will explore all options and linkages for addressing prioritised needs and goals.

Budget Management

The NASC manages, on behalf of the Ministry, a defined indicative budget based upon an annual allocation. Performance against the budget will be reviewed, at least, on a monthly basis by the NASC and the Ministry.

The NASC needs to ensure that people with the highest priority needs receive access to services first. The NASC must also ensure that commitments made to fund service packages for people are such that they will not exceed the indicative budget for the current and out years.

Budget management involves allocating cost effective packages of services within the indicative budget, according to the Support Package Allocation tool, and within Benchmark Indicators determined by the Ministry for the identified population for a region.

2. OBJECTIVES

2.1 General

A fundamental objective of the NASC is to maximise and support the abilities of people by facilitating a process for them to identify their needs and goals, and make decisions on how these can best be met. To achieve this objective the NASC must maintain a clear vision of NASC as the dynamic combination of a service working in partnership with people and the Ministry to achieve the best possible outcomes within the available resources.

For people with disability and full-time carers NASC is the means by which their strengths, resources and needs can be identified, their support options explored and support services accessed. In order to achieve these objectives a NASC needs to, at a minimum:

- be responsive to people and their communities
- be community focussed
- support the enhancement of the person's own natural strengths, resources and independence
- have minimal waiting times by adhering to timeframes set out in this specification.

Needs assessment and service co-ordination processes must be separated from the provision of support services. A NASC may not be the provider of support services, to ensure that no actual or perceived conflict of interest exists.

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2.2 Responding to Communities

The NASC will have mechanisms in place to gain the input of people and their communities. In line with the objectives of the Mäori Disability Action Plan, He Ratonga Tautoko I Te Hunga Haua, the input of Mäori in particular as mana whenua should also be sought. Examples of mechanisms that could appropriately demonstrate and achieve responsiveness to the community include community representation at the governance level of the provider and/or an advisory group to the NASC.

2.3 Mäori Health and Disability

The Crown Statement of Objectives outlines the Government's medium term objectives for, and expectations of, the Ministry. In response to the Crown's Objective for Mäori health and in line with its purpose statement, the Ministry has developed a Mäori Health Strategy, *He Korowai Oranga*, and a Mäori Health Action Plan, *Whakatataka*.

He Ratonga Tautoko i Te Hunga Haua, the DSD Mäori Disability Action Plan identifies four strategic goals aimed at increasing responsiveness to Mäori. The NASC is required to contribute to the implementation of *He Ratonga Tautoko i Te Hunga Haua* and the four strategic goals.

The four strategic goals are:

- Remove barriers for disabled Mäori
- Increase Mäori participation in the disability sector
- Develop effective disability services
- Work across sectors

Mauriora (positive life essence) is a key principle for Mäori with a disability as opposed to Oranga (health) as described in He Korowai Oranga. Mauriora and the four strategic goals may be achieved through the application of Tikanga (practice and process) i.e. the use of te reo, appropriate protocols, participation in Marae activities and regular whänau, hapü or Iwi initiatives.

3. SERVICE USERS

3.1 Inclusions

People eligible according to the Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand who have been assessed as having a physical, intellectual or sensory disability (or combination of these) that is likely to continue for a minimum of six months; result in reduction of independent function; and require ongoing support[1]. People with these disabilities constitute the Ministry's main client group, which largely consists of people aged under 65, many of whom have lifelong impairments.

People with physical, intellectual or sensory disability that co-exists with a personal health condition, mental health condition and/or injury, in relation to their disability support needs.

The NASC will consult with the Ministry for prior agreement in relation to people under 65 whose needs may have historically been recognised as disability-related within the parameters of the definition of disability.

[1] Although people with psychiatric disability and 'age-related' disability with support needs can be assessed for access to support services they are excluded from the Ministry's operation of the definition.

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3.2 Exclusions

- People who are covered under the Injury, Prevention, Rehabilitation and Compensation Act 2001. ACC has been responsible since 1974 for funding support services for people whose disability is caused by injury or accident[2].
- People aged 65 years and over who do not have a long term impairment (i.e physical, sensory, intellectual or cognitive disability that was acquired before the age of 65 years)
- People aged 65 years and over with a long term impairment who have been Ministry funded but who have been clinically assessed by a DHB or needs assessor as requiring age related residential care.
- People aged 50-64 years who have been assessed by a DHB or DHB needs assessor as "close in interest" to persons aged 65 years and over and whose needs would be best met by DHB integrated health and disability services.
- People who require an assessment solely as a result of a mental health need or addiction condition. These assessments are contracted for by the DHB through Mental Health Assessment Services or Community Mental Health teams.
- People who require assessment as a result of a personal health need. A personal health need is defined as when a person's level of independent function is reduced by a condition that requires ongoing supervision by a health professional.

3.3 Interface with NASC for people 65 years and over

The NASC will maintain working relationships and agreed protocols with DHB NASC working with older people.

3.4 Interface with Mental Health

For those people with a dual diagnosis, that being a co-existing mental illness and disability, the NASC will work in collaboration with the relevant Mental Health Service.

3.5 Interface with Personal Health

Following an acute illness and the completion of post-discharge care and treatment, a disabled person can be referred to a NASC for their disability support needs.

3.6 Interface with Other Agencies

Depending on the needs of the person it may be appropriate for the NASC to jointly facilitate needs assessment with other appropriate agencies.

4. SERVICE ACCESS

The NASC is expected to:

- encourage and enable the person to take an active role in the needs assessment and service co-ordination process
- ensure that there is full consideration of the person's chosen lifestyle in all aspects of the assessment and service co-ordination process
- determine with the person the appropriate level of NASC involvement. This may require full involvement by the assessment facilitator through to minimal involvement and advice where the person wants to take more responsibility for the process themselves, including accessing services which are funded or purchased outside the NASC process.

[2] Injury, Prevention, Rehabilitation and Compensation Act 2001 refers.

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Needs assessment and service co-ordination will be conducted with the person in an environment comfortable to them. The NASC will:

- provide information about the NASC service and work to ensure people, providers, GPs, other community groups and potential referrers are aware of NASC referral processes
- promote access to services by Mäori and Pacific peoples
- identify, and build into the service, strategies to overcome known barriers to access for Mäori, Pacific peoples, and other population groups with specific needs
- operate from premises that are appropriate, accessible and welcoming.
- have NASC premises open during normal business hours.

4.1 Referrals

The person may self refer to the NASC. Any other person or organisation can make referrals.

Initial contact will be made within two working days of receipt of the referral. This contact may be by phone, letter or visit. The type of contact and response will be determined by the nature of the referral i.e. urgency.

4.2 Prioritisation

The NASC will promote self-determination, quality of life and an environment that maximises community participation and independence for people. The NASC's role is to co-ordinate effective utilisation of disability support resources.

The NASC has a role in facilitating access, prioritising and allocating DSD funded resources. To achieve this the NASC will:

- acknowledge and support the person's own natural resources and existing supports
- give the person accurate information on eligibility and the limitations and boundaries of DSD funded services
- meet the safety needs of the person and community wherever possible
- promote equity for people to achieve similar outcomes for similar needs and circumstances
- work to safely reduce any disparities in equity between population and disability groups
- recognise the need for, and support access to, appropriate supports for groups with specific disability needs.
- support the continued needs based shift to supported community-based options for people previously living in institutional care or unsupported in the community
- support the continued needs based shift from service based to support based delivery
- be efficient, including creative and innovative use of resources to meet needs
- establish greater trust and credibility in the NASC process
- work within the funding and policy boundaries of the Ministry when allocating public resources.

The NASC will implement, and adhere to, consistent and transparent processes for priority setting and associated resource allocation. These processes need to adhere to the Ministry's relevant Disability Services Directorate policies and processes.

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4.3 Inter- NASC transfers

The NASC will provide service to all eligible people wherever they live, or subsequently shift to, within the NASC's specified geographic area.

The NASC will establish protocols and procedures with fellow NASC in other areas of New Zealand to ensure continuity of service for people moving into, and out of, the region. Such protocols should include but are not limited to:

- the timely transfer of relevant information including assessment, service and support planning records to the new NASC, subject to the provisions of the Health Information Privacy Code (Office of the Privacy Commissioner 1994).
- immediate commencement of services by the new NASC according to the person's transferred support plan until such time as a reassessment or review of the support plan are undertaken by the new NASC
- a process for, and agreement on, a transition plan developed by both NASC in conjunction with the person. This is particularly important in situations where different services are required and/or where particular services are not available in the new area
- a process for reporting changes to the Ministry for payment and planning purposes
- a process for temporary moves between areas e.g. for education, holiday, study. Note: In this situation the original NASC retains responsibility for ensuring that the person's disability support needs continue to be met while away and as outlined in the support plan.

5. SERVICE COMPONENTS

5.1 Screening

The NASC will ensure that it has personnel and systems in place to determine the eligibility of people being referred to the NASC using the definition of Service Users in 3.1, the functions of NASC in 1.0, and consistent also with the *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002).

The NASC will advise those who make referrals that are not appropriate to NASC and assist with information to effect appropriate on-referral.

5.2 Facilitated Needs Assessment

The role of the needs assessment facilitator is to work directly with the person to identify the person's current abilities, resources, goals and prioritised needs. The outcome of the process is a comprehensive needs assessment report. The level of detail required in the needs assessment will depend upon the situation of each person.

The objectives of the assessment process are to:

- confirm eligibility – including the nature of the person's disability, if appropriate
- work with the person to identify their current abilities, resources
- work with the person to identify prioritised needs and goals arising from their impairment
- refer to appropriate specialised assessment services including Assessment Treatment and Rehabilitation (AT&R) where appropriate.

The NASC will have a clear auditable separation in their business between the function of assessment facilitation and service co-ordination. The purpose of this separation and transparency is to demonstrate objectivity and show identification of the person's needs irrespective of resource availability.

The NASC will demonstrate that:

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- they have in place qualified and competent staff or sub-contracted assessment facilitators to provide choice of assessment facilitators and adequate coverage of the entire geographic area contracted for, including remote and rural areas
- access is facilitated to specialised assessment and/ or referral for treatment and followed up to ensure timely response from that assessor.

Outcomes of the needs assessment process may be either:

- a needs assessment is completed and service co-ordination commenced
- a needs assessment is partially completed and service co-ordination commenced to arrange access to urgent support needs
- a needs assessment is partially completed awaiting the outcome of specialised assessment

At the end of the assessment process the person, or their delegated advocate/representative, will sign off the completed assessment and receive a copy for their records.

Further information on the process and requirements for delivering facilitated needs assessment is provided in *Standards for Needs Assessment* (MOH 1994) and (MOH 1999) and *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002).

5.2.1 Cultural Component of Facilitated Needs Assessment

The purpose of the cultural component of assessment is to jointly identify, the person's cultural needs. This may include issues of social/cultural, spiritual, psychological and physical need, and strengths, assets, and support systems to assist in planning support.

The NASC will have the capacity to include a cultural component into the facilitated needs assessment process.

5.3 Specialised Assessment

The assessment facilitator may refer the person to a specialised assessor for a specialised assessment. The purpose of a specialised assessment is to obtain detailed information and knowledge to accurately assess the person's need and identify a range of possible options including treatment. Such assessments are generally funded directly by the Ministry (in most instances provided by a DHB) and will not be a charge on the NASC budget. Occasionally, in the absence of any Ministry funded specialised service, the NASC may need to access privately provided specialized assessment. Purchase of such assessments will be a charge against the budget managed by the NASC for purchase of services and must be in line with the prioritisation principles set out in section 4.2, and within available resources.

Specialised assessments include, but are not limited to, clinical, diagnostic or other assessment, the purpose of which is to:

- establish the physiological basis, extent and implications of the disability (e.g. testing, diagnosis and medical/physical prognosis)
- gain access to medical treatment and/or rehabilitation or habilitation (e.g. AT&R, corrective surgery, exercises, treatment or child development)
- determine the person's suitability for a specific service or type of assistance, including environmental support
- make recommendations on how specific needs of the individual can be met (e.g. communication support, activities of daily living (ADL), mobility assistance)
- provide advice on how support services can assist in furthering the rehabilitation process

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The NASC will also identify and facilitate access to assessors funded by other government departments e.g. education, vocational.

5.4 Service Co-ordination

The NASC is required to undertake service planning and service co-ordination, and agree a support plan with the person that indicates how prioritised needs will be met.

The service co-ordinator will ensure that, wherever possible, the person has a choice of service options, including involvement of family, community, voluntary or private (personally funded) services. The service coordinator will support and/or arrange innovative and flexible individually focussed service packages. Where appropriate services are not available the service co-ordinator and the person will consider other possible options for meeting the support needs.

Consideration of natural supports will be included in assessment and coordination processes for all people, including Hunga Haua (people with disability). Natural supports include but are not limited to friends, both outside and in service settings; immediate and extended whānau members including hapü and iwi; community activities/groups/education and courses; neighbours; workplaces.

The place of natural supports in a person's life is likely to be an important part of Mauriora. Hunga Haua should be encouraged to think about who or what these supports might be and should be supported to have contact with them, or, where no supports exist, should be supported to explore the possibilities of developing them.

Service co-ordination will:

- commence immediately following completion of the needs assessment. However, as the NASC is accountable for meeting the safety needs of the person, service co-ordination may need to commence before the completion of the assessment. Access to support services that maintain the safety and/ or dignity needs of the person should not be delayed where the completion of the needs assessment is subject to delays e.g. time involved in accessing or completing specialised assessments
- confirm financial eligibility for disability support services
- provide information to the person on all their options, including available service providers. The person should have the opportunity to choose the support service provider from whom they will receive services. The NASC will then refer the person to the chosen service provider
- develop an individualised support plan with the person, focusing on support for prioritised needs and goals
- prioritise access to publicly funded services
- ensure that the service package is cost effective, affordable and equitable and can be provided within the NASC defined budget and the Ministry's guidelines. The Ministry will work with the NASC to develop price and allocation guidelines during the course of the NASC contract
- ensure that all aspects of the package of services are co-ordinated and that services made available through the NASC budget are accessible by the person. The NASC should ensure, to the extent possible, that services provided by external agencies are co-ordinated and not duplicated.

Further information on the process and requirements for delivering service co-ordination is provided in the *Guidelines for Service Co-ordination* (MOH1995), *Standards for Service Coordination* (MOH 1999) and *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002), including the Support Allocation Tool (SPA).

5.5 Intensive Service Co-ordination

The NASC is responsible for providing intensive service co-ordination for the small number of people with high and complex needs, usually requiring the involvement of multiple providers and ongoing

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problem solving. Intensive service co-ordination requires an ongoing relationship between the person and the co-ordinator. The decision that intensive service coordination is needed will be made by the service co-ordinator following assessment.

The tasks of intensive service co-ordination include:

- negotiating the most appropriate means for achieving the desired outcomes and respective responsibilities with service providers and other sectors, for example education, justice, police, High and Complex Needs Unit MSD for children.
- arranging interim and crisis service provision pending further assessment
- involvement with specialised services e.g. Mental Health, for assessment and treatment planning, including joint needs assessment and service co-ordination for people with a dual diagnosis of intellectual disability and mental health
- convening or participating in meetings as required with the person and those involved in the development and/or implementation of a support plan
- monitoring the delivery of the support plan, review of needs and revision of the support plan at regular, specified intervals.

The NASC will:

- ensure that intensive service co-ordination is offered only to people with high and complex needs
- work with others involved in supporting the person to ensure all participants have a common understanding of the needs and goals of the person and are working together to achieve these
- regularly review the needs of the person and the purpose of intensive service co-ordination to ensure that it is appropriate.

5.6 Review and Reassessment

Review: The NASC is responsible for determining an appropriate time frame with the person to review their support package. The interval will be indicated by the person's needs and the package of supports. Generally it is expected that a person's supports will be reviewed at least annually. However, a person may at any time seek a review if the service is not meeting their needs or their eligibility has changed or expired e.g. eligibility for community services card, carer support. Review periods for people with high or complex needs or those in a crisis period may be considerably shorter.

Reassessment: Should the person's needs or circumstances undergo significant change and the support plan no longer meets their needs, a reassessment of needs will be required.

If it is likely that a person's support needs will increase or decrease over an identified period of time, a reassessment may also be required. This can be indicated when setting a timeframe for review.

The NASC will facilitate a reassessment at least every three years if the person has not been reassessed in the interim.

5.7 Crisis Response

The NASC will provide a crisis response service when required. It will have a 24 hour emergency call system available through which people, families, or carers experiencing genuine emergencies can access services such as respite care when required.

To fulfill this function the NASC will need to be able to source crisis response options.

5.8 Mäori Service Components

The NASC will recognise health as all encompassing as depicted in the Whare Tapa Wha model:

- Te Taha tinana – physical body

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- Te Taha wairua - spirit
- Te Taha whänau – the family
- Te Taha hinengaro - the mind.

The NASC will establish and implement a Mäori Service Plan that covers governance, management, organisational competencies, Mäori health and disability gain, assessment and coordination practices, and how these will contribute to improving outcomes for Mäori through the needs assessment and service coordination process.

In developing the plan the NASC will take into account the Ministry's strategic direction for Mäori health and disability. This plan should incorporate the minimum requirements for Mäori health and disability based on the Treaty of Waitangi, the Crown objectives for Mäori health and disability and any specific requirements negotiated from time to time with the Ministry.

The NASC will specify how it intends to implement this plan. In particular, the NASC will identify those services it will deliver as explicit contributions to reducing inequalities and other additional opportunities that may exist for improvements for Mäori with disabilities.

The NASC will be an Equal Employment Opportunity organisation and will ensure that they recruit, train and develop Mäori, and in so doing ensure provision of a more culturally competent service appropriate to Mäori.

The NASC will:

- have the capacity to include a cultural component in the facilitated needs assessment
- facilitate improved access for Mäori to disability support services by ensuring the equitable distribution of resources
- provide the NASC service in Te Reo Mäori where necessary or appropriate or specifically requested by the person.

The NASC is required to ensure:

- that needs assessment facilitators and service co-ordinators have a basic understanding of Mäori cultural values and beliefs, in particular Te Reo Mäori and Tikanga Mäori
- that people have access to needs assessment facilitators and service co-ordinators who have a strong understanding of the Mäori holistic concept of health (taha wairua, taha tinana, taha hinengaro and taha whänau) and are able to articulate this understanding in service implementation
- that needs assessment facilitators and service coordinators have appropriate cultural competencies and/or support from cultural experts and resources
- that people have access to kaumätua (respected elder) who can be instrumental in cultural assessment and application of tikanga
- that Mäori are offered the choice between Kaupapa Mäori services and generic services, or a combination of both
- that the NASC can demonstrate progress toward implementation of cultural competencies to be developed by the Ministry during the term of this contract.

5.9 Pacific Service Components

The Pacific Health and Disability Action Plan (the Action Plan) sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific

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and non-Pacific peoples. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders.

The Action Plan is a working document. It provides a foundation for priorities now and sets the direction for the future. The NASC is required to recognise the key principles of the Action Plan:

- dignity and the sacredness of life are integral in the delivery of health and disability services
- active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

The NASC is required to ensure:

- they can demonstrate progress toward implementation of cultural competencies to be developed by the Ministry during the term of this contract.

5.10 Other Cultures

NASC are expected to provide facilitated needs assessment and service coordination in a manner culturally appropriate for people of other cultures in their populations, including new migrants who meet eligibility criteria and people with the status of refugee. Interpreters will be engaged as necessary.

5.11 Information Management

Access to information is a vital function to support people's independence and is an integral component of the NASC business. The NASC will have the dual role of both providing information and acting as an information broker.

It is expected that the NASC will capture and store data according to specifications provided by the Ministry and will use any system, designated funded and supported by the Ministry or its agents, that is developed during the course of the contract.

The outcome of the management of information will be:

- effective service outcomes for people
- people's privacy is maintained
- efficient systems for quality, budget management and reporting
- equitable and consistent allocation of available resources.

NASC are responsible for providing and facilitating a range of information to and from a number of sources. Information managed by NASC will include:

- information about individuals e.g. needs assessment and service coordination information
- information for individuals regarding NASC processes e.g. information on NASC service users' rights and complaints processes
- information on service availability e.g. contracted providers for disability support services and occupancy information
- information for business management e.g. information for provider payment, and information for budget management

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- information on service issues including service gaps and/or boundary issues, quality issues regarding contracted providers.

5.11.1 Individual Information

Management of information on individuals is a core function of NASC. NASC must comply with the *Health Information Privacy Code* 1994.

NASC are required to work to key principles and practices under the code.
At a minimum:

Information must be

- necessary
- collected lawfully
- stored securely
- accurate, up to date, complete, and not misleading.

People must be informed

- of what information is collected
- of the purpose of collecting the information
- of and agree which agencies will receive the information collected
- how to access information kept on them
- that they have the right to correct inaccurate information about themselves

NASC should not keep personal information for longer than necessary and information should be disposed of in a secure manner.

Further information on the collection and management of personal information is provided in *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting*, (MOH 2002).

5.11.2 Disability Sector Information

NASC have the role of referring on to, and advising people and their families/whānau on, sources of further information. It is expected that general information will be readily available to the person and their family/whānau, at least, on:

- disabling conditions
- eligibility and entitlement to financial assistance, and benefit information
- details of the nature, type and quality of services available – both services accessed through NASC and services available from other sources, including how to access those services, expected outcomes and approximate costs of services
- referral paths for people who are not eligible for DSD funded support services but have support needs e.g. medical conditions which result in long term support needs
- other agencies where further specific and detailed information may be obtained regarding their impairment.

The NASC is not expected to compile and duplicate specific detailed information already available from other disability information agencies in their area. However the NASC will maintain effective networks and linkages with a wide range of appropriate organisations resulting in current, reliable information from which to advise and make referrals.

The Ministry considers it important that people:

- are supported through the process by having relevant information

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- have a co-ordinated and comprehensive method for accessing information.

5.11.3 Provider Information

The NASC will provide support services with sufficient information to enable them to provide service to people referred to them. To ensure this happens NASC must provide the minimum information detailed in *Support Needs Assessment & Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (MOH 2002), consistent with the requirements of the *Health Information Code* (Office of the Privacy Commissioner 1994).

Additionally, NASC must have Memoranda of Understanding with providers to cover such things as:

- specifying what information is to be provided by NASC
- timeframes in response to service requests
- timeframes for notification of a change to people's service, change in service levels, and/or the amount of service
- processes for passing on information regarding a change in need of a person.

This includes the transfer of personal and service information that may be used by support service providers as they plan their services e.g. information on unmet needs and service gaps etc.

As part of maintaining effective networks the NASC will provide information to other disability support service providers on trends, unmet needs etc, for the purpose of fostering creative, innovative, flexible services.

5.12 Monitoring of Support Service Delivery

The NASC will report quarterly to the Ministry on service delivery by support service providers contracted by the Ministry. It is expected that the NASC will implement a process of monitoring:

- negotiated and actual delivery timeframes
- actual delivery of the support plan as negotiated between the NASC and support service provider
- whether services being delivered are able to meet the needs of the person. The NASC might comment on the willingness of the service provider to understand the person's needs and be flexible, within reason, on how these are met
- gaps in services available from providers, particularly services that are being purchased in significant volumes outside of Ministry contracted providers (using discretionary funding for example). The Ministry will meet with the NASC at least annually to jointly plan the possible development by the Ministry of services to fill the identified gaps
- any unresolved issues, problems or complaints and significant risks with service delivery by contracted providers.

The NASC will report to the Ministry any major risk or complaint within 24 hours of it occurring. The NASC is responsible for ensuring the quality of services purchased from their discretionary budget. Further details on this requirement are in Appendix 3 "Requirements for NASC Discretionary Funding".

5.13 Reviews

The NASC will make available to all people information detailing the procedure by which people may request a review of the outcome of a part, or the whole, of the assessment or service co-ordination process. Such procedures are to include the following elements:

- ability to screen out, or resolve through discussion, complaints arising from misunderstandings

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- further assessment or a new support plan using assessment facilitators or staff members not involved in the previous assessment
- access to a second level of review within the NASC if the person remains dissatisfied

The NASC is required to ensure

- that the protocol for these Reviews, as included in the NASC Managers' Manual (2005), is known, consistently applied and monitored.

The above steps will be at the NASC's expense. If a complaint still exists, the Ministry may be requested to provide further review. The standard review procedure provided by the Ministry at that time will be followed.

5.14 Budget Management
The requirements for budget management are contained in Appendix 1, which forms part of this service specification.

5.15 Payment Processes and HealthPAC
The requirements for payment processes relating to HealthPAC are contained in Appendix 2, which forms part of this service specification.

5.16 Discretionary Funding
The requirements for Discretionary Funding are contained in Appendix 3, which forms part of this service specification.

5.17 Individualised Funding
The requirements for Individualised Funding are contained in Appendix 4 which forms part of this service specification.

5.18 Key Inputs
The NASC will:

- provide staff with the competence and confidence to professionally undertake the separate roles of needs assessment facilitation and service coordination
- be an Equal Employment Opportunity organisation
- provide for the cultural aspects of the NASC Service Components
- fulfill the responsibilities of budget management
- have systems to provide access to the NASC service, fulfill the quality, information and monitoring requirements of this specification, and maintain records and reporting.

The NASC will ensure that staff are supported to develop and maintain competence and undertake formal training and qualifications as they are developed.

6. SERVICE LINKAGES

The NASC will develop and maintain effective relationships with other organisations providing services to people. These relationships will reflect the population profile served and their communities and will include community organisations, voluntary groups, support service providers and other public sector agencies. These will include, but not be limited to, Environmental Support Services within DSS; and Child, Youth and Family (CYF); Group Special Education (GSE); Housing New Zealand Corporation; Work and Income.

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The Ministry will require the NASC to demonstrate effectiveness of relationships. For key agencies or providers the NASC should have in place Memoranda of Understanding, protocols and other liaison mechanisms that agree how the relationship will be conducted. These will be subject to audit.

The NASC will demonstrate effective linkages with the disability community (e.g. disability groups, support networks, advocacy), and Mäori and Pacific peoples' groups. Relationships will be managed with regard to the interrelationships that exist between people, their networks and social support systems.

In relation to Hunga Haua these need also to include, but not be limited to, Marae, Kohanga Reo and Kura Kaupapa Mäori; local Mäori disability, health and social service networks, including local and regional services; primary health care providers, including Marae based and Primary Health Organisations; and Te Puni Kokiri, as appropriate. All linkages must enable, support and promote Whänau ora (healthy families) and Mauriora perspectives, responsiveness to individual need and respect for the rights and opinions of the Hunga Haua.

7. SERVICE EXCLUSIONS

NASC services for people excluded under the Service User criteria, are not provided under this specification.

8. QUALITY REQUIREMENTS

The service is required to comply with the Ministry General Contract Terms and Conditions. In addition, the following quality standards and requirements also apply.

8.1 Quality Standards

National Health & Disability Sector Standards

Only specific parts of the Health and Disability Sector Standards (HDSS) are relevant to NASCs. All NASCs are required to meet the standards and criteria to be identified in the HDSS.

It is envisaged that NASC will work towards compliance with the HDSS over time. Until such time as a NASC is fully compliant it must meet the Provider Quality Specifications in this contract. Once it is compliant with the HDSS, or by 30 September 2006, the Provider Quality Specifications will be overridden by the HDSS.

a. Needs Assessment Standards (HFA 1999)
b. Service Co-ordination Standards (HFA 1999)
c. Standards for NASC Organisations (HFA 1999)

8.2 Quality Requirements

8.2.1 Access

Timeframes

First contact with the person will be made within two working days of receipt of the referral or enquiry on behalf of the person.

Time to complete needs assessment should be:

- following acknowledgement of referral in the remaining 20% of cases within 24 hours in a crisis where a person's safety is at risk

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- within 24 – 48 hours for urgent referrals, depending on the degree of urgency
- within 5 working days following acknowledgement of referral in 40% of cases
- within 14 working days following acknowledgement of referral in 40% of cases
- within 20 working days

Time to complete service co-ordination should be:

- within 10 working days of the completion of the needs assessment in 80% of cases
- within 20 working days of the completion of the needs assessment in the remaining 20% of cases.

Note: It is anticipated that in the majority of situations partial completion of needs assessment and service co-ordination will progress to the point where immediate support needs are clearly identified and services put in place within 14 working days of first contact. Service co-ordination in this context refers to the development of a support plan and arranging access to services. It is recognised that the full service co-ordination role may extend over a much longer period as services are reviewed, and adjusted to meet the needs of the person. The intent of the time lines for completion of service co-ordination is to ensure that access to available services occurs in a timely manner once needs and goals have been identified.

Information will be transferred to another NASC within five working days of the transfer request being received.

8.2.2 Person/ Family/ Whānau/ Aiga Involvement

The person, family/whānau/aiga members, support workers and advocates should be central to service delivery. This requires:

- the person be given a choice of who is involved in their needs assessment and service coordination processes
- the person, family/whānau/aiga members, support workers and advocates be provided information on how they can be involved in the needs assessment and service coordination processes
- the person, family/whānau/aiga members, support workers and advocates be notified of complaint procedures
- the family/whānau/aiga is involved in a culturally appropriate manner.

8.2.3 Acceptability

Acceptability of services will be monitored on an ongoing basis. This monitoring will use a range of methods to gather this information on the acceptability of services provided. All surveys will follow the guidelines for consumer surveys contained in the NASC managers' manual, 2005. The methods used will identify the acceptability of, at least, the following areas of service as indicated by the person, support service providers, support staff, family/whānau and the person's advocates:

- information distribution
- staff professionalism
- staff cultural sensitivity
- staff communication skills
- respect for privacy

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- rights of the consumer
- level of choice
- informed consent
- participation in community-based activities
- ease of use of NASC's services
- reduction of barriers that enable easier access to the NASC 's services
- complaint and feedback systems.

8.2.4 Safety

The NASC will have documented operational programmes/policies/protocols and guidelines that identify and minimise risk areas for the NASC. The use of these systems is to be included as part of the NASC Quality Improvement system. These areas must include, but are not limited to:

- abuse incidents, policy, protocols for response and reporting
- poor service delivery identification and how this will be reported to the Ministry
- service gap identification and how this is reported to the Ministry
- protocols if support service provider withdraws services to people and reporting this to the Ministry.

8.2.5 Reporting Change

The NASC is required to advise the Ministry of any significant change in the organisational structure or capability of the NASC, and of any other matters significantly affecting, or likely to affect, NASC function and quality.

9. PURCHASE UNITS

The service will be purchased for the eligible population of the region of coverage for a contract price.

PU Code	PU Description
DSS1040	Needs Assessment & Service Co-ordination
DSS1039D	Discretionary Funding

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10. REPORTING REQUIREMENTS

Note: Rather than include other reports on a monthly basis, the Ministry may, from time to time, seek exception reporting of the NASC.

10.1 Monthly Reports

PU Code	PU Description	PU Measure	Reporting Requirements	
			Frequency	Reporting Units
DSS1040	DSS Needs Assessment		Monthly	*Quantitative Reporting* 1. Number of Assessments by: • New clients* • Client transfer • Receiving service but no prior assessment • Re-entry after break • Total of above 2. Number of reassessments* 3. Number of people waiting for first assessment 4. Number of people waiting for a reassessment
DSS1040	DSS Service Co-ordination		Monthly	5. Number of people waiting for service co-ordination 6. Number of service reviews completed 7. Number of people waiting for a service review* 8. Number of requests for a service review following allocations
DSS1039D	DSS Discretionary Funding		Monthly	9. Number of service users receiving support options through discretionary funding *Narrative Reporting* 1. Excel Template Report** as per DSD format to form part of overall Narrative Report Further Narrative Report outlining: 2. How spend relates to service gap/unmet need 3. Issues/Concerns/Risk by: • Description • Action Taken/Solution Sought

***Glossary of Terms**

Term	Definition
New Client	A person this NASC has never assessed before
Reassessment	The needs/circumstances of an existing client have changed. Therefore reassessment of current support needs is required
Review	A review of current allocation of supports and services

** Excel format template supplied by DSD entitled "Base NASC DF Template". This is to be submitted as part of your monthly narrative report to HealthPAC and to the Agreement Manager.

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10.2 Quarterly Reports

In addition to above, a qualitative report is required on a quarterly basis, to be attached to your monitoring template.

PU Code	PU Description	PU Measure	Reporting Requirements	
			Frequency	Reporting Units
DSS1039	DSS Service Co-ordination		Quarterly	*Narrative Reporting* A written report which meets the requirements of: • Monitoring of Support Service Delivery (5.12); • Mäori Service Components (5.8); and includes at least • updates and trends in unmet needs and service gaps, including for Mäori, Pacific and other populations; • allocation patterns; • quality initiatives and risk management; • complaints, • issues, including any equity issues.

This information should be supplied within seven days after the end of each period, using the Ministry template format. Delays beyond this date will be notified to the Agreement Manager.

Where the agreement begins or ends part way through a period the report will be for that part of the period that falls within the term of the agreement.

You shall forward your completed Performance Monitoring Returns to:

Healthpac_m@moh.govt.nz

The Performance Reporting Team
Sector Services
Ministry of Health
Private Bag 1942
Dunedin 9054
or

The Performance Reporting Team
Sector Services
Ministry of Health
229 Moray Place
Dunedin 9016

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Note: When forwarding completed Performance Monitoring Returns electronically, please cc the Ministry of Health Agreement Manager noted on the front of this contract.

11. SPECIFIC REQUIREMENTS

11.1 Legislation

The NASC will be required, under the terms of the contract, to abide by all relevant New Zealand Legislation.

11.2 Policy

The NASC will be required to abide by all relevant Policy including, but not limited to:

- The New Zealand Framework for Disability Service Delivery - August 1994, Ministry of Health
- Standards for Needs Assessment for People with Disabilities – June 1994, Ministry of Health
- Guidelines for Service Co-ordination for People with Disabilities – February 1995, Ministry of Health
- He Korowai Oranga, 2002
- DSD Policy/Process to follow when Out of Home Placement may be necessary for Children and Young People with Disabilities", 2004.

11.3 Agreements

The NASC will observe:

- Memorandum of Understanding between the Ministry and CYF - 2000 (and revised version during term of this contract)
- Ministry of Education accredited therapy providers protocols agreed between the Ministry of Health/Ministry of Education, 1999

The provider will also observe other protocols and/or Memorandum's of Understanding negotiated between the Ministry and other government departments or agencies.

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Appendix 1 – BUDGET MANAGEMENT

A1.1 The NASC is required to:

- manage and maintain data on the NASC's Portfolio to make sure that the Client Claim Processing System (CCPS) accurately reflects the disability group and that the funder is correctly assigned to the Portfolio
- monitor and manage the utilisation levels of services
- promote consistent and equitable service coordination outcomes for people. This means using the Service Allocation Tool (SPA Tool) and allocating average levels of service to the client population consistent with Benchmark Indicators
- project/forecast future costs and planning for this within indicative budget
- provide clear processes for appeal review of packages including use of current Ministry review panel processes for complex and high cost support packages
- identify to the Ministry cost effective and appropriate solutions to supporting the needs of their population/sub-populations.
- ensure all requirements and guidelines are followed, including, but not restricted to:
  - *Support Needs Assessment and Service Coordination Policy, Procedure and Information Reporting*, 2002
  - NASC Managers' Manual, 2005
  - Discretionary funding requirements
  - Supported independent living specification and guidelines
  - Intensive service co-ordination guidelines
  - SPA tool, or its equivalent as determined by the Ministry, is known to all NASC staff, adhered to, and appropriate application is evidenced and monitored to ensure equitable and nationally consistent access to support services
  - mandatory letters to service users provided by the Ministry
  - meeting regularly with the Ministry.

A1.2 To assist the NASC with budget management the Ministry will provide NASC with the following tools:

- an annual indicative budget
- access to CCPS
- reports on service utilisation and service allocations including trend reports
- reports on the Client Portfolio and status and history of the service user
- population service indicators
- access to a moderation and review panel for people with complex needs and high cost packages
- a schedule of providers contracted by the Ministry, details of the services contracted, contracted rates or pricing models such as the Allocation Resource (ART) Tool, with update of these from time to time as contracts are varied and/or renewed

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and will meet regularly with the NASC manager.

A1.3 In managing the budget the NASC will need to take into account the following factors:

- people's needs may increase over time and they may seek more services at greater cost. Changing demographics e.g. the increase in the age of the population
- cessation rates from services due to improvement in condition (effective outcome of rehabilitation or treatment), service exit, death, etc
- crisis events will occur for people and they may then require immediate extra support
- any factors that may lead to an increased number of referrals to the NASC e.g. pressure from other funders to fund support for people or increased referrals from agencies where people may no longer be eligible e.g. CYF and/or SES.
- price increases agreed to by the Ministry. Projects managed by the Ministry that may directly or indirectly result in higher costs e.g. the move to more appropriate services for younger people who reside in aged residential care

A1.4 In order to manage these factors the NASC will need to adopt strategies and procedures, such as, but not limited to:

- prioritising needs and providing services so that people with the highest needs receive support first. Protocols and processes for prioritising need will be established in conjunction with the Ministry to ensure consistency of approach by NASCs
- allocating support packages for the disability population of the region consistent with the population service indicators
- managing boundary and other eligibility issues so that the Ministry is paying for only those supports for which they are responsible
- identifying situations where reassessment could result in lower cost through use of creative service packages where appropriate
- identifying situations where rehabilitation, access to treatment or other specialised services could result in lower service packages
- maintaining a crisis pool of resource for emergency service demands. The Ministry will discuss and review this crisis pool with the NASC quarterly.

The Ministry will assist with forecasting by providing relevant information on demographic trends and other information to input into trend analysis. The Ministry will develop with the NASC allocation guidelines according to clients' support needs level.

A1.5 The NASC is required to ensure all supports/services are funded by the appropriate funder. It is expected that the NASC will observe, where they exist, Memoranda of Understanding between the Ministry and other government funders and agencies e.g. ACC, SES, CYFS and Work and Income. The NASC will also have in place protocols defining areas of responsibility for providing access to support services with other providers, including the DHB.

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APPENDIX 2 - PAYMENT and HEALTHPAC PROCESSES

A2.1 General

An important function of the NASC is to supply information to HealthPAC so that providers can be paid through the Client Claim Processing System (CCPS). The information transmitted must be complete, accurate and timely.

The NASC must use the correct forms, both electronic and manual, for sending information to HealthPAC. For paper forms the NASC must use the stamp provided for completing the NASC organisation's name. HealthPAC will send back to the NASC any forms that are not completed correctly.

A2.2 Eligibility load into CCPS and Provider invoice rejections

NASC have the responsibility of ensuring that legitimate claims are not rejected, and to ensure that legitimate claims that have been rejected are rectified in a timely way. Specifically the NASC must:

- have a data quality rate higher than 95% i.e. the NASC's data feed should not have rejections greater than 5% for any given period
- send to HealthPAC assessment data within five business days from the service coordination completion date
- process 80% of invoice rejections referred by non residential service providers within 10 business days i.e. NASC's must submit to HealthPAC the correct assessment details to allow the non residential invoice claim to process in the next invoicing period
- process 100% of invoice rejections referred by non residential services providers, these corrected assessments must be received by HealthPAC within four weeks of the original invoice rejection notification issued by HealthPAC being received by the NASC.

It is important for NASC to manage legitimate claims that have been rejected. Failure to do this creates unnecessary work for Home Based Support Service (HBSS) providers, other providers, NASC, and the Ministry.

Invoice rejections are caused because the HBSS provider has

- made a claim that they have not been authorised for, or
- made a legitimate claim but the NASC authorisation has not been processed in CCPS

On any occasion that the NASC is unable to fix a legitimate invoice rejection the NASC must notify HealthPAC, with a copy to the Ministry Service Manager, of any data issues that prevents the NASC from meeting these targets.

The Ministry will provide NASC with access to invoice and eligibility data stored in CCPS to assist with the management of invoice rejections. The Ministry will also provide monthly reports on NASC and HBSS provider rejections.

A2.3 Client Portfolio

The list of eligible persons is central to the NASC budget management system. The Ministry will provide the NASC with the list of their eligible persons.

The NASC must check their list each month to ensure that the list reflects:

- new people who entered their service

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- people who have exited their service
- the correct funder.

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Appendix 3 - REQUIREMENTS FOR NASC DISCRETIONARY FUNDING

A3.1 BACKGROUND

This appendix is to be read in conjunction with the Ministry of Health's (the Ministry) Needs Assessment Service Co-ordination (NASC) Service Specification. All the requirements of the base service specification apply with regard to the implementation of discretionary funding, in particular with respect to a person's eligibility for service.

A3.2 DEFINITION

The Ministry is responsible for funding a range of services for people with a disability. These are outlined in the Service Coverage document and include services such as needs assessment and service co-ordination, information services, household assistance, personal care, carer support, short and long-term residential care, rehabilitation and environmental support services.

In the majority of situations, most people's needs will be able to be successfully met through the standard range of services funded directly through the Ministry.

However, the Ministry notes that there may be occasions when an individual's needs are not able to be met through the Ministry's directly contracted services and therefore may require access to other support options tailored to meet an individual's needs.

Therefore, the Ministry has supported the development of discretionary funding arrangements through NASC as a way of providing more flexible and innovative supports to meet the needs of a small number of people. A person can be in receipt of Ministry contracted services and/or discretionary funding support.

A3.3 OBJECTIVES

The original purpose of discretionary funding was to enable NASC to be more innovative and flexible in developing support packages that could meet a person's identified needs. Thus, achieving better outcomes for the person that might not have been possible through traditional Disability Services Directorate (DSD) services. To be able to achieve this the NASC is expected to engage the services of other organisations to provide these supports. Dependent on the situation, these supports would usually either be one-off, or, in a limited number of cases, may be on an ongoing basis for a set length of time.

The NASC will not directly provide flexible support services to people, but will engage other parties to do so. The NASC will facilitate the provision of this support.

The Ministry notes that in the past it has allowed the development of direct payments, self-managing contracts or individualised hosting for individual clients. However, the Ministry has introduced a moratorium on these supports. As this is still in place, NASC are unable to offer these options to any new people entering NASC services. The development of a national Individualised Funding Agency will mean all such packages will be managed by this new agency in the future.

A3.4 OUTCOMES

Discretionary funding will complement the natural supports and existing resources that the client may have access to by:

- enabling Marae based and/or cultural activities to enhance participation
- resourcing creative solutions that achieve desired outcomes
- developing solutions to meet identified service gaps of Ministry contracted services

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- tailoring service packages to meet unique individual support needs
- enhancement of the service users autonomy, control and self reliance
- integration of the person into community life, in accordance with each person's needs agreed through the needs assessment and service coordination process.

A3.5 EXCLUSIONS

Flexible service options do not include:

- provision of service that is the responsibility of other funders and agencies such as the DHB, ACC, Child Youth & Family, Education and Work and Income.
- reimbursement of payments for services that require a user charge
- provision of services/supports already purchased though other DSD contractual arrangements such as environmental support, residential care, home based support services or supported independent living, including services which are capacity funded.

A3.6 SERVICE COMPONENTS

The Ministry will advise each NASC of its budget for discretionary funding and each NASC is expected to stay within these budget allocations.

A3.6.1 Discretionary Funding
NASC are required to work with individual and groups of providers in their area to provide information on the unmet need with a view to facilitating new service developments to respond to that need. Particular effort should be made to develop services in keeping with stated Ministry targets and priority areas.

The NASC may have sub-contractors provide goods and services through its discretionary funding budget (in accordance with Ministry policy or frameworks). The NASC remains liable for ensuring that all sub contracts are in place and responsibilities are met including regular review of these contracts and the actual service provision.

NASC must ensure the service provision meets all Ministry requirements.

NASC must have contracting, accounting and payment policies and processes for the utilisation of discretionary funding.

A3.6.2 Quality Requirements
The Ministry's expectations are that any sub-contract set up through a NASC will reflect the same level of quality as outlined in all Ministry contracts.

NASC should ensure that they do not enter into sub-contractual arrangements that expose themselves, and therefore the Ministry, to any unnecessary service quality risks.

A3.6.3 Essential requirements for NASC Entering into Sub- Contracts with Service Providers, utilising Discretionary Funding
Arrangements between the NASC and provider for discretionary funded support (other than providers already directly contracted by the Ministry) will be documented in a written agreement between the two parties.

The NASCs will ensure that agreements with providers clearly specify:

- the services/support to be provided
- the roles and responsibilities of both parties
- price and volume

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- the Ministry's access to premises and records
- any specific quality standards
- term of agreement (up to 12 months maximum)
- start date and end date for the provision of the service
- any review dates of the service
- information and reporting requirements
- method of payment
- dispute and termination processes
- the Ministry's right of veto of agreements which do not meet requirements specified in this agreement

A3.6.4Limitations on sub-contracting arrangements with providers
NASC must not enter into agreements:

- that make payment at a rate which compromises the provision of the specified quality of support i.e. rate must be realistic
- with rest homes or hospitals which do not have a current contract with the Ministry for the provision of residential support services
- with organisations that are business partners of the NASCs (without the express agreement of the Ministry)
- where the proposed service is estimated to cost greater than **$10,000** per annum without the specific prior agreement of the Ministry. In this instance the NASC needs to work with the Ministry with a view to trying to establish a direct contract between the provider and the Ministry
- with individual providers for provision of discretionary support options i.e. as an employee of the NASC. The NASC must ensure that providers who are individuals are legitimately classified and treated as self-employed (Employment Relations Act 2000)

The Ministry retains the right to veto agreements entered into by the NASC, particularly in the event the requirements specified in this Schedule have not been adhered to.

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A3.7 REPORTING

The NASC will provide a narrative report monthly to HealthPAC and DSD Service Manager (via email using Ministry provided template format) detailing:

- types of support provided
- number of contracts with prices.

Written comment should also be provided on:

- how spend relates to service gap/unmet need

A3.8 INVOICING

The NASC is required to submit an invoice to the Ministry on a monthly basis for the actual amount spent on discretionary funding. The NASC is to attach a schedule detailing:

- the names of sub-contracted provider organisations
- amount spent per provider

- number of people on Direct Payments (should be those under grandparented arrangements only)
- amount spent per person by NHI number
- service purchased with discretionary funding
- provider name who conducted the service
- service description

A3.8 SPECIFIC REQUIREMENTS

Any service costing over $1000 at any one time or that is proposed on an ongoing basis (more than 12 months) must be agreed in writing by the Ministry service manager.

NASC will observe the *Support Needs Assessment and Service Coordination Policy and Procedure Information Reporting Guidelines*, MOH 2002.

A3.9 GUIDELINES

The NASC will observe the following guidelines:

- to ensure NASC understand discretionary options information requirements
- to ensure that discretionary options are used well and aligned with the intent of the Ministry
- to provide support to NASC in their use of discretionary options
- to ensure that NASC are aware of the responsibilities of the Ministry and how they impact on the decisions
- to provide information that enables NASC to use discretionary funding appropriately.

A3.10 NASC Responsibilities
There is a balance between managing responsibilities and creating an environment that enables service co-ordinators to be flexible and innovative in their use of resources. Where a NASC is not sure that a solution is appropriate then they should contact the Ministry for advice.

There are three key responsibilities that the Ministry needs to consider as it carries out its business that are relevant to NASC when considering using discretionary funding.

A3.10.1 The Funding Agreement between the Ministry and Crown
DSD receives funds to purchase disability support services to meet the needs of the eligible population. Other government departments, of course, receive funds to purchase and meet a range of other needs e.g. Education, MSD. A NASC is not expected to purchase solutions that are the responsibility of another funder, although solutions may complement the services of another funder, e.g. after school care.

For most services there needs to be a level of prioritisation, with highest needs being met first. Discretionary funding should not be used to avoid or shortcut processes and criteria for accessing existing disability-contracted services. However if all other options have been exhausted, it may be used to purchase intermediate solutions e.g. while a client waits for a residential support service.

The Ministry is required to assure the quality of services provided. Where the NASC is contracting directly for provision of a service, then the contract should specify quality requirements.

A3.10.2 The DSD Framework
The auditable boundaries separating needs assessment and service coordination purchasing and service provision should be maintained. This means that NASC are not expected to provide services, and therefore must ensure that they do not engage in activities that would usually be carried out by providers i.e the recruitment of suitable carers for individuals. Where the parent company of a NASC is also a service provider, the NASC will need the approval of the Ministry before they can contract with the parent or one of its subsidiaries.

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NASC and the Ministry need to be aware of all legislative obligations in relation to use of Discretionary Funding, for example that particular arrangements are not anti competitive or restrict trade practice.

A3.10.3 Process
The NASC is required to:

- determine that all available contracted support options have been explored
- determine that the discretionary funded option(s) is the most appropriate option for the individual
- identify the solution, ensure that it is acceptable to the person and will meet identified goals and outcomes sought
- ensure that the solution will not put the person or carer in any greater risk than other available support options
- ensure that the NASC Manager has signed-off the discretionary funding proposal and sent this onto the Ministry for approval if necessary (i.e where the cost is over $1000 or is on-going)
- ensure all internal and Ministry requirements relating to the process, delegated authorities and approvals have been followed.

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APPENDIX 4 - INDIVIDUALISED FUNDING

Individualised Funding (IF) is a means of enabling some people with disability to manage their own needs assessed budgets and employ their own support staff.

A two year national programme is underway to introduce IF. During 2005-2006 eligibility and suitability for the scheme will be determined through facilitated needs assessment by the NASC in accordance with the eligibility criteria and other regulations operated by the Individualised Funding Agency (IFA) for the scheme. Individual people considered eligible, competent and confident to manage their own budgets will be referred on to the IFA by the NASC. The IFA will then make administrative and other support arrangements necessary to enable budget holders to manage their budgets successfully.

NASC and the IFA will be required to sign a Memorandum of Understanding that clearly describes the scope of their joint and individual responsibilities to each other, the scheme and to the budget holders.

It needs to be noted that initially only those people currently on a form of IF will be assessed for the new programme and this will occur on a region by region basis as the new agency is set up. It will take some time to work through all the current people and the IF agency will liaise with each NASC around timeframes for their area. No new referrals will be accepted until current assessments have been completed.

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NASC DISCRETIONARY SUB-REPORTING TEMPLATE

This template is to be completed and submitted as part of your contractual narrative reporting.

It should be emailed at the time your Reporting is submitted to HealthPAC Dunedin, and/or submitted in writing. Please copy to the Agreement Manager responsible for this agreement.

Service User NHI	Disability	Service Purchased	Service Detail	Provider	Payment Amt (Month)	Payment Detail		Start Date	End Date	Type
						Price Per Unit	Unit Measure			

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Disability Support Services

Tier Two Service Specification

Purchase Unit Name: Supported Living Services
Purchase Unit Code: DSSL2620

1. Introduction

New Zealand is a signatory to the United Nations Convention on the Rights of Persons with Disabilities. Whaikaha – Ministry of Disabled People ("the Ministry") supports the objectives of the Convention.

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, the Ministry 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 Ministry 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 and whanau, and enable people to make informed decisions about their own lives.

(NOTE: Subsequent references in this document to "the Person" or "people" should be understood as referring to a person/people with impairment(s). There are circumstances where this may include chosen significant others, but for clarity if there is any dispute between the person with an impairment and his/her significant other(s), the person's views take precedent unless the person is shown to have diminished responsibility.)

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2. THE SERVICES

2.1 Why the service is purchased

The Ministry purchases Supported Living Services for people who are eligible for Ministry-funded Disability Support Services and have been referred by a contracted Needs Assessment Service Coordination (NASC) organisation. The Service supports achievement of individual goals that are consistent with the long-term life aspirations of eligible people. The overarching intent is that the person is at all times central to the development and control of all aspects of assessment and service delivery. It is expected that the Service will lead to people making greater use of natural supports, thus reducing the need for Government funded support as people are more engaged with their community.

2.2 Definition[1]

Supported Living Services:

- are a range of flexible and individually responsive service approaches for eligible people that are based on an individual support plan;
- encourage and support people to think about how they might want to live and how self defined supports can be provided to foster opportunities for people to access their choices;
- are based on a collaborative approach and are contingent on the development of strong partnering between disabled people, families and/or whanau, service providers, generic community support and wider communities;
- provided under this Specification may be additional to other funded services provided for the person as part of a wider support package. (see 7 - Exclusions);
- are provided to people living in their own home, except when supporting a person to move from their current living arrangement (which may be the family home or a residential service) to a more independent living situation - such transitions are expected to be supported for no longer than 3 months, other than exceptional circumstances as agreed with the NASC organisation;
- are not provided in living arrangements where the Person leases the house from the Provider.

2.3 Principles of Supported Living

(a) Inclusiveness[1]: Barriers to inclusion should be minimised, supporting disabled people to make informed choices and decisions. Supported Living builds links and opportunities which may increase levels of inclusiveness of disabled people in the community.

(b) Individualised and flexible support[1]: Supports must focus exclusively on the individual within and across any chosen community environment. The services/supports that a person receives should reflect changing needs.

(c) Relationships[1]: A commitment to building community and meaningful networks. People's family and/or whanau, friends, other important people in their lives and their community are central to the person. An emphasis should be placed on identifying, developing and supporting these natural supports.

(d) Choice and control[1]: Individuals should be able to exercise choice over where and with whom they live, take a central role in deciding what they do, and the types of services, supports and activities they participate in.

(e) Life building[1]: the focus of support is long term and services need to be committed to the ongoing pursuit of autonomy and life long personal fulfilment for the person.

[1] Adapted from the Constitution of Supported Living New Zealand

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(f) Eligibility: Supported Living is an option for all people who meet the eligibility criteria for Ministry of Health disability services, if this is their preferred support arrangement and support can be provided within available resources. However, for the purpose of this Agreement, the Ministry's funding is available only in respect of a NASC organisation referral to the Ministry-funded Supported Living Provider.

(g) Separation of accommodation and support: there must be separation between the ownership of the place where the person lives and the provider delivering Supported Living to ensure the person can have security of tenure if they choose to change Provider.

(h) Cost: Supported Living funding should not be used to pay for services which should be funded by other agencies or the service user. The service user should not be required to pay, in part or full, for any Supported Living supports allocated by the NASC organisation.

2.4 Supported Living Operational Guide

In carrying out responsibilities under this service specification, the provider shall have regard to the Supported Living Operational Guide ("the Guide") issued by the Ministry, as updated from time to time. The Guide sets out the Ministry's advice and further guidance about how providers and NASC's should carry out their responsibilities under this specification.

3. SERVICE OUTCOMES

3.1 Outcomes

The primary outcome for a Supported Living Service is the support for an individual to have a greater opportunity for an ordinary life.

Service outcomes include but are not limited to:

- A person has increased personal knowledge and self determination;
- A person holds the central role in all planning and decisions about their life;
- A person is satisfied with the service;
- Sustainable natural supports, relationships and networks are fostered and sustained over time so that people can be part of their community;
- A person expresses satisfaction with their quality of life;
- Meaningful connections with local iwi and hapu, as desired, are fostered and developed;
- Formal supports respond to varying levels of need which may reduce over time;
- There is enough and the right information so the person can make informed choices and decisions (self determination);
- The person's sense of being respected and valued is enhanced;
- The home environment is safe and meets the person's preferences;
- There is a collaborative and equal relationship between the three parties (the person, the NASC organisation and the service provider);

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- Supports are provided in a timely manner to meet the person's needs, and may be at any time during a 24 hour period.

3.2 Māori

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service

4. WHO THE SERVICES ARE FOR

DSS funded Supported Living Services are for those people who are 17 years of age or older with a disability who meet eligibility criteria and have been referred to the Provider by a Ministry-contracted NASC organisation.

NASC organisations will apply DSS eligibility criteria. There may be circumstances where it is appropriate that DSS is not the only funder of supports received by the person.

5. HOW A PERSON GETS SUPPORT

5.1 Entry

The process for entry to Supported Living services is:

- A person will be referred to the relevant NASC organisation - this can be through self-referral or other means
- The NASC organisation will complete a Needs Assessment
- The NASC organisation will confirm that the Person is eligible for services funded via DSS
- Following the Needs Assessment, the NASC organisation will work with the Person to determine the best way to meet the identified needs
- When Supported Living is the identified service to be provided, the NASC organisation will provide the Person with information about Supported Living providers in their locality
- The Person may meet with a number of Supported Living providers before deciding which Provider they wish to be referred to
- Once the Person has chosen a Provider, the NASC organisation will make a referral to that Provider, if the Provider is able to provide the service
- The Provider will accept the referral and begin working with the Person on the Plan (see 6.1)

The Supported Living support package will be agreed between the Person, the NASC organisation and the Provider, is to be based on the person's needs, existing natural supports and desired outcomes, and available Government funding.

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5.2 Exit

The Person may choose to exit Supported Living or ask to be supported by another Provider. There may also be circumstances where the Provider is unable to meet the Person's needs. The Provider will notify the NASC organisation within 2 working days of becoming aware that a person no longer wishes to receive support from the Provider.

The NASC organisation will work with the person, the Provider and significant others where appropriate to ensure the safe and appropriate transfer of supports and records that relate to the person.

6. WHAT THE SERVICE INCLUDES

Supported Living provides eligible disabled people with a creative, responsive and flexible person-centred approach to support. Support is provided consistent with the individual support plan (see 6.1)

Supported Living Services are designed to enable disabled people to live in their own homes, to develop relevant skills, to develop and access community resources, to actively participate in their community, to define and achieve their goals, and ultimately experience autonomy on an equal basis to others.

The support that a person receives changes as the Person's needs and aspirations change – this means that support is adjusted in response to the disabled Person's changing needs for support and assistance.
As people are more connected with their communities and natural support networks it is generally expected there will be less reliance on formal supports.

Support is available to assist people to transition from an existing living arrangement; this may include the family home or a residential service. The transition is expected to be complete in three months, other than exceptional circumstances as agreed with the NASC organisation.

Where sleepover/night support is required, this will be provided through the Home and Community Support Service contract. This will respond to an exceptional situation, where it represents the least restrictive option for a transitional period not exceeding one month. Examples of this include leaving home or a residential service through a crisis, or as an Intentional Safeguard.

The Supported Living Service must be provided in ways that are consistent with the Ministry policy regarding paid family caregivers.

6.1 Individual Support Plan

Each person will have an Individual Support Plan ("Plan") prepared by the Provider in conjunction with the Person, based on the goals and support needs as identified by the Person. The Provider's staff will support individuals to have as much input as possible into their plans and the Plan will be completed within four weeks of the Person accessing Supported Living funding. The Plan will

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capture the goals and aspirations of the Person, and it will be Informally Reviewed by the Provider on a regular basis.

The Plan will be written in such a way that the Person understands and agrees with the content, the Provider's staff are clear about the outcomes required, and it ensures that the NASC organisation can see how referral needs will be met. The plan will be reviewed by the NASC organisation twelve monthly, or more frequently if there is significant progress with goals, life changes, or if requested by the person.

The planning process includes all natural supports and other agencies involved in providing support to the person, including the referring NASC organisation.

The Plan identifies those supports provided by the Supported Living Services, alongside those provided by other agencies and natural supports.

Where required, the Plan will include strategies or actions to safeguard the person in various individual circumstances and be clearly linked to any risk management documents that relate to the person or the Service (where applicable).

The Plan belongs to the disabled person. This means that the disabled person has final say in the content of the Plan with agreement indicated by signing it, unless he/she is shown to have diminished responsibility. In this situation the Plan should be signed by a Welfare Guardian on his/her behalf.

6.2 Staffing

The Provider will ensure that it has sufficient staff who are suitably qualified to provide the Supported Living Services as described in this Specification. This will include Coordination and Support functions. The Provider will also ensure that Support Workers have access to appropriate training. The Coordination function may include providing training.

6.2.1 Coordination

The Provider will ensure that every person for whom services are provided has an identified person who knows the person well and takes responsibility for the co-ordination, development, oversight of implementation and review of the person's plan.

The Coordination function is integral to the design, development, and delivery of individualised Supported Living Services and ensures that regular and effective communication happens between all those involved in the planning process; particularly as needs change or issues arise.

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6.2.2 Community Support

The Provider will be responsible for employing skilled staff to meet individual client needs and to provide continuity of support. Staff will be appropriately matched to each person based on the person's preferences and needs. This may include consideration of preference, gender, age and culture.

It is expected that the primary skills required to provide effective support will include general competency and attributes to provide support according to each person's needs. Support workers will be supervised by a person who ensures that training is provided. The supervisor will also oversee service delivery to ensure quality services are being provided.

Some of the things support staff may be required to do include, but are not limited to:

- Responding to the changing needs and aspirations of the individual in a creative and flexible manner;
- Understanding how to assist a disabled person to define, work towards, and achieve goals;
- Understanding the learning style of the disabled person and the course of action that needs to be taken to enable the person to achieve the outcomes and goals identified in the Plan;
- Creating opportunities for disabled people and educating others;
- Working with, learning with, and supporting the disabled person;
- Fostering and developing links to a wide range of people, organisations and community based supports and services;
- Developing strategies and resources to ensure that people are able to develop new skills;
- Ensuring that any Intentional Safeguards are in place and regularly reviewed so that they do not restrict the person's life and/or choices but do enable the person to live as safely as possible in their home and in their community.

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7. Exclusions

Excluded from services under this specification will be any individual or individuals entitled to the support under the Injury Prevention, Rehabilitation and Compensation Act (2001) or where this service is not considered appropriate to meet the individuals identified support needs as identified by NASC.

The Supported Living Service is not to deliver services that are separately purchased, such as:

- Household Management - The Ministry contracts for this type of support through Home and Community Support Services, and a Community Services Card is required before this service can be received.
- Personal Care - The Ministry contracts for this type of support through Home and Community Support Services.
- Day Services and Vocational Services - These services are funded and contracted through the Ministry of Social Development, other than a limited

group of people who meet strict eligibility criteria for Ministry of Health funded Day Services.

- Rehabilitation Services - These services are funded through separate contracts by District Health Boards and in limited circumstances by DSS.

8. LINKAGES

The Provider is required to facilitate access and information for service users to make and sustain links with other services and supports in the community. This includes but is not limited to:

- needs assessment and service co-ordination services
- family / whanau and other networks the person may have
- local communities
- independent advocates
- person/carer community support services
- disability consumer groups
- appropriate ethnic, spiritual and cultural groups
- services linking Maori service users with whanau, hapu and Marae
- mental health services
- specialist support team
- primary health services
- day activity, vocational or education services
- employers
- equipment and modification services
- rehabilitation services
- Government departments

9. QUALITY REQUIREMENTS

9.1 General

All providers contracting with the Ministry of Health are expected to ensure that services are delivered in an efficient and cost-effective manner.

A Supported Living provider can charge for any activity within the hours approved by the NASC organisation that progress the Individual Plan. Specifically this means:

- Initial set-up
- Direct support
- Monitoring of the achievement of the Person's plan, recognising this should be done face to face
- Formal review of the plan at agreed intervals
- Meetings or activities that support achievement of the Person's plan, e.g. with family, advocates or other agencies; court proceedings, community liaison, finding places to live; or activities that respond to an incident or unexpected event relating to the person
- Researching options for the Person
- Any activities must be directly linked to the Person's individual support plan as agreed by the NASC organisation. All hours associated with these

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individual activities must be documented in a way that they can be validated against the support hours provided
- The hourly rate paid for Supported Living includes an overhead component from which the provider is responsible for administration, monitoring of staff and the overall service, service and staff development and research.

The invoice for hours will reflect the hours delivered against the support plan developed with the Person and/or NASC organisation. It is also subject to any allocation of support hours made by the NASC organisation as part of the service coordination process.

The Provider is required to comply with the General Contract Terms and the Provider Quality Specifications of the Agreement in addition to this service specification. A companion document to this Specification is being developed and will provide additional detail about Supported Living.

In accordance with the Provider Quality Service Specifications, other quality indicators will be incorporated as part of your internal evaluation and service development plan.

9.2 Staff Management and Training

The Provider will provide its staff with a planned orientation to their role and responsibilities, and the service, which covers areas of service philosophy and values, knowledge and skills required, service and organisational procedures. Note also sections 6.2.1 and 6.2.2.

9.3 Acceptability

People who are supported will have opportunities to indicate their level of satisfaction with the service they have received, and the Provider must be able to produce evidence of the information gathered. This may be in the form of surveys or similar. The Provider should use information gathered from people who are supported as part of the Provider's continuous quality improvement process.

9.4 Safety

The Provider will have a set of documented policies/ protocols as part of its Risk and Quality Management framework including, but not limited to:

- Code of Conduct, including professional boundaries
- Conflict of interest
- Approved Service Standard and Complaints policy and processes
- An abuse policy that covers recognising and reporting physical or sexual abuse from others and preventing abuse (physical, sexual, financial and psychological) from staff
- Confidentiality
- Positive behavioural approaches

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- A process to identify vulnerabilities in relation to specific people supported by the service, and intentional safeguards that respond.

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9.5 Reporting

The Ministry will work with the sector to develop a reporting framework that will measure outcomes. The Reporting section of the specification will be altered by way of a contract variation when the framework is implemented.

PU Code	PU Short Name	PU Measure	Reporting Requirements	
			Frequency	**Information**
DSSL2620	**Community Supported Living**	As requested	**Six monthly**	***Quality Measure*** 1.1 Number of people with written individual plans 1.2 Number of individual plan reviews completed 1.3 Percentage of Individual Plans goals met for those people reviewed 1.4 Total number of complaints received in the reporting period, and the number resolved 1.5 Total number of compliments received in the reporting period 1.6 Total number and description of critical incidents that occurred in the reporting period
			Annually	A written narrative 2. The outcome of person and family satisfaction survey 3. Organisational strategic plan for Maori including: • strategies to recruit and train Maori staff • Maori consumer satisfaction • Services meet the needs of Maori • Maori participation • Quality plan • Support for Maori • Number of FTEs • By type (Maori, total) 4. Report on service delivery issues (for example staff turnover, staff training, undelivered services), contingencies, emerging trends or innovative approaches taken.

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NB. Narrative reports can be submitted at any time if there are issues that you wish to raise (e.g. unmet need).

You shall forward your completed Performance Monitoring Returns to:

The Monitoring Team
Ministry of Health – Dunedin
Private Bag 1942
Dunedin

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GLOSSARY OF TERMS

Intentional Safeguard
Planned and deliberate interventions that are designed to minimise any potential impact from known risks. E.g. ensuring that a person who is known to have limited understanding of time or place to always carry a cell-phone on their person.

Needs Assessment Service Co-ordination Organisations (NASC):
These organisations are funded by the Ministry. Their roles are first to assess service user's needs, and then to co-ordinate other services to meet those needs within available funding.

Needs Assessment:
A needs assessment is a process of determining the current abilities, resources, goals and needs of a client with a disability and identifying which of those needs are the most important. The purpose of the process is to decide what a client needs to maximize independence and participate as fully as possible in society, in accordance with their abilities, resources, culture and goals. A client's needs will also include where appropriate the needs of their family/whanau and carers; their recreational, social and personal development needs; their training and education needs; and their vocational and employment needs

Person
The recipient of DSS funded services.

Plan
The Individual Support Plan prepared by the Provider in conjunction with the person.

Provider
The Supported Living Service Provider.

Review

Informal Review - This is the ongoing review of progress towards achieving goals, and identification of new goals that occurs as part of the regular communication between the person receiving services and the Supported Living Provider. This informal review is expected to occur as part of normal business.

Formal Review - the Individual Plan should be formally reviewed at intervals agreed between the person, the Provider and the referring NASC organisation, but at least annually. The formal review is to consider the goals in the Individual Plan, the need for new goals and to determine what further support will be needed. It is expected to include other people significant to the person. The cost of formal review is met through the identified set-up and review allocation.

Service Coordination:
Service co-ordination is the process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the client and, where appropriate, their family/whanau and carers. Service co-ordination will also determine which of those needs can be met by government

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funded and other services and will explore all options and linkages for addressing prioritised needs and goals.

Approved Service Standard
The Provider is required to maintain Certification as required under the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. All overarching services must be compliant with partially new standards by1 August 2023 and must be fully compliant with the new standards by 1 February 2024.

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Disability Support Services

Printed from: https://www.disabilitysupport.govt.nz/about-us/taskforce/independent-review/review-panel/terms-of-reference-review-panel

Printed on: 1 October 2025

Review Panel Terms of Reference (as of 1 July 2025)

This is the Terms of Reference (ToR) for the Review Panel referred to in the Operational Policy and Guidelines 2025/26 Financial Year - Management of NASC and EGL site budgets.

- Download the Terms of Reference (DOCX 69 KB)
- Download the Terms of Reference (PDF 119 KB).

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What's changed?

The Review Panel Terms of Reference were updated on 1 July 2025 to reflect the changes that were made to the Operational Policy and Guidelines 2025/26 Financial Year - Management of NASC and EGL site budgets.

The NASC and EGL decisions that need to be referred to the Review Panel have also been updated. These are set out in both the Operational Policy and Guidelines, and the Review Panel Terms of Reference. There is also a requirement for the Review Panel to apply the Operational Policy and Guidelines.

Purpose of the Review Panel

The purpose of the Review Panel is to provide assurance to the Associate Deputy Chief Executive (ADCE), Disability Support Services (DSS), within the Ministry of Social Development (MSD) that certain Needs Assessment and Service Coordination (NASC) organisation and Enabling Good Lives (EGL) site decisions are in accordance with Cabinet's decisions and relevant policy and service specifications.

Application of the Operational Policy and Guidelines 2025/26

The Review Panel must comply with the Operational Policy and Guidelines 2025/26 in carrying out its work.

How the Review Panel must carry out its work

In carrying out its work, the Review Panel must:

- have regard to the needs of individuals, fairness, and equity within the legal requirements to manage the budget for disability supports;
- operate in ways that are consistent with the principles of good public decision making, including ensuring all relevant factors have been taken into consideration and that the decision is reasonable, transparent, consistent, and appropriately documented[1]; and
- consider alternatives to residential care and higher cost community packages, in a way that is equitable and ensures overall affordability of packages.

Appointment and Composition of the Review Panel

The Review Panel members are appointed by the ADCE, DSS, who can also approve changes to the membership of the panel.

The Review Panel will comprise four employees of DSS who, collectively, have a deep understanding and knowledge of the following:

- delivery of residential care;
- pricing of DSS funded supports;
- budget and financial management;
- equity principles, including the provision of support that is culturally appropriate for tāngata whaikaha Māori and Pacific disabled people;
- the NASC, EGL site and provider operating environment and processes;
- clinical care for those with high needs;
- any other skills and knowledge considered necessary.

The Review Panel will include at least one registered health professional. The role of the registered health professional on the Panel is to analyse any health evidence that it receives with a referral and provide advice on the implications of that health evidence for the issues the panel is considering. The health professional will not carry out health assessments for the Panel.

The Review Panel will make recommendations by consensus wherever possible. Where consensus is not possible, the Chair will call for a vote, in which case the matter will be decided on a simple majority. In the event of a tie, the Chair will have a casting vote.

The provision of advice by registered health professionals on the panel will be provided in accordance with the standard required by the appropriate regulatory body.

Complaints directed at Panel members in the conduct of their responsibilities, in good faith, under these terms of reference will be responded to by MSD.

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The Review Panel may from time-to-time seek advice from:

- the Deputy Chief Legal Advisor DSS within MSD or their delegate;
- any other person, whether employed by MSD or otherwise, they consider has expertise on any matter that the Review Panel otherwise feels unable to resolve.

The Review Panel will be supported by a secretariat of employees of DSS who will:

- triage applications to the Review Panel, and send them back to the NASC or EGL site for reconsideration or more information as required;
- collate agendas, prepare papers, take minutes, prepare reporting, ensure that decisions are reported back to all parties in a timely way and with the rationale clearly explained, and
- bring to the Chair's attention any urgent matters for consideration between meetings.

Frequency of meetings and a Quorum

The frequency of meetings will be determined by the Chair in consultation with other members of the Review Panel, having regard to the volume of requests, the need to consider them comprehensively and in a timely way, and the need to be responsive to emerging situations.

A quorum will exist when two of the four panel members attend the meeting, either in person or online.

Status of recommendations by the Review Panel

The Panel provides assurance to the ADCE, DSS that certain decisions by NASCs and EGL sites are in accordance with relevant criteria (arising from the Independent Review, other relevant policy, and service specifications) by

- reviewing information supporting the decision supplied by the NASC or EGL site to determine:
  - whether the evidence shows that the criteria have been met; or
  - whether the evidence does not show that the criteria have been met.
- The Review Panel then make recommendations to the ADCE, DSS on which NASC or EGL site decisions satisfy the relevant criteria, and which ones do not satisfy the relevant criteria. These recommendations are based on the outcomes of their work and are from them collectively.

Following final sign-off, the secretariat will write to the NASC or EGL site setting out the reasons for not endorsing their decision. a NASC or EGL site will be advised that:

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- Either the information supplied supported their decision, and they can implement it;
- Or the information supplied does not support their decision, and they are not able to implement it.

If they wish to do so, a NASC or EGL site can supply additional relevant information to the Review Panel. The Review Panel will consider this additional information.

In carrying out this work, the Review Panel and the ADCE, DSS, will be exercising MSD's contract management responsibilities of providing assurance as to the proper and consistent application of relevant criteria. We consider this is not the exercise of a power or function of the Chief Executive beyond what has already been agreed under the contracts MSD has in place with NASCs.

The Review Panel's decisions relate to levels of support that can be allocated within existing contracts or through personal budgets or individualised funding arrangements (where these are allowed within existing policy). The Review Panel holds no delegation to make decisions about new contracts, or funding outside of existing arrangements.

Matters in scope of the Review Panel

The Review Panel will continue to provide an assurance function for at least the next 12 to 18 months while the disability support system is stabilised and strengthened, and assurance processes are built into the system.

While NASCs and EGL sites will have discretion about how they manage expenditure within their Annual Budgets, certain decisions about high-cost packages will continue to require endorsement from the Review Panel prior to implementation.

From 1 July 2025, NASCs and EGL sites are required to seek consideration by the Review Panel in the following situations:

- A persons' residential care, EGL Personal Budget, or community support package exceeds $105,000 for the first time.
- A person's residential care, EGL Personal Budget, or community support package already exceeds $105,000 and increases.

NASCs and EGL sites can only request consideration of a decision by the Review Panel if they can provide assurance that they have sufficient funding available within their Annual Budget, or that all of the exceptional circumstances criteria have been met.

A NASC or an EGL site can make an exception to the residential affordability criterion in the following circumstances:

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- there is a reasonably foreseeable and imminent risk of serious harm that cannot be addressed through non-residential support options;
- the initial assessment of the NASC or EGL site is that they are unable to provide immediate assurance that they can afford the residential entry within their current annual budget; and
- the NASC or EGL site provides assurance to the Panel that they are or will take reasonable and practicable steps to return to being within their Annual Budget by year-end.

Further detail on the application of the thresholds

Decisions on whether the thresholds for referring funding packages to the Review Panel should exclude the following:

- Expenditure that is not funded through the DSS appropriation[2].
- One-off expenditure (such as for Early Investment or Immediate Resourcing within EGL sites) that is for less than 12 months.
- Community participation and Very High Needs funding for people within EGL sites that has been transferred to the DSS appropriation.
- Specialist Behaviour Support.

When the Review Panel is considering a package that includes funding that is excluded from the calculation of thresholds, it may need to consider whether the package, as a whole, including the funding from other sources, appropriately responds to all of the disability-related needs identified.

Price increases in the following situations do not need to be referred to the Panel:

- Price increases of less than $5,000 a year to the DSS contribution to support packages that are managed by Health NZ.
- Price increases for residential care that result solely from implementation of the CGH Pricing Model from 1 December 2025.

Residential and community packages allocated by either NASCs or EGL sites do not need to be referred to the Review Panel if they remain the same or decrease (unless they meet one of the other criteria for being considered by the Panel).

Quality of information required

The evidence required to support a referral shall:

- whenever possible, be primary evidence (e.g., recent health practitioner notes or reports, needs assessments or good life plans) rather than secondary information (e.g.,

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discussions about primary evidence);

- be sufficient to show that all the criteria relevant to a decision have been met; and
- be sufficiently recent to show what has changed, resulting in a decision needing to be referred to the Panel.

Ability of the Chair to consider NASC or EGL site decisions urgently

From time-to-time situations may arise between Review Panel meetings where urgent action is required to protect the health and safety of the disabled person and those supporting them, or to avoid a person being held in an inappropriately restrictive environment.

In this situation, the Chair of the Review Panel may consider the issue without a full meeting of the Review Panel being called. In these cases, the criteria they consider are whether the information shows that:

- the situation falls within one of the priority groupings for residential service;
- all other reasonably practicable options to effectively manage immediate risks to the health and safety of the disabled person or those who support them have been considered;
- doing so will not compromise another higher priority entry; and
- the temporary placement has been consented to by the disabled person in line with Right 7 of the Code of Health and Disability Services Consumers' Rights.

The Chair of the Review Panel has the authority to advise the NASC or EGL site, as appropriate, that:

- Either the information supplied supported their decision, and the Panel endorses their decision, so they are able to implement it.
- Or the information supplied does not support their decision, so the Panel is unable to endorse it, so they are unable to implement it.

It is recognised there may be less information available when urgent action is proposed than would normally be required by the Review Panel. As a result:

- If the NASC or EGL site is advised by the Chair of the Review Panel that they have reached a view that the available information supports their decision, the arrangement must be put in place for the shortest duration in which it is reasonable to manage the risk and maintain the wellbeing of the disabled person. This will generally be less than 6 weeks.
- The Review Panel will reconsider the decision as soon as possible, to maintain oversight of residential and community support costs generally and to set expectations of longer-

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term solutions – in particular whether a transitional period in residential care will be considered, or whether a community alternative should be pursued.

Appeal of Review Panel Recommendations

Where a disabled person, their family, or the NASC/EGL site involved is concerned that the Review Panel has not followed this Terms of Reference in making its recommendation, they may seek a review of the decision by the Deputy Chief Executive for DSS at MSD.

The principles of natural justice apply to any appeal.

Following the Appeal, the Deputy Chief Executive, DSS can:

- decide whether to accept the Panel's advice; or
- refer the Panel's advice back to the Panel for re-consideration.

The Deputy Chief Executive of DSS must set out their reasons in writing to the disabled person or their nominated representative, and the NASC/EGL site involved, within six weeks of the review being sought.

Reporting of Review Panel Recommendations

The Review Panel must provide regular reports to, and at a frequency agreed with, the ADCE on:

- the recommendations it has made (including packages it has not endorsed to review);
- the costs involved;
- the rationale for its recommendations; and
- any trends and emerging issues.

The Review Panel must do so at a level of detail consistent with maintaining the privacy and anonymity of the individuals involved.

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Footnotes

[1] For more information, see The Judge Over Your Shoulder » Crown Law

[2] DSS funding is currently contained within the Supporting Tāngata Whaikaha Māori and Disabled People Multi-Category Appropriation, although this may change in the future.

Index of page links

1. **Download the Terms of Reference (DOCX 69 KB)** - https://www.disabilitysupport.govt.nz/assets/about-us/Review-Panel-Terms-of-Reference-

2025-26.docx

2. **Download the Terms of Reference (PDF 119 KB)** - https://www.disabilitysupport.govt.nz/assets/about-us/Review-Panel-Terms-of-Reference-2025-26.pdf
3. **[1]** - https://www.disabilitysupport.govt.nz/about-us/taskforce/independent-review/review-panel/terms-of-reference-review-panel#_ftn1
4. **[2]** - https://www.disabilitysupport.govt.nz/about-us/taskforce/independent-review/review-panel/terms-of-reference-review-panel#_ftn2
5. **[1]** - https://www.disabilitysupport.govt.nz/about-us/taskforce/independent-review/review-panel/terms-of-reference-review-panel#_ftnref1
6. **[2]** - https://www.disabilitysupport.govt.nz/about-us/taskforce/independent-review/review-panel/terms-of-reference-review-panel#_ftnref2

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PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

Accident Services

A guide for DHB and ACC staff

2018

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Contact details

For operational queries and queries about ACC invoices and schedules:

Provider contact centre: 0800 222 070

Email: providerhelp@acc.co.nz

Provider order line: 0800 802 444 (for ACC forms)

ACC32 Treatment Extension Requests:

Phone: 0800 222 070

Email: ACC32@acc.co.nz

Online web form: https://forms.acc.co.nz/ACC32

Website: https://www.acc.co.nz/for-providers/treatment-recovery/prior-approval-treatment/

Sensitive claims:

PO Box 1426

Wellington 6140

Phone: 0800 735 566 select option 1

Treatment Injury Centre:

ACC

PO Box 430

Dunedin 9054

Phone: 0800 735 566 select option 2

For queries regarding content of this guide:

ACC contact details

Provider Service Delivery

ACC Corporate Office

PO Box 242

Wellington 6011

Phone: 04 816 7400

Website: www.acc.co.nz

Ministry of Health (including Disability Support Services for people under 65) contact details:

Ministry of Health

PO Box 5013

Wellington 6140

Phone: 04 496 2000

Website: www.moh.govt.nz

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Disclaimer

This is a joint Ministry of Health (MoH)/Accident Compensation Corporation (ACC) guide and has been developed in collaboration with District Health Boards (DHBs)

The following interpretations of ACC legislation are designed to serve as a guide for DHBs and relevant agencies in determining where services are provided under the Public Health Acute Services Agreement and where ACC directly purchases particular treatment and rehabilitation services provided in public hospitals. For financial and legal purposes, the Accident Compensation Act 2001 and the Annual Service Agreement between the Minister of Health and the Minister for ACC, and contractual agreements between funders and providers, take precedence over this guide.

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Introduction

Purpose

This guide has been developed by the Accident Compensation Corporation (ACC) and the Ministry of Health (MoH) primarily for health and disability providers working for District Health Boards (DHBs) and, in some instances, working for other agencies, and for ACC staff and Accredited Employers working with those providers.

This guide will assist in determining who is responsible for funding the treatment, rehabilitation and related services required by an injured person, when that person has a personal injury for which they are covered under the Accident Compensation Act 2001 (AC Act 2001).

Background

This guide replaces previous versions; *Accident Services A guide for DHB and ACC Staff* (January 2014), *Accident Services – Who Pays?* Edition One (July 1999), Edition Two (March 2001) and Edition Three (July 2002). It also replaces *Purchasing ACC Treatment Services,* Edition One (1998) and Edition Two (1998). This guide will be updated if there are changes in legislation or policy that affects the accuracy of the guide's content.

We recognise that further work is required in developing robust procedures for interfaces between agencies, for example ACC, DHB hospital and community services, and MoH. In the absence of such procedures, this guide attempts to highlight where such interfaces may occur.

This guide does not attempt to provide solutions to issues relating to the accident/illness boundary, as these usually relate to clinical judgements on individual cases. However, there is guidance for hospitals, other funders and ACC to assist with some boundary issues, particularly in respect of the move from acute medical treatment to rehabilitation. A pathway for dispute resolution is provided – the guiding principle in such cases is for services to continue until these boundaries have been clarified by ACC and MoH.

Terms used in this guide in relation to arrangements for the provision of services

ACC pays for the provision of services for injured persons through DHBs via two mechanisms:

a. Public Health Acute Services (PHAS): These services are funded by Vote: Health through an annual service agreement between the Minister of Health and the Minister for ACC. DHBs receive funding for these services from the MoH as part of their annual funding package with distribution to each DHB according to the population based funding formula (PBFF). ACC's reimburses the Crown for PHAS via a monthly payment to the MoH, which is paid into the Crown Account. ACC's annual PHAS contribution is calculated by MoH which includes any annual changes to the contribution. The change in contribution represents a mix of price and demographic changes against the previous year's allocation. In this guide, acute treatment/services for ACC clients through the public health care system is referred to as **'covered by PHAS'**.

b. Direct purchases of other services[1] by ACC[2]. In this guide, this type of service is referred to as **'purchased directly by ACC'**.

The terms patient, client and claimant are used interchangeably throughout this guide, depending on context. 'Claimant' is used in legislative references and 'client' and 'patient' in describing operational references.

[1] Conditions relating to prior approval may apply
[2] Throughout this guide

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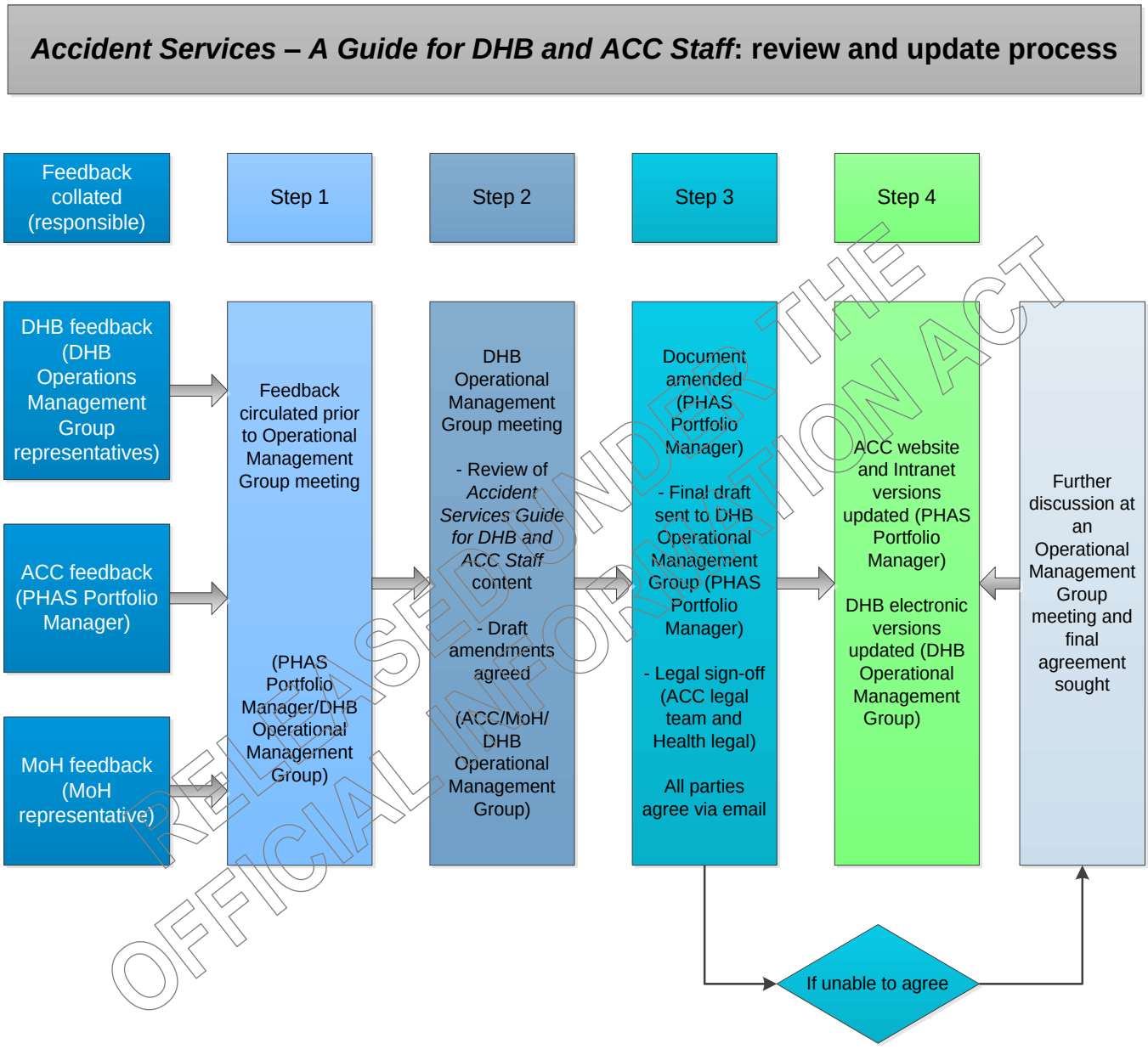
Update process

This guide will serve as a 'living document', designed to be used electronically, with updates made as required and agreed by both parties as per the process map below:



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The intent is that changes to processes/policies will be updated annually using the above process. Legislative changes and/or major service/contract/policy changes may need to be updated prior to the annual review. Updates required prior to the annual review will be made using a similar process to the one outline above, will be agreed by ACC/MoH in consultations with the DHB Operational Management Group, and will be signed off by ACC Legal team and Health Legal.

Structure of the guide

Section 1 **Outlines the AC Act 2001** and gives an overview of the ACC system.

Section 2 Discusses general categories of service and **how ACC legislation translates into operational use**. In particular, it discusses PHAS timeframes as set in regulation.

Section 3 Discusses examples of services that may require **interfaces between agencies**.

Section 4 Covers **ancillary services** that support treatment and rehabilitation services.

Section 5 Describes key **administrative processes** to be used by DHBs in relation to services for ACC clients, and includes a section on **treatment injury**.

Information on **frequently used forms** is included in this section.

Section 6 Outlines the **process for resolving ACC/MoH boundary issues**.

Section 7 Discusses **provider performance**.

Glossary

Appendix 1 A guideline for transfer of funding responsibilities from DHBs to ACC.

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Section 1: The Accident Compensation Act 2001

The AC Act was passed in September 2001.The majority of the provisions in the Act came into force on 1 April 2002.

Prior to March 2010, this Act was known as the Injury Prevention, Rehabilitation, and Compensation Act 2001 (IPRC Act 2001). The Accident Compensation Act Amendment Bill 2010 changed the name of the Act to the Accident Compensation Act 2001. Some regulations and past amendments retain their IPRC titles.

1.1 ACC legislation currently in force

The AC Act 2001 (Note: There are a number of amending Acts to the principal legislation. The most current 'version' of the AC Act should always be sourced, and is available online). Regulations to the AC Act can also be sourced online, for example:

a. Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 (IPRC (PHAS) Regulations 2002)

b. Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 (Cost of Treatment Regulations 2003 (CoTR 2003)

c. Accident Compensation (Ancillary Services) Regulations 2002 (Ancillary Services Regulations 2002).

1.1.1 Main features of the AC Act 2001

The AC Act 2001 aims to provide a fair and sustainable scheme for managing personal injury, and reflects the Government's key goals of:

a. injury prevention through the promotion of measures to reduce the incidence and severity of personal injury

b. timely rehabilitation – including social and vocational rehabilitation, treatment (including physical and cognitive rehabilitation) and ancillary services

c. fair compensation – including the reinstatement of lump sum compensation, and changes to rehabilitation, weekly compensation and death benefits

d. the development of a Code of ACC Claimants' Rights – specifying clients' rights and service standards for ACC.

1.2 Coverage of the AC Act 2001

1.2.1 Who is covered?

The AC Act 2001 covers everyone in New Zealand.

1.2.1.1 New Zealanders

New Zealanders who are 'ordinarily resident' in New Zealand are covered by the Act, even if, in some circumstances, they are injured while temporarily overseas.

1.2.1.2 Overseas visitors and foreign diplomats

Overseas visitors and foreign diplomats are covered for personal injury sustained in New Zealand. They are considered to be in New Zealand once they disembark from the aircraft or boat bringing them to New Zealand, and have the same eligibility for acute treatment services for injury as New Zealand residents.

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In all cases of an overseas visitor sustaining a personal injury by way of accident in New Zealand, the DHB, or first treating health provider if not a DHB, should lodge an ACC claim on behalf of the client. This claim must be signed by the client or their authorised representative. ACC will determine whether the injury is covered by the AC Act 2001.

The AC Act 2001 takes precedence over any other funding arrangements (including reciprocal agreements). If a visitor refuses to submit a claim they should be advised that they may be liable for payment. An overseas visitor may only be charged if:

a. they refuse to submit a claim, or

b. a claim is declined, or

c. they are not otherwise covered by a reciprocal agreement.

Information on eligibility for publicly funded health and disability services (including those for injured persons) can be found on the MoH website. This also has information on the reciprocal agreements with the United Kingdom and Australia.

1.2.2 What is covered?

People who sustain personal injuries caused by accidents – whether in the home, during recreation, on the sports field, on the road, at work or in certain other circumstances – are eligible for ACC cover. Cover can only be granted when an ACC45[3] Injury Claim form is completed by a treatment provider, signed by the client or their authorised representative[4] and accepted by ACC.

a. There are several key terms used in defining coverage under the AC Act 2001, including:

b. accident

c. personal injury: this cover includes damage (other than wear and tear) as a result of an accident to dentures or prostheses that are replacing a part of the human body at the time of the accident. (It does not include hearing aids, spectacles or contact lenses)

d. mental injury

e. work-related personal injury.

The legislative definitions for these terms are provided in section 6 of the AC Act 2001.

The AC Act 2001 also contains details of the cover provided for particular types of personal injury and circumstances, for example:

a. New Zealanders injured overseas (section 22, AC Act 2001)

b. exclusions for visitors while on aircraft or ship (section 23, AC Act 2001)

c. specific instances of mental injury covered by ACC (section 21 and Schedule 3, AC Act 2001)

d. treatment injury (section 32, AC Act 2001)

e. hearing loss (section 26, AC Act 2001).

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[3] The ACC46 injury claim form is also used by some DHBs to assist with gathering information to lodge ACC claims. The order of questions on the ACC46 is designed to assist providers with entering data into a Practice Management System (PMS) or the ACC web-based eLodgement system. The ACC46 cannot be used to lodge claims directly with ACC.

[4] In the case of electronic lodgement of forms, providers need to keep signed copies in paper or image form that show the claims were authorised by the client or their authorised representative.

1.2.3 Who manages injury claims?

1.2.3.1 ACC

ACC manages claims for personal injuries, including work-related personal injuries. The only exceptions to this are work-related injuries to employees of accredited employers within the ACC Accredited Employer Programme.

1.2.3.2 Accredited employers

Accredited employers take on the role of ACC and are responsible for providing statutory entitlements in relation to their employees' work-related (as opposed to non-work-related) injuries that occur from the date of the employers' accreditation (the earliest date for any accreditation is 1 July 2000). Accredited employers have the same legislative/regulatory and contractual obligations as ACC. However, it should be noted that employees of accredited employers are covered by PHAS for both work-related and non-work-related personal injuries[5].

Accredited employers must meet specific criteria for entering and maintaining their participation in ACC's Accredited Employer Programme. They are obliged to pay at least the regulated costs of their employees' claims for an agreed claim management period[6]. At the end of this period, open claims are transferred back to ACC for further management. Accredited employers are entitled to the same level of work-related injury information as ACC, to enable them to manage their workplace injuries effectively. The usual privacy requirements apply to the provision of personal and non-work injury information.

For information on lodging a claim for an employee of an accredited employer, see section 5.2.1.2 of this guide.

1.2.3.3 Accredited employer third party administrators

Under the ACC Accredited Employer Programme, accredited employers may, subject to ACC's approval, contract 'third party administrators' (TPAs) to deliver injury and claim management services to their employees. While TPAs act as payment agents and day-to-day point of contact for some accredited employers, the claim and injury management responsibilities for injured employees remain the responsibility of the accredited employers.

1.2.3.4 Accredited employers – useful resources

a. ACC web page 'Lodging a claim if your patient works for an Accredited Employer'.

b. 'Managing employees injuries' web page

c. Telephone the ACC Provider Contact Centre – 0800 222 070.

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[5] Accredited employers pay levies to ACC to cover the provision of PHAS to their employees.

[6] Time periods are individual to each accredited employer and should be identified in instances of employees of accredited employers requiring longer-term treatment.

1.3 Treatment under the AC Act 2001

1.3.1 Treatment conditions that need to be met under the AC Act 2001

The AC Act 2001 states that the purpose of treatment is to restore a claimant's health to the maximum extent practicable. The term 'practicable' is defined in section 6 of the AC Act 2001.

Schedule 1, clause 2 of the AC Act 2001 states:

"(1) The Corporation is liable to pay the cost of the claimant's treatment if the treatment is for the purpose of restoring the claimant's health to the maximum extent practicable, and the treatment –

(a) is necessary and appropriate, and of the quality required, for that purpose; and

(b) has been, or will be, performed only on the number of occasions necessary for that purpose; and

(c) has been, or will be, given at a time or place for that purpose; and

(d) is of a type normally provided by a treatment provider; and

(e) is provided by a treatment provider of a type who is qualified to provide that treatment and who normally provides that treatment; and

(f) has been provided after the Corporation has agreed to the treatment, unless clause 4(2) [of Schedule 1] applies. See also section 1.4.3 of this guide.

(2) In deciding whether sub clause (1)(a) to (e) applies to the claimant's treatment, the Corporation must take into account –

(a) the nature and severity of the injury; and

(b) the generally accepted means of treatment for such an injury in New Zealand; and

(c) the other options available in New Zealand for the treatment of such an injury; and

(d) the cost in New Zealand of the generally accepted means of treatment and of the other options, compared with the benefit that the claimant is likely to receive from the treatment."

Patients with wilfully self-inflicted personal injuries are covered by ACC and are entitled to treatment and ancillary services for treatment. However, for suicide and wilfully self-inflicted injuries that occur on/after 1 July 2010, ACC does not provide other entitlements for these patients/clients, except in limited circumstances (see sections 119 and 122A of the AC Act 2001).

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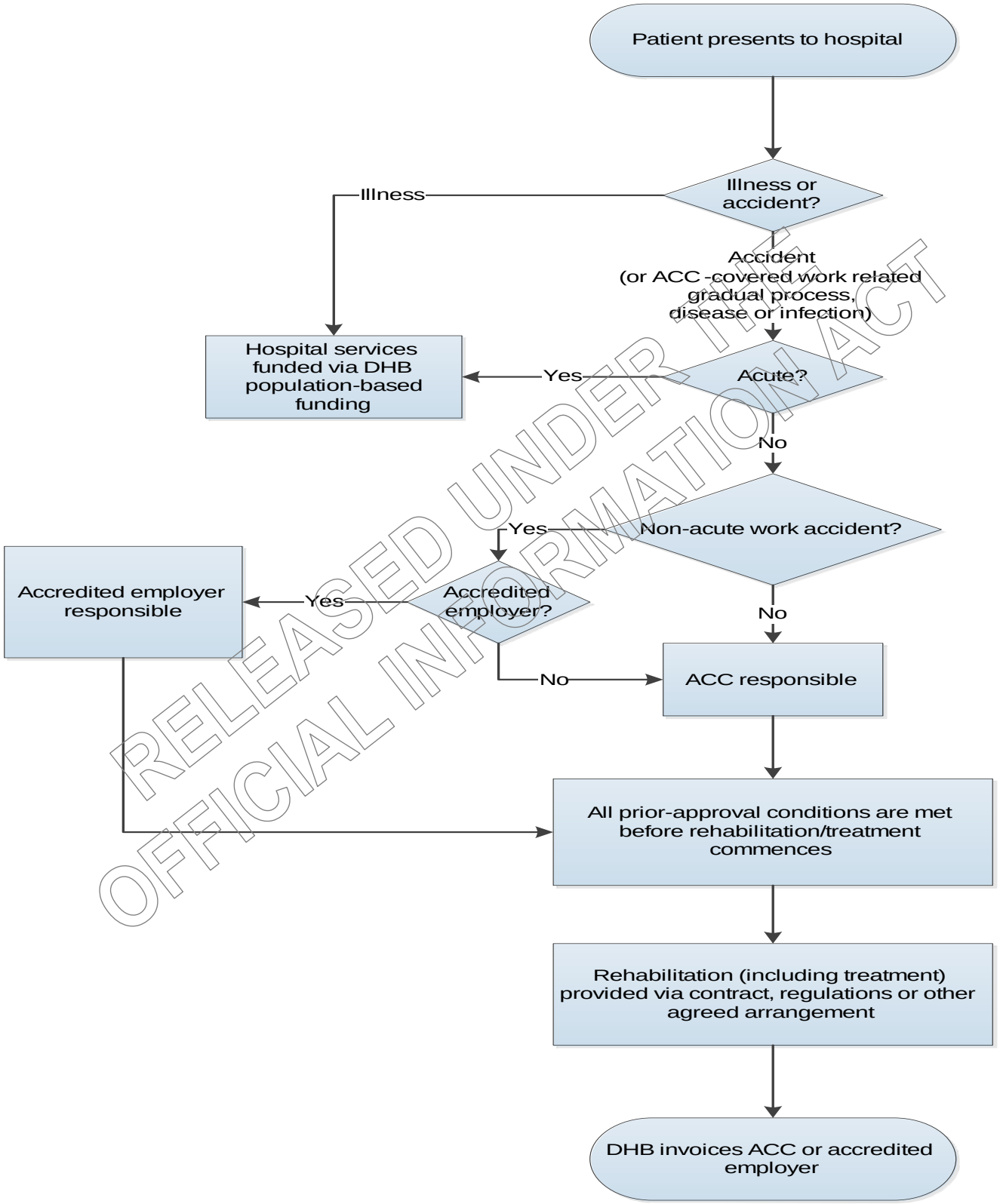
1.4 What are the funding arrangements for treatment under the AC Act 2001?

Figure 1: Diagrammatic representation of funding streams



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1.4.1 Public Health Acute Services (PHAS)

The IPRC (PHAS) Regulations 2002 define PHAS in relation to the treatment of a client for a covered personal injury. A summary of that definition, with examples of the durations of PHAS (as defined in the Regulations), is given in section 2 of this guide.

PHAS funding agreements are set out in the AC Act 2001, section 301. ACC's annual PHAS contribution is calculated by the Ministry of Health (MoH) and agreed by ACC. This covers the cost of ACC clients receiving acute services in publicly funded hospitals.

The AC Act 2001, section 303, prohibits ACC from purchasing PHAS directly from DHBs or other publicly funded providers.

Tracking actual injury-related events requiring acute inpatient hospital admission relies on

a. coding of accident details for discharge records loaded into the National Minimum Data Set (NMDS)
b. DHBs lodging claims for all accidents with ACC (or accredited employer claim managers).

This allows the identification of injury treatments associated with accepted claims, to determine frequencies and costs.

1.4.1.1 The Annual Service Agreement for Public Health Acute Services, Pharmaceuticals and Laboratory Tests

Section 301(2) of the AC Act 2001 states that the Annual "Service Agreement must−

(a) provide for the payment of money to the Crown in return for the Minister of Health–

  (i) funding the provision of public health acute services, and any other services (including pharmaceuticals and laboratory services) agreed by DHBs or other providers, under Crown funding agreements on behalf of the Corporation; and

  (ii) arranging the funding of that provision; and

(b) provide how the Minister of Health's implementation of the agreement is to be monitored; and

(c) contain the terms and conditions that the Minister of Health and the Minister [for ACC] agree on; and

(d) specify service levels for the delivery of such services; and

(e) specify the level of payment from the Corporation to the Crown; and

(f) specify the mechanism for calculating the sum payable by the Corporation and the method of payment."

Note:
PHAS funding covers laboratory tests referred by private providers.

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1.4.1.2 Requirements of providers of PHAS

DHBs must:

a. identify and track service provision for people who are being treated under multiple purchasing arrangements

b. complete the appropriate claim forms (i.e. the ACC45 for all ACC and accredited employer patients), and ensure that they are signed by the patient or their authorised representative. They must ensure that these details are recorded against all the patient's accident events

c. use clinical coding to assign diagnosis, procedure and external cause codes via acceptable classification systems such as International Classification of Diseases-10 (ICD-10) or Systematised Nomenclature of Medicine - Clinical Terms (SNOMED CT)

d. invoice ACC (or accredited employers) for approved treatment that is not included within the definition of PHAS.

1.4.2 Assessment and rehabilitation services that fall outside PHAS (non-PHAS)

ACC is responsible for directly purchasing any services outside PHAS to which a patient/client is entitled[7]. ACC is prohibited by the AC Act 2001 (section 303) from entering into contracts for PHAS with DHBs or other publicly funded providers.

However, ACC can enter into direct contractual arrangements with providers of its choice for specified elective surgery, or any other treatment[8] that is not included in PHAS. These providers include DHBs, Community Trust Hospitals and private providers.

When a DHB provides assessment and treatment services that fall outside PHAS or regulations or specific contract arrangements, the DHB must, where appropriate, seek and obtain prior approval, and invoice ACC or the accredited employer.

The cost payable by ACC for non-PHAS is an amount:

a. agreed in a contract between ACC and the provider
For those services where ACC has entered into a contract or agreement for the purchase of non-PHAS, ACC is liable to pay the amount specified in the contract or agreement with the provider for the service. Examples of contracts between ACC and DHBs include elective surgery and non-acute inpatient rehabilitation assessment contracts, and social rehabilitation assessment contracts; or

b. specified in regulations
For example, the CoTR 2003 cover the costs of treatment provided by counsellors, dentists, radiologists, medical practitioners (including registered specialists), specified treatment providers and practice nurses, or services; or

c. covering the cost of treatment
Where there is no contract or agreement or regulations that specify the amount ACC must pay, ACC is liable to pay the cost of treatment for eligible clients provided by a 'treatment provider' (see section 2.4.1 of this guide); and
Schedule 1, Clause 1(2) of the AC Act 2001 states:
"(2) … cost means the cost –
  a. that is appropriate in the circumstances; and
  b. as agreed by the Corporation and the treatment provider."

Prior-approval conditions may apply to treatment; see section 1.4.3 below.

[7] In respect of a personal injury for which they have cover under the AC Act 2001.
[8] The AC Act 2001 defines rehabilitation as comprising treatment, social rehabilitation and vocational rehabilitation

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For mental health services please see section 3.4 of this guide

1.4.3 Prior approval for treatment

Non-acute care is purchased via contracts and regulations that may carry their own entry criteria, such as prior approval. In addition, in some instances (e g physiotherapy) prior approval may be required after a certain number of treatments for a particular injury.

The requirement for a treatment provider to obtain ACC's prior agreement to treatment *does not* apply if the treatment is:

a. acute treatment; or

b. PHAS; or

c. of a type specified in Regulations made under the AC Act 2001 as treatment that does not require ACC's prior approval; or

d. of a type specified in or under an agreement or contract between ACC and a treatment provider as treatment that does not require ACC's prior approval, and the treatment is to be provided by that treatment provider.

ACC may seek a professional second opinion to validate a patient's/client's treatment condition.

ACC is not liable to pay for any services provided by other types of health care providers (eg dieticians, social workers) unless such treatment has been agreed by ACC as part of a rehabilitation plan, *or* the DHBs have the prior approval of ACC (see section 5.2.2 of this guide).

1.4.4 Using an agency to purchase non-PHAS

ACC and accredited employers may use other organisations to purchase services on their behalf, eg TPAs, or other agencies that purchase treatment services.

In some instances, MoH may act as an agent and purchase services that are non-PHAS on behalf of ACC or accredited employers, eg private laboratory services, pharmaceuticals, or residential care for elderly victims of crime.

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Section 2: How the AC Act 2001 translates into operational use

This section lists the general categories of service provided to injured people and describes the services and payment responsibilities. Table 1 gives an introductory overview of the provision of these services.

Table 1: Hospital service categories

(This table should be used in conjunction with 'PHAS and how to calculate the PHAS period' overleaf)

Note:
Non-PHAS specialist clinical mental health services for people with ACC cover are funded by ring-fenced, population-based mental health funding. Please see section 3.4 of this guide for more detail.

Service category	Service type	Covered by PHAS	Purchased directly by ACC[9]
DHB hospital admissions (including day cases)	Acute admissions through to discharge from the acute event (to home or non-acute services)	✓	
	Elective admissions through to discharge		✓
	Non-acute inpatient or residential rehabilitation services		✓
DHB emergency department (ED) attendances (see section 2.1.1 of this guide)	Initial presentation	✓	
	Subsequent service within seven days from initial presentation for that injury	✓	
	Subsequent service post seven days after initial presentation for that injury		✓
DHB hospital medical specialist outpatient services (see section 2.1.1 of this guide)	Services[10] provided by a medical practitioner **within six weeks**: (i) after the day of discharge from acute admission; or (ii) after ED presentation	✓	
	Services provided by a medical practitioner **post six weeks**: (i) after the day of discharge from acute admission; or (ii) after ED presentation		✓

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[9] Through regulations or contract, subject where appropriate to any prior approval conditions being met.
[10] 'Services' include all radiology services required by patients or ordered during acute admissions or ED attendances and as part of medical outpatient services for up to six weeks from discharge or treatment, unless requested privately by a medical practitioner.

Service category	Service type	Covered by PHAS	Purchased directly by ACC[9]
DHB hospital medical specialist outpatient services (see section 2.1.1 of this guide) *(continued)*	Services provided by a medical practitioner **less than seven days** after the date of referral by another medical practitioner[11]	✓	
	Services provided by a medical practitioner **post seven days** after the day of referral by another medical practitioner		✓
Other services – medical specialist	Elective surgery procedure costs include pre-assessment and six weeks post-surgical outpatient attendances, orthotics and equipment		✓
Other services – non medical specialist (see section 2.1.1.4 of this guide)	Services provided by other health professionals, eg physiotherapy, occupational therapy, outpatient nurse-led clinics, provided after discharge from an acute admission, or ED attendance, or on referral from a General Practitioner (GP). Additional information on mental health services is available in section 3.4 of this guide.		✓
	Non-acute outpatient rehabilitation services		✓
DHB community health services (see section 2.3 of this guide)[12]	District/community nursing services and all other services (eg physiotherapy, occupational therapy) provided after discharge from an acute admission, or ED attendance, or on referral from a GP, or from ACC Elective surgery		✓

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[11] Referrals to radiologists by medical practitioners are not included in PHAS if the referral is made as part of providing non-public health acute treatment.
[12] Non-hospital treatment services provided by 'treatment providers' (eg GPs, nurses, physiotherapists, osteopaths, dentists, counsellors etc.), and other rehabilitation services, are purchased directly by ACC under regulations when an ACC45 is lodged and accepted.

2.1 PHAS and how to calculate the PHAS period

The AC Act 2001 defines PHAS as services (as defined in Regulations made under section 322(2) that are funded by the Minister of Health (via the PHAS levy) and provided by publicly funded providers.

The following examples have been developed in consultation with legal experts to clarify PHAS timeframes. It should be noted that some descriptions appear to contradict each other. This is because they reflect the actual legislation. In order to manage this, each situation should be calculated in its own right, eg acute and elective admissions, calculated with their own date explanations.

Table 2: How to calculate PHAS using the IPRC (PHAS) Regulations 2002

Note:
These apply only to services purchased through the Minister of Health and provided by publicly funded providers.

Regulation 4 IPRC (PHAS) Regulations 2002	Duration	Example
(a) Services provided as part of an acute admission[13]	PHAS covers all services related to the acute admission until the date of discharge (see definition in Glossary)	**For example:** Decision to admit made on Monday. Person must be admitted before midnight the following Monday to be an acute admission
(b) Services provided as part of an ED presentation and any subsequent services provided by the ED within seven days after that presentation	Where day zero is the day of the initial ED presentation. The following one to seven days (up to midnight on the seventh day) are included in the provision of subsequent services under PHAS	**For example:** Person initially presents to ED on Monday. Should the person require subsequent ED services, the following seven days – Tuesday to midnight the following Monday – are included in the PHAS period
(c) Outpatient services provided by a medical practitioner and associated with services described in paragraph (a) if those outpatient services are provided within six weeks after the date of discharge from acute admission	Where day zero is the day of discharge from acute admission, the day after the day of discharge is day one and the final day of PHAS is day 42 of the provision of outpatient services	**For example:** Person initially discharged from an acute admission on Monday. The following 42 days (or six weeks Tuesday to midnight Monday) are included in the PHAS period should the person require outpatient services
(d) Outpatient services provided by a medical practitioner and associated with services described in paragraph (b) if those outpatient services are provided within six weeks after the day of treatment (i.e. from ED presentation)	Where day zero is the day of final treatment in ED (within seven days of the initial presentation). Day one is the day after the day of final treatment in ED and the final day of PHAS is day 42 of the provision of outpatient services	**For example:** Person receives final ED treatment for injury on Monday. The following 42 days (or six weeks Tuesday to midnight Monday) are included in the PHAS period should the person require outpatient services

[13] That is, admission to a publicly funded hospital or agreed facility within seven days of a medical practitioner's decision to admit the person to hospital, unless otherwise specified in the regulations (see the definition of acute admission in the Glossary).

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Regulation 4 IPRC (PHAS) Regulations 2002	Duration	Example
(e) Services that are provided by a medical practitioner less than seven days after the date on which the client is referred for those services by another medical practitioner, other than: (i) services associated with services described in (a) or (b); and (ii) referrals to a radiologist by a medical practitioner who is providing treatment for which a payment or contribution is to be made under section 73 or under Schedule 1, clause 1 of the Act	Where day of referral is day zero and day one is the day after the date the referral is made and PHAS ends at midnight seven days after the making of the referral	**For example:** Referral is made on Monday. The following seven days – Tuesday to midnight the following Monday – are included in the PHAS period should the person receive services that are provided by the medical practitioner to whom the referral was made
(f) Services that are ancillary to any of the services described in paragraphs (a) to (e), including non-emergency travel and accommodation for the client, and an escort or support person for the client, but excluding emergency transport (Emergency transport means transport that— (a) starts within 24 hours of a client suffering a personal injury or being found after suffering a personal injury, whichever is the later; and (b) is necessary for the purpose of obtaining treatment urgently for the client's personal injury)	Duration as for (a) to (e) above	
(g) Services that relate to the provision of treatment described in paragraphs (a) to (f), including, for example, the provision of consumables, diagnostic imaging and equipment	Duration as for (a) to (f) above	

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Table 3: Examples of what is included within PHAS (for example during ED attendance)

Note: refer to Appendix 1 - 'a guideline for transfer of funding responsibilities from DHBs to ACC'.

	ED treatment provided under PHAS includes related services directly associated with visit. Services include:	Acute admission[14] services include all hospital-based treatment required during the period from admission to safe discharge home, or transfer to non-acute inpatient rehabilitation services. Services include:	Medical outpatient services[15] include those directly associated with the visit and include urgent attendance at a DHB-facility-based medical practitioner that have been provided less than seven days after the date on which the patient was referred for those services by another medical practitioner. Services include:
Trauma management services	Required during the attendance	Encompass ED care and intensive care	Nil required
Diagnostic support services[16]	Ordered during the attendance	As required	Ordered by DHB medical practitioners and related to attendance
Therapeutic support services[17]	Provided in the ED	As required	Provided during the attendance, including allied health (where multidisciplinary clinics are involved. For example, a specialist visit that includes a physiotherapist attending the session)
Procedures required	During the attendance, eg suturing, plastering, fracture manipulation, urgent dental treatment	As required, eg skin grafting, Open Reduction and Internal Fixation (ORIF), tissue repairs, urgent dental treatment	As required during the attendance, such as wound dressing, plastering, fracture manipulation, urgent dental treatment
Pharmaceuticals	As required	As required	As required
Medical supplies	Used during the attendance eg plasters, dressings	As required, eg plasters, dressings, incontinence products. (For medical consumables required by patients	Used during the attendance, eg plasters, dressings

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[14] An acute admission may be from an ED, an outpatient department or a GP/private specialist referral.
[15] PHAS covers attendance at a DHB-facility-based medical practitioner, not involving an admission to a DHB, for up to six weeks from the date of discharge from acute inpatient, day patient and ED services.
[16] Examples: diagnostic imaging, laboratory services, audiology, electro-diagnostic imaging, optometry, spirometry and urodynamics.
[17] Examples: nursing, allied health, pharmacy, blood transfusion, counselling and interpreter services.

	ED treatment provided under PHAS includes related services directly associated with visit. Services include:	Acute admission[14] services include all hospital-based treatment required during the period from admission to safe discharge home, or transfer to non-acute inpatient rehabilitation services. Services include:	Medical outpatient services[15] include those directly associated with the visit and include urgent attendance at a DHB-facility-based medical practitioner that have been provided less than seven days after the date on which the patient was referred for those services by another medical practitioner. Services include:
		immediately upon discharge, see section 4.7 of this guide)	
Aids and appliances eg orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints (ACC responsible after six weeks from ED attendance or discharge from acute admission)[18]	Assessed by ED as required by the patient during the attendance or immediately on discharge (see section 4.5.1 of this guide)	As required during the admission, eg orthoses, walking aids, wheelchairs, raised toilet seats, bath boards, splints (aids and appliances required upon discharge are discussed in section 4.5.3 of this guide)	Assessed by clinic staff as required by the patient during the attendance or for the six weeks following discharge from acute admission or discharge from outpatients
Administrative support services eg information systems, clerical support, medical records	As required	As required	As required
Hotel services eg accommodation, food, cleaning	Nil required	As required	Nil required (unless attendance is required out of client's area eg National Burn Centre)
Ancillary services including transport and accommodation	Nil required	As required (See Table 23, section 4.12)	As required (see Table 24, section 4.12)

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[18] For information on persons with pre-existing equipment needs, see section 4.5.3.1 of this guide.

	ED treatment provided under PHAS includes related services directly associated with visit. Services include:	Acute admission[14] services include all hospital-based treatment required during the period from admission to safe discharge home, or transfer to non-acute inpatient rehabilitation services. Services include:	Medical outpatient services[15] include those directly associated with the visit and include urgent attendance at a DHB-facility-based medical practitioner that have been provided less than seven days after the date on which the patient was referred for those services by another medical practitioner. Services include:
Notes and exclusions from PHAS	N/A	N/A	**Exclusion:** visit to a health service (eg physiotherapy), community nursing, non-acute outpatient rehabilitation service or nurse-led outpatient service **that is not part** of a visit to a medical specialist outpatient service visit is directly billable to ACC. Provision of any follow-up DHB medical specialist outpatient services or associated services provided by the DHB following the six-week period after discharge from acute admission or date of last presentation at ED, is directly billable to ACC. Exclusion: Medical referrals do not include radiology referrals related to non-public health acute treatment. ACC is responsible for directly purchasing these services for eligible clients.

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2.1.1 Specific examples of treatment and how they are funded

The following tables give specific examples of what is included within PHAS and what is purchased directly by ACC under contract or regulation.

Table 4: Fracture treatment and removal of metal

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment at DHB, including decision to admit within seven days, dependent on clinical need	✓ DHB inpatient or ED treatment (eg removal of plaster or metal for reasons of infection)	
Treatment by a medical practitioner at DHB outpatients within six weeks of discharge from acute admission or ED attendance	✓	
Elective treatment		✓ Providing any contractual/ legislative requirements for prior approval have been met

Table 5: Hyperbaric oxygen treatment

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment at DHB	✓ DHB acute admission, ED attendance or acute outpatient attendance	
Acute treatment at private provider	✓ Acute admission, or acute outpatient	
Non-acute treatment		✓ Under contract arrangement or (if no contract exists) under CoTR 2003

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2.1.1.1 General dental treatment

General dental treatment is provided by registered general dental practitioners[19] within the scope of practice as determined by the Dental Council.

Forms to be used when lodging dental claims

An ACC42 Dental claim registration form must be completed and signed by the client (or their authorised representative) for every dental claim. The ACC42 details the nature and severity of the damage to the affected teeth[20]. Supporting information such as X-rays and patient/client records can be included with the ACC42 to speed up the claim decision.

The initial non-dental medical practitioner who identifies a personal injury may have completed an ACC45 in line with the established process for other injuries. If this occurs ACC lodges the claim using the ACC45, but requires the ACC42 to be completed by the assessing/treating dentist before any prior approval can be given for long-term management of the dental claim. The ACC42 and ACC45 claim numbers are linked in ACC's claim management system.

How ACC purchases dental services

Dental services are purchased at CoTR 2003 rates. There are instances when a person with an accepted ACC claim is unable to receive general dentistry in a dental chair or is unable to comply with treatment without general anaesthetic, due to conditions such as traumatic brain injury or birth injury. In these cases, prior approval from ACC is required for the theatre and anaesthetic services (including when delivered on an outreach surgical bus). However, ACC does not pay for general dentistry that is not injury related.

Table 6: General dental treatment

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment a provided by the DHB in ED or DHB dental department on day of ED presentation or during an admission because general anaesthetic is required	✓	
Acute self-referral directly to DHB dental department for initial treatment as an outpatient		✓ Regulations
DHB outpatient follow-up treatment (general dentistry)		✓ Regulations

General dentistry and specialist needs such as endodontic, periodontic, paedodontic, orthodontic, restorative, prosthetic, public health and special needs are expected to be managed by a patient's own community dental provider and should be referred on for ongoing management at the earliest opportunity.

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[19] Clinical dental technicians and dental therapists who work within dental services and are registered with the Dental Council are not currently on the list of registered treatment providers to ACC.
[20] The Dental Trauma Guide is a web-based tool to evidence based dental traumatology developed by the University Hospital of Copenhagen and the International Association of Dental Traumatology. The Dental Trauma Guide can be accessed via the Dental Trauma Guide Organisation for a small fee.

Table 7: Oral and maxillo-facial surgery

Oral and maxillo-facial surgeons are considered as **specialist medical practitioners** who, when working in a DHB, provide services within the scope of their specialty targeted at those patients who have a clinical need for specialist care.

This may include mandibular maxillary zygomatic arch reconstruction, repair of lacerations and treatment for complex trauma to the face and oral cavity.

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment a provided by the DHB in ED or DHB dental department on day of ED presentation or during an admission because general anaesthetic is required	✓	
DHB outpatient treatment by oral or maxillo- facial surgeon within seven days after the day of referral by a medical practitioner *or* within six weeks of discharge from acute admission or most recent ED attendance	✓	
DHB outpatient treatment after seven days following referral by a medical practitioner *or* after six weeks of discharge from acute admission or most recent ED attendance		✓
Elective treatment at DHB		✓ Providing requirements for prior approval are met. Purchased at regulation rate unless otherwise specified in contract

Table 8: Renal treatment

Service to injured person	Covered by PHAS	Purchased directly by ACC
Acute treatment at DHB	✓ DHB acute admission or ED attendance	
Non-acute treatment at DHB	✓ DHB	

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Table 9: Mental health services

The following table gives specific examples of what is included within PHAS, what is provided by DHBs with population-based mental health funding, and what is purchased directly by ACC under direct contract or regulation. For full details of mental health services, please see section 3.4.

Service to injured person	Covered by PHAS	Those most severely affected by mental injury covered by population-based mental health funding	Purchased directly by ACC
Acute treatment at DHB	✓ DHB acute admission or ED or crisis team attendance		
Non-acute treatment at DHB		✓ Clinical services provided by outpatients or community mental health team	If not under 3% with lower level need: mild to moderate mental health need go to GP or ACC-registered/contracted psychiatrist, psychologist, psychotherapist or counsellor
Community residential or home-based non-clinical support		✓ With dual mental health needs, joint funding between ACC and DHB considered	✓ Where mental health need is only directly linked to covered ACC mental injury claim

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2.1.1.2 Date of discharge from acute admission

The treatment of a client comes under PHAS until the requirement for 'safe discharge' can be met. The date of discharge is the date the client is safely discharged from the acute admission to their home or to non-acute inpatient rehabilitation services – see section 5.6 of this guide.

Exclusion:
A client returning home 'on leave' from a hospital does not constitute a permanent discharge (eg weekend leave for a seriously injured client).

2.1.1.3 Medical referrals

PHAS covers urgent consultations with a DHB medical practitioner that have been provided within seven days after the date on which the patient/client was referred for those services by another medical practitioner. Services covered include services directly associated with the visit – see Table 3. DHBs should note that the seven-day rule applies from the date when the referral is made – the date of the client's injury only provides an indication of the urgency of the need for referral.

Exclusion:
Medical referrals *do not* include radiology referrals related to non-public health acute treatment. ACC is responsible for purchasing these services directly for eligible clients.

2.1.1.4 Other outpatient services (non-medical specialist)

All other outpatient services are purchased directly by ACC, including services such as allied health attendances, non-urgent referrals from medical practitioners, referrals from other treatment providers and medical follow-ups beyond the six-week and seven-day periods outlined above. Prior-approval conditions may apply (see section 5.2.2 of this guide).

DHB hospital treatment providers *may* also refer the client to the private sector for these 'other' services. When making such a referral, the DHB hospital treatment provider must ensure that:

a. the ACC45 injury claim form has been completed and signed by the patient/client or an authorised representative, and sent to ACC

b. a written referral is made to the private sector treatment provider that includes all the information required to ensure continuity of care (this could be in the form of a letter that includes treatment and claim details, a copy of the discharge report, or a copy of the completed ACC45).

Note:
The private provider is responsible for ensuring that any prior-approval conditions have been met before the commencement of treatment.

2.1.1.5 Self-referrals to DHB outpatient services

Patients/clients who self-refer to DHB outpatient services, other than ED services (see section 2.1.1 of this guide), may be treated by any of the non-medical specialist treatment providers listed in section 2.4.1, subject to the correct ACC prior-approval conditions being met. ACC is liable to pay for any such acute treatment, by paying the:

a. amount specified in the DHB's contractual arrangements with ACC; or

b. amount specified in the CoTR 2003; or

c. the cost of the treatment if no contract/agreement or regulations applies.

Prior approval is required for any treatment provided by health professionals who are not 'treatment providers'.

2.1.1.6 Follow-up from other treatment providers (excluding medical specialists)

Clients who are referred to DHB outpatient services (excluding medical specialists) following treatment by a non-DHB-owned provider should be treated as new referrals.

ACC is responsible for directly purchasing this treatment unless the client is referred to a medical practitioner by another medical practitioner and is clinically required to be seen within seven days of referral (see section 2.1.1.3 of this guide).

Note:
The number of treatments provided by a 'referring' provider must be included in the total number of 'allowed' treatments, before prior approval for additional treatment is sought through the ACC32 Treatment extension request for prior approval of treatment form (for example, referrals from private physiotherapists).

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2.2 Elective surgery

Elective surgery is surgery performed outside the PHAS period. PHAS funding covers any acute surgery within the PHAS period. Elective surgery requires prior approval from ACC, to ensure cover is confirmed and the treatment plan is in accordance with entitlements. A Surgical Assessment Report and Treatment Plan (ARTP) must be completed and forwarded to the Treatment Assessment Centre for approval **before** surgery or any preparation for surgery is commenced. ACC is not liable and will decline to pay for elective surgery performed without prior approval unless it is performed as an unanticipated requirement in the course of approved elective surgery.

ACC is responsible for all elective surgery where the admission date is not within seven days of the date the decision was made by the specialist that the admission was necessary. The date of the decision to admit is counted as day zero. Therefore, if the decision to admit is made on a Monday, any admission *after* midnight on the following Monday is an elective admission. In exceptional circumstances, this may be negotiable with ACC.

A decision to admit for elective surgery purchased by ACC can be made during an inpatient admission, outpatient attendance or ED attendance (excluding diagnostic procedures required to support the outpatient assessment or treatment).

Details of ACC's responsibilities for elective surgery costs are contained in the CoTR 2003 (section 18). ACC may enter into contractual agreements with providers (including DHBs) for elective surgery on terms superior to the Regulations for most providers.

Where a client chooses to have elective surgery (contracted or regulation) performed at a DHB, ACC pays 100% of the contracted fee for the treatment to the DHB (as outlined in the Elective Surgery contract), and the client is not liable for any co-payment or part-charge.

If a transport need arises following ACC approved Elective Surgery, ACC pays for this as non-emergency transport under Ancillary Services Regulations 2002. When considering non-emergency transport by air, prior approval is required from ACC.

2.2.1 Other treatment

Occasionally clients require treatment that is not surgical, for example work-related asbestosis requiring chemotherapy, or treatment for infertility that has arisen as a result of a covered personal injury.

In these instances, PHAS rules apply and ACC funds non-PHAS treatment and services. Prior approval must be sought via the Treatment Assessment Centre for any non-PHAS services using the ARTP process.

2.3 DHB community services

All community health services required in relation to a personal injury[21] are purchased directly by ACC, as are any related services[22] **during a community health visit**, such as diagnostic services, equipment and consumables.

This provision includes clients referred to DHB community health services by primary care service providers.

[21] Includes district/community nursing, allied health domiciliary services, home help and personal care services.
[22] Or identified as required and referred in accordance with appropriate practice.

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2.3.1 Self-referrals to DHB community health services

Clients who self-refer to DHB community health services may be treated by any of the 'treatment providers' (listed in section 2.4.1 of this guide). ACC is liable to purchase treatment for patients/clients with a covered injury.

Prior approval is required for most non-acute treatment as well as any rehabilitation provided by health professionals who are not 'treatment providers' (see section 5.2.2 of this guide).

2.4 Community-based (or non-hospital) treatment and rehabilitation services

Acute treatment in the community is provided under regulation and rehabilitation is provided under contract. The same disciplines may be provided under both frameworks, for example occupational therapists.

2.4.1 Non-hospital-based acute treatment in the community

Treatment providers can exercise their clinical judgement as to the urgency of need for treatment. However, this is only if they are appropriately qualified to make clinical judgements of that kind. If not, they must refer the patient/client to an appropriately qualified treatment provider.

ACC's Provider Claim Lodgement Framework details which providers can give the initial treatment and lodge an ACC45 for the injury. In some cases, treatment providers, eg acupuncturists, can give the initial treatment and populate the ACC45 but the patient/client must be referred to a provider who can lodge the ACC claim to complete lodgement before ACC can determine cover.

Table 10: Non-hospital-based acute treatment providers in the community

Provided an ACC45 is completed and signed by the patient/client, the following treatment providers can provide acute treatment for the patient/client for the personal injury for which they have cover under the AC Act 2001, (see the Glossary for a definition of acute treatment).

Non-hospital-based acute treatment providers	
Acupuncturist[23]	Audiologist
Chiropractor	Counsellor[24]
Dentist	Medical laboratory technologist
Nurse	Occupational therapist[23]
Optometrist	Osteopath
Physiotherapist	Podiatrist
Medical practitioner	Speech therapist

Note:
The treatment conditions listed in section 1.3.1 of this guide apply.

[23] Under ACC's Provider Claim Lodgement Framework, acupuncturists and occupational therapists cannot lodge claims (ACC45s) – they can provide acute treatment where the client already has an approved claim that has been lodged by another provider.
[24] Defined in the Accident Insurance ("Counsellor") Regulations 1999.

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2.4.2 Rehabilitation entitlements (including non-acute treatment)

A person who has sustained a personal injury is entitled to rehabilitation purchased by ACC to the extent outlined in the AC Act 2001, to assist in restoring their health, independence and participation to the maximum extent practicable (see section 70 of the AC Act 2001). The injured person is also responsible for their own rehabilitation to the extent practicable, having regard to the consequences of their personal injury (see section 72 of the AC Act 2001).

Table 11: Types of rehabilitation assistance

Where applicable, ACC purchases rehabilitation services (including treatment) from a range of treatment and rehabilitation providers. A client may be entitled to any of the following types of rehabilitation assistance, in addition to acute treatment.

Types of rehabilitation assistance	
Non-acute treatment	Aids and appliances
Attendant care	Child care
Education support	Home help
Modification to the injured person's home	Training for independence
Transport for independence	Vocational rehabilitation assistance

However, a client with a wilfully self-inflicted injury is not eligible for rehabilitation assistance (other than treatment or ancillary services for treatment) unless the injury results from a mental injury covered by the AC Act 2001 (see section 1.3.1 of this guide). Different types of assistance may be funded by other agencies, eg MoH, and each will have its own eligibility criteria.

2.4.3 Individual rehabilitation plans

Under section 75 of the AC Act 2001, ACC is required to develop an Individual Rehabilitation Plan (IRP) in consultation with the client within 13 weeks of the acceptance of the claim for cover if the client is likely to need social or vocational rehabilitation after the 13 weeks have ended. Prior to that plan being developed, ACC is liable for the provision of social and vocational rehabilitation in accordance with the provisions of the AC Act 2001 (Schedule 1, Part 1).

The IRP must identify the patient's/client's need for rehabilitation, the assessments to be done, the services appropriate to meet those needs, and which of the services ACC will provide, pay for or contribute to.

The development of the IRP will require access to relevant information, eg Individual Education Plans and/or a support plan from a Needs Assessment and Service Coordination organisation. ACC will require liaison with the patient's/client's health providers and with disability service providers if there is a pre-existing disability, condition or mental illness. These relationships may need further clarification.

Those seriously injured clients who were assessed as eligible to receive social rehabilitation entitlements under the (now revoked) Accident Rehabilitation and Compensation Insurance (Complex Personal Injury) Interim Regulations 1994 will continue to receive their social rehabilitation entitlements provided for in Individual Rehabilitation Programmes made under those Regulations.

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2.5 Non-acute inpatient rehabilitation service

This service is for ACC clients who require inpatient rehabilitation within a specialist unit and is purchased directly by ACC. Providers must have a contract with ACC to be able to provide non-acute inpatient rehabilitation for ACC clients. The process for transfer of patients/clients from acute services (PHAS) to non-acute inpatient rehabilitation is outlined in more detail in section 5.6.1.1 of this guide.

These patients/clients must meet specific clinical criteria, including prior approval. When patients/clients transfer from acute to non-acute inpatient rehabilitation, DHBs should discharge them from their acute admission and admit them to the rehabilitation facilities with the appropriate health service purchase codes.

Note:
Where a client has a dual diagnosis/multiple diagnoses or concurrent medical condition, ACC is liable if admission to a post-acute inpatient rehabilitation facility is a result of the personal injury. Additional information will normally be required to support the injury-related need.

Refer to Appendix 1: 'a guideline for transfer of funding responsibilities from DHBs to ACC'.

2.6 Services provided by Community Trust Hospitals

The AC Act 2001 includes Community Trust Hospitals as providers of PHAS when they are funded by the Minister of Health or DHBs to provide those services (see the definitions of 'public health acute services' and 'publicly funded provider' in the Glossary).

As with DHBs, ACC is only responsible for paying for treatment provided by a Community Trust Hospital when:

a. the treatment is not part of PHAS
b. the patient/client qualifies for the treatment for personal injury
c. the treatment is provided by an appropriate treatment provider.

See section 1.4.2 of this guide for more information about purchasing arrangements for non-public health acute services including treatment conditions, what ACC pays, and prior-approval requirements.

2.7 Work-related gradual process, disease or infection

ACC covers personal injury caused wholly or substantially by a gradual process, disease or infection in certain circumstances (eg work-related personal injury) as defined in section 26 of the AC Act 2001.

Work-related gradual process claim can only be lodged by a medical or a nurse practitioner by completing an ACC45 form and ticking the gradual process box on the form. Any other provider who believes a person has a gradual process, disease or infection should refer them to a medical or nurse practitioner. Upon receipt of the completed ACC45 form, ACC sends three questionnaires to the patient. The patient must complete their questionnaire and ensure the employer and medical practitioner fills in theirs (medical practitioner completes ACC271 Medical practitioner cover questionnaire). All questionnaires must be returned to ACC so that a cover decision can be made.

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Section 3: Interfaces between agencies

This section discusses examples of services and situations that may require interfaces between agencies, for example, where an injured person has an existing medical condition or disability. Some of these services remain the subject of discussion and resolution between ACC and MoH (which includes disability support services for people under 65).

Where responsibility is unclear, services should be provided while funding responsibility is resolved. Section 6 of this guide, specifically discusses the process for resolving Health/ACC boundary issues. Section 4 covers the services that support the provision of specific treatment and rehabilitation (eg pharmaceuticals).

3.1 Acute/Elective treatment for concurrent medical conditions, pre-existing disabilities or mental conditions or dual/multiple diagnoses

Where patients/clients with an underlying or pre-existing medical condition or disability require an accident-related intervention, the acute treatment is covered by PHAS taking into account the clients' needs.

ACC is responsible for purchasing elective surgery and related services directly for eligible patients/clients, taking into account the patient's/client's individual circumstances and providing any prior-approval conditions have been met. In general, ACC does not purchase treatment for the underlying or pre-existing medical condition.

If an injured person has been receiving ongoing support, for example from MoH for an existing condition, this support should continue to the level it was required before the personal injury occurred. Additional support required because of the personal injury is the responsibility of ACC.

In terms of ongoing care after acute discharge, the personal-injury-related component of care is funded by ACC. DHBs/MoH have responsibility for the non-accident-related health and disability support component of care.

When such a case is identified, the DHB should contact the client's case owner and, if necessary, other involved agencies (eg MoH/Needs Assessment and Service Coordination service) to discuss the process for identifying shared funding responsibilities.

Some common scenarios for ACC, MoH and DHB responsibilities are outlined in Table 12 – it is recognised that these are not exhaustive.

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Table 12: Management of injured person with an underlying or pre-existing condition(s)

If the person has an accident…	Acute phase	Ongoing treatment
…in the community and is admitted to an acute facility, and it is identified that the person has significant medical/mental health issues, or pre-existing impairment or disability	• Covered by PHAS for the injury-related component (health component funded by DHB) until the person meets the clinical criteria • A rehabilitation specialist enters the person into a rehabilitation facility	• ACC funds relevant rehabilitation bed day price (*except mental health)* as long as the rehabilitation is related to the injury; and *DHB funds inpatient mental health rehabilitation* • DHB funds ongoing medical/mental health issues that pre-date that injury event of any new medical condition
…and is discharged home following acute/rehabilitation admission and has ongoing needs	• Not applicable	• DHB funds ongoing disability supports that pre-date that injury event where the person is 65 or over[25] (other than MoH-funded environment support services) • MoH funds ongoing disability supports that pre-date that injury event where the person concerned is *under 65*[26]; • ACC funds ongoing needs that are related to the covered injury
… in the community and they are not admitted acutely for their accident but do require acute admission for a medical condition	• They are admitted and funded by the DHB for their medical treatment	• DHB funds
…in the community and they are admitted for ACC elective treatment, and prior to discharge require acute treatment for a medical condition, eg admitted electively for removal of metal and has cardiac arrest while still admitted	• ACC funds the injury/elective component • PHAS covers the medical acute component[27]	• ACC funds ongoing treatment related to the elective admission • DHB funds ongoing treatment for medical health issues

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[25] Or people who are between 50 and 64 but have disability needs that are similar to those who are 65 and over.
[26] Including MoH-funded environmental support services.
[27] This may be reported to the NMDS as two events if the patient meets the facility or the specialty or funding criteria for ending the event (see the NMDS data dictionary – event end type code). If the event does not meet these criteria, report as one NMDS event and the PHAS component will be agreed between ACC and MoH.

If the person has an accident…	Acute phase	Ongoing treatment
…while in hospital and they suffer a minor personal injury	• DHB funds. The person remains in the same ward and under the same specialist because the injury does not affect the existing clinical treatment plan. An ACC45 number should be reported in the NMDS and details of the accident included in the discharge clinical coding along with external cause codes[28]	• DHB continues to pay
…while in hospital and their injury is major	• PHAS covers the injury component of admission if it is significant enough to affect the complexity of care or length of stay • An ACC45 should be lodged and details of the accident reported in the discharge clinical coding (along with external cause codes)[29] • Note: If treatment injury, an ACC2152 Treatment injury claim form should also be completed	• DHB funds ongoing medical/mental health issues • ACC funds ongoing treatment related to the injury

3.2 Acute admission of persons with existing specialised community care needs

There are ACC clients with long term impairments as a result of a personal injury who receive highly specialised personal care in the community. For example, specialised bowel cares for a person with tetraplegia. In such exceptional circumstances and for client's safety; where it has been determined that a client requires support from their regular community provider to safely deliver specialised care when admitted to hospital, the client needs to raise the need for this support via their ACC case manager. The ACC case manager will request DHB to provide supporting information.

If approved by ACC, the cost of support provided by a community provider will be paid by ACC. DHBs need to have their own policies and procedures to ensure obligations of the DHB are met in relation to patient safety, health and safety, privacy and security. Where community support is not approved and during the period of time ACC takes to make a decision to approve support, the DHB must meet the client's health and support needs. Any requests for assistance must clearly specify the level of support required and why this cannot safely be delivered by the DHB.

Note:
The DHB is expected to communicate early with ACC and involve the relevant case manager in the discharge planning to ensure that the client receives appropriate care to meet their identified needs and entitlements in a timely manner – see section 5.6 of this guide.

[28] In the NMDS the ACC45 number is reported and the accident flag is set to 'N'.
[29] The ACC45 number is reported in the NMDS and the accident flag is set to 'N'. If the patient meets the criteria for a statistical discharge from the admitting event (see the NMDS data dictionary – event end type code), report as two NMDS events. If the patient does not, then report as one event.

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3.3 Other government rehabilitation and disability support services

The DHB is the appropriate contact for issues regarding disability support services for

a. people 65 and over

b. people who are between 50 and 64 but have disability needs that are similar to those who are 65 and over[30].

Where a person requires treatment/rehabilitation but is not entitled to services provided by ACC because they do not have ACC personal injury cover, they may be eligible for either:

a. MoH support if they have a long-term disability and are under the age of 65; or

b. DHB older persons' services if they are 65 years and older or are close in age and interest and between 50 and 64 years of age (see section 3.7, paragraph two of this guide for additional information on this definition).

Acute period – the acute component of related specialised services, such as traumatic brain injury and spinal injury services, is provided by DHBs as part of PHAS (acute medical/surgical services) when there is an accepted ACC claim. The acute period ends when the patient is safely discharged home or into non-acute inpatient rehabilitation services.

Post-acute period – in some instances a person will have ACC cover for personal injury but be disentitled to rehabilitation services in terms of sections 118-122[31] of the AC Act 2001. In the case of disentitlement, a person may be eligible for other rehabilitation and disability support services, but must meet the same access criteria as people with health/disability needs for that service.

Any matters of doubt or difficulty should be referred through a boundary issues resolution procedure (see section 6 of this guide). If there is a delay in deciding an ACC claim (for example in cases of treatment injury) and the injured person receives services from another agency, ACC may require that agency to send supporting information with an invoice for reimbursement within 12 months of the claim being accepted (see section 5.7.4 of this guide).

3.4 Mental health services

3.4.1 Eligibility

ACC provides cover and entitlements for people who have a clinically significant mental health condition diagnosed using standardised diagnostic systems and by appropriately qualified mental health practitioners[32], that is:

a. caused by certain criminal acts (sensitive claims, as per Schedule 3 of the AC Act 2001); or

b. a consequence of a physical injury for which a person has ACC personal injury cover, (for example traumatic brain injury); or

c. a consequence of a work-related mental injury for which a person has ACC personal injury cover (for example, a taxi driver traumatised when a knife is used to threaten them while they were working); or

[30] For issues regarding disability support services for people under 65, contact MoH's Disability Support Services.
[31] Note that section 119, Disentitlement for wilfully self-inflicted personal injuries and suicide, was re-introduced from 1 July 2010 by the Accident Compensation Amendment Act 2010. The new section 119 does not apply to claims lodged prior to 1 July 2010. The Accident Compensation Amendment Act 2010 also introduced a provision that disentitles certain imprisoned offenders (section 122), which applies to claims lodged on or after 1 July 2010.
[32] A 'clinically significant' mental health condition is a mental health condition that requires treatment.

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d. a consequence of a treatment injury for which a person has ACC personal injury cover (for example, a person suffering from psychological distress due to a delay in receiving critical treatment and has had to undergo far more invasive treatment than they would have needed if the treatment had been given earlier).

Publicly funded specialist mental health and alcohol and other drug services (mental health services) provided by, or funded by, DHBs are targeted at the 3% of the population most severely affected by mental illness or substance dependence.

ACC clients who meet the eligibility criteria to receive publicly funded specialist mental health services are included in this funding arrangement in the same way as non-ACC clients where they are:

a. provided by a DHB; and

b. are not purchased through the Minister of Health's funding arrangements for PHAS.

Under an agreement between ACC and MoH, non-clinical mental health support services such as residential, home-based support and vocational services will be funded by ACC where the need arises from a covered injury, even though these services are usually funded by MoH for people with severe mental illness who are not able to be supported in their own home[33].

This decision recognises that ACC is responsible for funding services to support the fundamentals of daily living, where a client's need for support with the activities of daily living is a consequence of trauma covered by ACC. The decision is consistent with arrangements relating to mental health services for people whose disability support needs are met by MoH.

3.4.2 Specific services

This section describes the types of services that ACC clients with a mental health condition might receive.

3.4.2.1 ED attendances

Any consultation or treatment delivered by mental health staff for personal injury (physical or mental) at a hospital ED is purchased through PHAS.

3.4.2.2 Acute inpatient admissions to mental health services

These services provide care for people in the acute stage of mental illness, as well as care for people in need of a period of close observation, intensive investigation and/or intervention where this cannot be provided safely in a community setting.

Inpatient services include assessment and treatment provided by psychiatrists, nurses and allied health professionals (eg psychologists, counsellors and social workers). Acute inpatient mental health services are purchased through PHAS for the period of the acute admission.

3.4.2.3 Consultation/liaison services (inpatient)

Mental health consultation/liaison services are provided by mental health staff to staff and patients in non-psychiatric inpatient services. These services are provided to people with ACC cover and are funded by PHAS during acute admissions or mental health funding for non-PHAS admissions.

3.4.2.4 Post-acute inpatient mental health services provided by DHBs

The expectation is that patients will return to community living. In very exceptional cases the most appropriate long-term arrangement is in a DHB-operated facility (for example, when clients are unable to be discharged from inpatient MoH facilities because there is a lack of appropriate community-based residential facilities to safely meet the client's needs). In these cases, DHBs can request ACC to purchase

[33] Access to the support services will be arranged by agreement with ACC.

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(or contribute to the cost of) ongoing inpatient services. It is expected that a DHB will advise ACC of any potential issues requiring a joint funding approach as early as possible, so that both organisations can work together to develop a plan to find the best solution in each situation.

3.4.2.5 Post-acute community-based residential rehabilitation for mental health patients

ACC purchases post-acute community-based residential rehabilitation via contract for patients/clients who have cover for a sensitive claim or physical injury, such as traumatic brain injury, which results in the need for support provided in a mental health setting.

If a DHB identifies a need for a person to receive post-acute residential rehabilitation because of a mental injury caused by a sensitive claim event, the DHB must contact the Sensitive Claims Unit on 0800 735 566 to discuss the patient's needs before a placement decision is made.

If the need for post-acute residential rehabilitation arises from physical injury, the DHB must contact the person's case manager if known, or the nearest ACC Branch, to discuss the patient's needs before a placement decision is made.

3.4.2.6 Community clinical mental health services, including follow-up outpatient services

Attendance at an ED, a mental health crisis service or a mental health inpatient unit is purchased under PHAS. Once a person has been discharged from these services they may need a community mental health team or alcohol and drug team to help them in their recovery.

Treatment for personal injury by a DHB community mental health service is purchased through PHAS if a registered medical practitioner provides the outpatient service:

a. as part of the outpatient follow-up to an acute admission or ED attendance, for up to six weeks after the discharge or treatment date; or

b. there is a doctor-to-doctor referral, and the person is seen within seven days of referral.

PHAS covers all services directly associated with the consultation (see section 2.1 of this guide). After the PHAS period, ACC clients who meet the eligibility criteria for publicly funded specialist mental health services are eligible for community clinical mental health services (including alcohol and drug services) funded in the same way as for non-ACC clients.

This means that subsequent medical services and referral to allied health services provided by community mental health teams (including drug and alcohol services) in the community are covered by ring-fenced mental health funding.

If a mental injury is not covered by a DHB's mental health service (i.e. mild to moderate severity) or services would not be provided by the DHB under ordinary circumstances, then the DHB should contact ACC to advise of ongoing treatment needs. In this situation, any follow-up treatment (such as counselling) in the primary or private sector will be purchased by ACC and/or the client.

3.4.2.7 Pharmaceuticals

Please see section 4.2 of this guide.

3.4.2.8 Mental health services for older people

People who are 65 years and over and have a mental health condition which is managed by mental health services will be funded as for people under 65.

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3.5 Self-injury

Mental health treatment required by people who have a self-inflicted injury covered by ACC is purchased through the same mechanisms as other mental health services.

The AC Act 2001 does not provide an entitlement to treatment for any underlying mental condition (such as depression) that pre-dates a self-inflicted injury unless the underlying condition is covered by ACC as a prior mental injury.

3.6 Sexual assault services and sensitive claims

See section 3.4 of this guide for more information about mental health services and counselling services for patients/clients who have a diagnosed clinically significant mental injury caused by a sensitive claims event.

MoH, New Zealand Police and ACC fund Sexual Abuse Assessment and Treatment Services (SAATS). This service primarily addresses the medical and/or forensic needs of patients/clients where there is alleged sexual abuse or assault.

Most DHBs are suppliers for SAATS and are responsible for ensuring linkages are created with crisis support agencies. If a patient/client is demonstrating psychological distress in response to a sensitive claims event and support is clinically indicated, then the SAATS clinician should refer the patient/client to an appropriate agency or the Integrated Services for Sensitive Claims (ISSC) contract for the patient/client to access immediate support and treatment via an ISSC supplier located on www.findsupport.co.nz. Other agencies may include Rape Crisis, Victim Support and DHB mental health teams.

3.7 Residential care for elderly victims of crime

Funding arrangements effective from 1 November 1998 have ensured that an elderly person who required long-term residential care as a direct result of being a victim of a violent crime would not be responsible for paying for their long-term residential care.

For these purposes 'elderly people' are defined as people 65 years and older or people who are close in age and interest and between 50 and 64 years of age. In the latter case, a clinical decision must be made by a geriatrician/psycho-geriatrician to determine whether a person has similar care needs to a person who is over the age of 65.

In the instance of an elderly victim of crime needing long-term residential care, ACC (through the client's case manager) works in conjunction with the client's DHB (usually through their local Needs Assessment Services Coordination agency).

ACC should be advised as early as possible, using an ACC706 Early notification of complex case form, if the DHB believes that long-term residential care is likely to be required for an individual.

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Section 4: Services that support treatment and rehabilitation

This section lists ancillary services provided to injured people. It describes when these services are included in PHAS, and outlines funding responsibilities. Where responsibility is unclear, interim arrangements are in place to resolve the issue. Section 6 of this guide specifically discusses the process for resolving Health/ACC boundary issues.

4.1 Blood and blood products

Blood is donated and cannot be charged for by the blood service provider. The provision of blood services (cross-matching, supply of blood and blood products, storage and administration of blood and blood products) outside PHAS is included in the costs of elective services purchased by ACC as a part of treatment. Blood services required within the PHAS period are included in PHAS funding.

If a patient/client receiving treatment for a personal injury also requires blood products for the treatment of an underlying medical condition, eg Factor VIII for people with haemophilia, these blood products will be purchased by the DHB.

4.2 Pharmaceuticals

The AC Act 2001 definition of pharmaceutical is provided in the Glossary to this guide.

ACC is liable to pay or contribute to the cost of pharmaceuticals (prescription medicines, restricted medicines, pharmacy-only medicines and controlled drugs) when:

a. they are prescribed by a treatment provider who has statutory authority to prescribe pharmaceuticals

b. the pharmaceuticals are reasonably required to facilitate a client's treatment for personal injury.

ACC pays or contributes to pharmaceutical costs for ACC clients:

a. through bulk funding payments under the Annual Service Agreement between the Minister of Health and the Minister for ACC for PHAS and community pharmaceuticals and laboratory tests

b. through reimbursements to clients for co-payments on community pharmaceuticals, and in some cases reimbursement of the cost of pharmaceuticals not on the Pharmaceutical Schedule

c. through direct payments to pharmacies/providers who have direct billing approval from ACC

d. via service contracts that are inclusive of the costs for pharmaceuticals.

The bulk funding arrangements for PHAS include pharmacy services and pharmaceuticals that are provided as part of the services that DHBs and other publicly funded providers are responsible for. PHAS includes pharmaceuticals:

a. required by patients/clients during acute admissions or ED attendances

b. administered by a medical practitioner as part of the treatment associated with an outpatient visit for up to six weeks from discharge or treatment

c. required during treatment provided by medical practitioners less than seven days from referral by another medical practitioner

d. for patients/clients that are prescribed and dispensed in the community and that meet the funding criteria of the Pharmaceutical Schedule.

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Clients can seek reimbursement of co-payments on community pharmaceuticals from ACC or their accredited employer.

If a prescriber wishes to prescribe a pharmaceutical for use in the community that is not on the Pharmaceutical Schedule (i.e. a pharmaceutical that is not subsidised), they may apply to ACC or the accredited employer on behalf of the client to seek funding for this. The prescriber must complete an ACC1171 Request for pharmaceutical funding form to request funding from ACC for non-subsidised pharmaceuticals. On discharge, DHB prescribers should write prescriptions for subsidised pharmaceuticals to avoid high patient pharmaceutical costs in the community.

DHBs are required to record the accident claim form (ACC45) number against each item when prescribing medicines. A MoH identifier must be recorded for all medical illness prescriptions to distinguish between accident and medical cases.

4.2.1 Overseas residents and pharmaceuticals

Overseas residents who are in New Zealand are considered 'eligible people' for health services if they are covered for injury by ACC. This means they should get the same funding for pharmaceuticals as New Zealand residents if the pharmaceuticals are required to treat an injury covered by ACC.

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Table 13: Process for accessing PHAS/ACC directly purchased pharmaceuticals

Injury scenario	Prescription pharmaceuticals	Funding approval	Funding source
Person admitted acutely or treated in ED	All pharmaceuticals included	• Not required from ACC. • Standard hospital prescribing process applies	PHAS
Person being discharged from inpatient stay or ED	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria and **hospital is supplying** the pharmaceuticals. (Clients are eligible for any named patient pharmaceutical applications and discretionary supply guidance)	• Not required from ACC. • Standard hospital prescribing process applies	PHAS
	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria and **hospital is not supplying** the pharmaceuticals	• Not required from ACC. • Standard hospital prescribing process applies	PHAS **Note:** Community pharmacies may charge a co-payment and client can seek reimbursement from ACC
	If required pharmaceuticals not included in Pharmaceutical Schedule	• Funding approval required from ACC before pharmaceutical is prescribed	ACC. If approval gained, client can seek reimbursement for agreed costs
			If funding approval not sought or not given, then client reimbursement may be declined

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Injury scenario	Prescription pharmaceuticals	Funding approval	Funding source
Person not admitted acutely to DHB and seen by community prescriber eg GP, specialist nurse, optometrist	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria	• Not required from ACC. • Standard hospital prescribing process applies	PHAS **Note:** Community pharmacies may charge a co-payment and client can seek reimbursement from ACC
	If required pharmaceuticals not included in Pharmaceutical Schedule	• Funding approval required from ACC before pharmaceutical is prescribed	ACC. If approval gained, client can seek reimbursement for agreed costs
			If funding approval not sought or not given, then client reimbursement may be declined
Person referred to ACC directly funded service and pharmaceuticals included in service specification eg Residential Support Services	All pharmaceuticals included	• Not required from ACC	Paid for within contracted rate
Person referred to ACC directly funded service and pharmaceuticals are not included in service specification for contract eg home-based nursing	If required pharmaceuticals included in Pharmaceutical Schedule and person meets criteria	• Not required from ACC. • Standard community prescribing process applies	PHAS **Note:** Community pharmacies may charge a co-payment and client can seek reimbursement from ACC
	If required pharmaceuticals not included in Pharmaceutical Schedule	• Funding approval required from ACC before pharmaceutical is prescribed	ACC. If approval gained, client can seek reimbursement for agreed costs
			If funding approval not sought or not given, then client reimbursement may be declined

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4.3 Laboratory services

The PHAS agreement includes funding for laboratory services provided to clients during acute ED, outpatient and inpatient presentations.

Outside the PHAS period, the agreement covers the cost of community laboratory services provided from community referrals, non-acute medical specialist outpatient services (including private), community nursing services, all allied health outpatient services and services provided as part of elective assessments or admissions. Laboratory tests supporting the above services are covered by the DHB even when private laboratories provide them, and clients cannot be charged for these tests.

DHBs and community providers are required to record the accident claim form number (from the ACC45) on any form requesting laboratory tests.

4.4 Radiology services

PHAS funding includes radiology services. It covers all diagnostic imaging (including high-tech imaging) required by clients or ordered during acute admissions or ED attendances and as part of medical outpatient services for up to six weeks from discharge or treatment.

Radiology referrals to a private provider are the responsibility of ACC to directly purchase even within the acute service timeframes, if the referral is made by an appropriate treatment provider as part of providing non-PHAS services. Clients must meet relevant contract eligibility criteria.

Should a DHB subcontract radiology services during the PHAS period (for example, due to strikes), the DHB is responsible for funding those radiology services.

Outside the PHAS period, ACC purchases radiology services provided as part of services funded directly by ACC. This covers primary care referrals, post-six-week follow-up services, and services provided as part of elective assessments or admissions. This applies whether clients are referred to private or DHB radiology clinics.

DHBs are required to record the accident claim form number (from the ACC45) on any forms requesting diagnostic imaging.

4.5 Equipment (aids and appliances – excluding orthotics)

Equipment (aids and appliances) comprises reusable items that are supplied to assist in restoring clients' independence in everyday activities to the maximum extent practicable.

Note:
Wheelchair batteries and negative-pressure wound therapy units are reusable, and therefore also considered to be equipment.

4.5.1 Eligibility criteria for equipment

A patient/client is eligible to receive equipment if they have an accepted claim and an entitlement to receive funding for rehabilitation equipment (social or vocational).

A patient/client with a wilfully self-inflicted injury is not entitled to receive equipment unless the injury results from a mental injury covered by the AC Act 2001.

ACC is not responsible for providing equipment if the:

a. patient/client already possesses equipment that has a similar function to that recommended in the assessment. Exceptions to this can occur if the piece of equipment is unsuitable due to its age or condition (eg needs renewing or upgrading)

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b. piece of equipment is more expensive than an item that is strictly required to meet the patient's/client's identified needs

c. equipment (or any item used in association with the equipment) requires replacement due to the patient/client neglecting, abusing or misusing the equipment

d. patient/client, after injury, disposed of a piece of equipment that had a similar function and was suitable

e. equipment relates to a medical need, pre-existing disability or impairment, rather than a need through personal injury.

Note:
Where a personal injury leads to an increased need for equipment that is already used by a patient/client because of an existing condition or need, ACC is responsible for the provision of appropriate equipment or modifications to equipment to meet the individual's new needs. See section 4.5.3.1 of this guide.

4.5.2 Responsibility for the provision of equipment

Table 14: Provision of equipment

Patient requires:	DHB or rehabilitation provider	ACC
…equipment to assist recovery from a personal injury and is being discharged home from the acute admission	• Assesses the immediate need for equipment supply[34] or loan of equipment for the initial six-week period after discharge from the acute admission. Costs associated with this assessment and supply are covered by PHAS funding • Advises ACC if ongoing equipment is needed after six-week period	ACC provides equipment after the post-discharge PHAS period
… equipment to assist recovery from a personal injury and is being **discharged home by a DHB different from their DHB of domicile**	• Makes arrangements with the person's DHB of domicile to supply the assessed equipment. Costs associated with this assessment and supply are covered by PHAS funding • Advises ACC if ongoing equipment is needed after six-week period	ACC provides equipment after the post-discharge PHAS period
… **reassessment within six weeks of discharge** as part of a medical outpatient service	• Remains responsible for providing the equipment until the expiry of the six-week period (PHAS funding) • Advises ACC if ongoing equipment is needed after six-week period	ACC provides equipment after the post-discharge PHAS period

[34] This includes temporary ramps.

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Patient requires:	DHB or rehabilitation provider	ACC
… **transfer from acute admission into (ACC directly purchased) inpatient rehabilitation** and is in rehabilitation for **less than six weeks**	• Rehabilitation provider provides equipment needed during inpatient rehabilitation as part of their ACC contract (inclusive of bed stay charge) • DHB (of domicile) funds (under PHAS) equipment needed for the remainder of six-week post-discharge period if patient is discharged home from inpatient rehabilitation within six weeks of acute discharge date • Advises ACC if ongoing equipment is needed after six-week period	PHAS covers equipment needs for up to six weeks post discharge from acute care. (Note: The six-week period begins upon admission to Non-Acute Rehabilitation (NAR) i.e. the client is discharged from acute care) After this time, ACC is responsible for purchasing equipment where the eligibility criteria above is met
… **transfer from acute admission to ACC directly purchased inpatient rehabilitation**, and requires equipment during rehabilitation, eg wheelchair, **and the need for equipment is being reviewed during inpatient rehabilitation admission**	• Rehabilitation provider provides equipment needed during inpatient rehabilitation as part of their ACC contract (inclusive of bed stay charge) • Advises ACC if ongoing equipment is needed	ACC provides appropriate equipment needed at home post inpatient rehabilitation discharge (unless discharge was still within PHAS period– see above)
…**transfer from acute admission to ACC directly purchased inpatient rehabilitation, and requires the identical specialised equipment during and after rehabilitation**	• ACC must be advised of this need for specialist equipment prior to acute discharge	ACC may provide equipment from the date of discharge from the acute admission

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Equipment required by a person who has suffered a personal injury, for which they have cover under the AC Act 2001, is funded through PHAS for the acute period, including the six-week medical specialist outpatient period after acute discharge or ED attendance. Once the six-week period has elapsed, the responsibility for provision of equipment falls to ACC, except in some circumstances eg if cover has not yet been agreed and the MoH becomes the interim funder.

ACC's responsibilities for equipment cover: self-referrals, primary referrals, post-six-week outpatient services, allied health outpatient services (eg occupational therapy and physiotherapy), and services provided as part of non-PHAS, including elective assessments and elective surgery.

4.5.3 Processes when equipment is needed after discharge

On discharge from hospital (post-acute/ED discharge and post-elective-surgery discharge) or inpatient rehabilitation, the client may require equipment after the six-week period for which the DHB is responsible. In the case of directly purchased inpatient rehabilitation**,** there may also be a need for equipment after inpatient rehabilitation has ended.

If after the six-week period the client still requires the equipment, ACC provides it from the six-week 'cut-off'. ACC may provide the equipment from the point of acute discharge if it is required for more than six months. In both cases:

a. the DHB should give ACC one month's notice of the need for this service

b. ACC should supply the equipment through a Managed Rehabilitation Equipment Service (MRES) supplier.

The scenarios in Table 15 may apply depending on the DHB's/rehabilitation provider's recommendation.

4.5.3.1 Replacement or modification of pre-existing equipment

Where a person already has equipment because of a pre-existing disability or medical condition and this equipment needs replacement or modification as a result of a covered personal injury, the DHB or relevant disability support service should contact the client's case manager to discuss options for equipment replacement or modification.

4.5.4 Deposit for loan of equipment

A DHB may charge the patient/client a refundable deposit for the supply or loan of equipment. Such deposits are not considered to be a user charge. The patient/client may not be required to pay a deposit if they can demonstrate resultant financial hardship.

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Table 15: Equipment provision scenarios

If the DHB/rehabilitation provider recommends that equipment is required:				
…for less than six weeks	the DHB is required to provide *all* equipment at no additional cost to ACC. Under *no* circumstances will ACC fund any part of any equipment on discharge of a client from hospital. ACC has already paid for this equipment as part of other agreements			
If the DHB/rehabilitation provider recommends that equipment is required:				
...for more than…	**the DHB should…**	**the ACC case owner…**	**then…**	**and…**
… six weeks	use the ACC705 "Referral for support services on discharge" or the ACC706 "Early notification of complex case" form pre discharge; or post discharge use the ACC4249 "Short-Term Equipment (needed post six weeks discharge) request" form if the client needs equipment for a PHAS period of more than six weeks	either places an online equipment order with the MRES supplier[35]; or if more information is required, organises a Social Rehabilitation Assessment, from which an online equipment order is sent to the MRES supplier	ACC equipment is delivered to the client by the MRES supplier[36]	the DHB collect their equipment.
	Note: If the equipment is: • required for just a short time longer than six weeks • difficult to install or remove and doing this would disrupt the client • cost effective to continue to supply through the DHB	determines how much longer equipment is required, generates a purchase approval authorising the DHB to extend the equipment loan beyond six weeks, and sends this to the DHB	the DHB equipment remains with the client	the DHB collect their equipment at the end of the approved timeframe
…six months	ACC starts funding the equipment from the point of discharge. If the hospital assessment is sufficient to satisfy a purchasing decision for the equipment, the case owner orders the equipment. The MRES supplier can consider purchasing the equipment items from the hospital if equipment has been customised for the client. Otherwise the case owner arranges a Social Rehabilitation Assessment and follows the equipment supply process			

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[35] The MRES supplier manages ACC's rehabilitation equipment on behalf of ACC. ACC owns the equipment that is loaned to clients and the MRES supplier manages the process of loans and collection.
[36] Where there is an overlap in equipment provision, because equipment loaned by a DHB for a six-week period has not been collected by the DHB (even though ACC has provided equipment to the client), ACC is not responsible for loan costs incurred during the overlap period.

4.6 House modifications and transport for independence

4.6.1 Housing modifications

Housing modifications are funded by ACC to assist a client to live as independently and safely as possible given the limitations imposed by their injury; this is achieved by removing structural barriers and/or adding fixed features. Entry is via an appropriate assessment conducted by ACC-contracted occupational therapists specialising in housing modifications.

In deciding whether to provide or contribute to the cost of modifications to a person's home, ACC needs to consider:

a. the rehabilitation outcome that would be achieved by providing the modifications
b. the difficulties faced by the person in doing the following without the proposed modifications:
    i) gaining access to their home
    ii) enjoying reasonable freedom of movement within the home
    iii) living independently in their home
c. the likely duration of the person's residence in the home
d. the cost, and the relevant benefit, to the person of the proposed modifications
e. whether the property owner agrees to the proposed modifications being undertaken
f. the likely cost of reasonable alternative living arrangements
g. the likely duration of the person's limitations arising from the personal injury for which they have cover.

It is important that early discharge planning consider any housing modifications that may be required by the person on discharge and that these are communicated to ACC to initiate a housing modification assessment.

ACC's contracted Housing Assessor will identify the limitations encountered by the person in their home environment given their injury-related needs and, in collaboration with ACC's Housing Modification Service, identify the most appropriate and cost-effective equipment or housing modification solutions to address those needs.

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4.6.2 Transport for independence

Transport for independence aims to restore a client's independence to the maximum extent practicable, particularly their ability to access transport safely and be mobile. Entry is via an appropriate assessment conducted by an ACC-contracted transport for independence assessor.

Table 16: Transport options

ACC can consider supporting transport for independence in several ways. The AC Act 2001 requires that ACC considers all possible transport options. These include making a contribution towards:

Transport Option	Meaning
Funded transport i.e. public transport, taxi or escort in a private vehicle. Note: This is not used for transport to treatment, rehabilitation, or to visit an ACC office	Funded transport can include a contribution for additional travel costs incurred by the client because of their injury-related needs, over and above the costs they would normally incur, eg the additional costs of taking a taxi to the supermarket if they are unable to drive themselves
Vehicle modifications Essential modifications to a client's vehicle to enable them to drive independently	Vehicle modification means adding or removing features of a vehicle so that the client can: • gain access to vehicle and have freedom and safety of movement while in it • drive or operate the vehicle safely • travel safely as a passenger • transport essential mobility equipment
Vehicle contribution	To assist a client in obtaining a suitable motor vehicle with assessed injury-related features
Driver licence retraining	To assist a client to regain their driver licence

The type of assistance or support that ACC can provide depends on the client's individual transport needs and the rehabilitation outcomes to be achieved.

Any requests for funded transportation should be referred to ACC to discuss with the client the activities that they need transport for and the frequency of those requirements.

4.7 Medical consumables

A medical consumable is a medical product, or a product used for a therapeutic purpose, that:

a. is not a pharmaceutical
b. is not reusable
c. a patient/client has an assessed need for
d. is required as a result of the patient's/client's personal injury, to assist in restoring the patient's/client's health, independence and participation to the maximum extent practicable
e. is cost effective
f. has evidence to justify its use.

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Table 17: Medical consumables terms and meanings

The definition includes the following terms and meanings:

Term	Meaning
Medical products	Products used for a therapeutic purpose on humans or related products.
Therapeutic purpose	Used for the purpose of treating or preventing disease.
Not reusable	The product is single use, disposable or non-recyclable.
Assessed	The process by which the need for medical consumables are determined by a contracted assessor or provided within treatment regulations.
Required	Products that are essential as a consequence of the injury.
Covered personal injury	That only the 'covered' injury is being addressed and not any pre-existing condition. **Note:** It is not always possible to differentiate between the two, and some joint funding arrangements may apply.
Restoring (in relation to client)	Returning to the client's original condition or maintenance so that their condition does not deteriorate.
Practicable	Practicable after considering and balancing: the nature and consequences of the injury; the achievement of rehabilitation outcomes; cost; cost effectiveness; the availability of other forms of rehabilitation; and other relevant factors (from section 6 of the AC Act 2001).
Cost effective	The best-quality product for the best price.
Evidence based	There is good clinical literature available concerning the efficacy of the product.

Table 18: Medical consumables

Examples of medical consumables include:	
incontinence sheets and pads	hearing aid batteries
wound care/prevention products	tracheostomy brushes, tubes and holders
syringes and needles	dressing and catheter packs
ventilator disposables – humidifiers and oxygen	tubing, swivel connectors and filters
feeding tube sets	catheters (urinary and suction) and irrigation solutions for bladder irrigations
urine bags and associated tubing	ostomy bags
connectors and tapes	gastrostomy and nasogastric tubing

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Table 19: Medical consumables – funding responsibility

The responsibility for funding medical consumables is as follows:

Medical consumables used during PHAS[37] period of treatment	Medical consumables used outside PHAS period (when ACC is funding the service to the injured person)
Funded under PHAS. (Note: Nurse visits after acute discharge are purchased directly by ACC)	Funded by ACC via contract arrangements, eg community nursing contracts, including ACC-purchased community-based services (eg for changing of dressings) during the six-week period when the client is attending medical outpatients

Prior to a patient's/client's discharge, the DHB needs to assess the patient's/client's immediate need for medical consumables. In cases where discharge planning with ACC is not possible, the DHB should arrange a reasonable supply for the patient/client, sufficient to cover the period until ACC can organise medical consumables (about a week).

It should be noted that treatment covered under the CoTR 2003 include the costs of medical supplies associated with that treatment. For example, plaster costs are included in the payment for fracture treatments.

4.8 Orthotics

Orthotics must be prescribed by an approved health practitioner, eg Orthopaedic surgeon, Rheumatologist, Sports medicine specialist, General Practitioner, Podiatrist or Physiotherapist, and the orthotic device must be required as a result of a covered personal injury[38].

Table 20: Funding responsibility for orthotics

	Funded under PHAS	Purchased directly by ACC
Orthotics required for less than six weeks	The hospital is required to provide these orthotics at no additional cost to ACC. Under *no* circumstances will ACC fund any part of orthotics on discharge of a client from hospital	ACC has already paid for this equipment as part of other agreements[39]
Orthotics required for longer than six weeks and less than six months	First six weeks after ED attendance or discharge from acute admission. ACC should be informed one month prior to 'handover' if orthotic use will extend beyond the six-week period	From six-week period
Orthotics required for more than six months		From point of discharge from acute admission, or ED attendance. Note: Prescription required from appropriate health practitioner

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[37] Including consumables used during medical specialist outpatient visits within six weeks of acute discharge or ED attendance.

[38] A client with a wilfully self-inflicted injury is not entitled to receive orthotics unless the injury results from a mental injury covered by the AC Act 2001. The current provisions of section 119 of the AC Act 2001 only apply to suicides or wilfully self-inflicted injuries that occur on or after 1 July 2010. See the Accident Compensation Amendment Act 2010, section 53. However, if funding for orthotics is covered under PHAS (eg orthotics required for less than six weeks) or under an agreement for treatment such as elective surgery, then orthotics may be supplied if there is no additional cost to ACC.

[39] The elective surgery contracts cover post-discharge/post-procedure care including, but not limited to, any orthotics (and any associated orthoses) required for up to six weeks post discharge.

4.9 Prostheses (eg artificial limbs and eyes, breast prostheses)[40]

Table 21: Funding responsibility for prosthetics

	Funded under PHAS	Purchased directly by ACC
Prosthetics required for less than six weeks (eg temporary wigs)	The hospital is required to provide *all* prosthetics at no additional cost to ACC. Under *no* circumstances will ACC fund any part of prosthetics on discharge of a client from hospital	ACC has already paid for this equipment as part of other agreements
Prosthetics required for longer than six weeks (and less than six months)	First six weeks after ED attendance or discharge from acute admission. ACC should be informed one month prior to 'handover' if prosthetic use will extend beyond the six-week period	From six-week period
Prosthetics required for longer than six months	Treatment is covered under PHAS until acute discharge. This would include the cost of any prostheses provided prior to discharge	ACC purchases permanent prostheses provided to a client from the point of discharge. Note: amputees who require prostheses as a result of war action remain the responsibility of Work and Income, Ministry of Social Development

4.10 Implants (eg hip prostheses, cochlear implants, spinal stimulators)

Table 22: Funding responsibility for implants

	Funded under PHAS	Purchased directly by ACC
Injury-related implants	Insertion, maintenance or replacement of implants during acute inpatient admission	Insertion, maintenance or replacement of implants provided during elective surgery

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[40] A client with a wilfully self-inflicted injury is not entitled to receive prosthetics unless the injury results from a mental injury covered by the AC Act 2001. However, if funding for prosthetics is covered under PHAS (eg prosthetics required for less than six weeks) or under an agreement for treatment such as elective surgery, prosthetics may be supplied if there is no additional cost to ACC.

4.11 Hearing aids

Table 23: Funding responsibility for hearing aids

	Funded under PHAS	Purchased directly by ACC
Hearing aids where there is an accepted claim for hearing loss due to personal injury	Treatment is covered under PHAS until acute discharge. This would include the cost of any hearing devices provided prior to discharge	ACC is responsible for contributing towards the costs of hearing aids from the point of discharge

Hearing aids where there is no accepted claim for hearing loss due to personal injury

Options for funding assistance are:

a. where a person meets specific criteria, hearing aid funding may be available via the MoH hearing equipment provider (Enable New Zealand)

b. if an individual is not eligible under the above criteria, they may be eligible for the MoH hearing aid subsidy[41]

c. if eligible, funding may be available through Veterans' Affairs. (Veterans' Affairs also pays an allowance to cover battery costs.) Phone 0800 483 8372

d. some people on benefits may be eligible for a loan through the Ministry of Social Development. Phone 0800 559 009.

4.12 Transport and accommodation

Transport and accommodation can be provided through different funding mechanisms, for example the Emergency Ambulance Services agreement (see the Nationwide Service Framework Library, the Ancillary Services Regulations 2002 and the National Travel Assistance (NTA) policy). The responsibility for determining eligibility to access transport assistance is split between DHBs and ACC depending on the scenario, as detailed in the table below.

As a general rule, DHBs are responsible for decisions on transport and accommodation associated with treatment provided as part of PHAS. This excludes emergency transport within 24 hours of a person being injured or the discovery of the injured person (where ACC determines eligibility). An exception to this exclusion is where transfer within 24 hours is required because the DHB's normal services are not available (eg if the intensive care unit [ICU] is full or the specialist is on leave).

ACC is responsible for decisions on the provision of transport and accommodation required by accident patients outside the PHAS period, as well as emergency transport required within 24 hours[42].

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[41] Information on MoH subsidies for hearing aids can be accessed via Enable New Zealand website.
[42] The 24-hour period starts when a client is injured or is found after being injured (whichever is later).

Table 24: How is transport purchased/funded?

Table 24 shows which agencies are responsible for determining travel assistance eligibility in different scenarios. Eligibility is always on a case-by-case basis. The NTA policy and ACC may have different criteria to determine eligibility for assistance and different levels of assistance available.

Type of hospital-related attendance	Type of transport	How transport is purchased/funded[43]
DHB ED attendance	Emergency transport of injured person within 24 hours[44]	ACC
	Non-emergency transport (non-ambulance)[45] prior to admission	ACC
	Non-emergency transport of a client travelling home after an ED attendance or discharge from an acute admission	DHB[46] (must meet NTA policy criteria)[47]
DHB acute admission	Emergency transport of injured person within 24 hours[48]	ACC
	Inter-hospital transfers within 24 hours because of specialist treatment requirements (i.e. specialist level of treatment required that is not normally available at DHB)	ACC
	Inter-hospital transfers within 24 hours because normal services are not available (eg lack of ICU beds)[49]	DHB
	Any inter-hospital transfers after 24 hours	DHB
	Non-emergency transport prior to admission	ACC
	Non-emergency transport of a client transferring to a non-acute inpatient rehabilitation facility after discharge from an acute admission	DHB
	Non-emergency transport for family/support person to travel between their home and the DHB[50]	DHB (must meet NTA policy criteria)

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[43] Where the DHB is responsible for purchasing transport assistance, it is the injured person's DHB of domicile (the DHB of the area in which the patient usually resides).
[44] The 24-hour period starts when a client is injured or is found after being injured (whichever is later).
[45] ACC does not consider it necessary, or appropriate, to pay for non-emergency transportation in an ambulance to an ED.
[46] DHBs do not normally pay for transport for patients to discharge home from an acute admission or ED attendance.
[47] NTA funding is only available if the person meets the eligibility criteria of the NTA policy.
[48] The 24-hour period starts when a client is injured or is found after being injured (whichever is later).
[49] Funding comes from the DHB that is transferring the patient.
[50] It is the situation of the patient that determines eligibility for the NTA, not the situation of the supporters. If an injured person is eligible for the NTA, their specialist must approve funding for a support person.

Type of hospital-related attendance	Type of transport	How transport is purchased/funded[43]
DHB outpatient services – medical follow-up: • provided by a doctor within six weeks of ED attendance discharge or six weeks following an acute admission • provided within seven days of GP referral	Non-emergency transport for the injured person (and family/support person) to travel to and from the DHB for treatment at medical outpatients	DHB (must meet NTA policy criteria)
DHB other outpatient services: • all non-medical outpatient services (eg physiotherapy, occupational therapy) • medical outpatient services outside the six-week PHAS	Non-emergency transport for the injured person (and escort) to travel to and from the DHB for treatment at outpatients	ACC
DHB elective admissions	Non-emergency transport and other travel assistance for the injured person (and support person/escort) for hospital visits associated with elective admissions	ACC
Services provided by non-DHB hospital treatment providers[51]	All non-emergency transport and travel assistance	ACC

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[51] Treatment must be from a treatment provider specified in the AC Act 2001.

4.12.1 PHAS and National Travel Assistance (NTA) Policy 2009

The NTA provides some financial assistance towards meeting the expenses associated with travel that may be a barrier to a person accessing the specialist care they require. During the PHAS period, injured persons have the same access to the NTA's travel and accommodation assistance as persons with a medical condition or a disability. Outside that period, ACC's own policies with regard to travel and accommodation assistance apply.

NTA Policy 2009 is targeted at those people who:

a. have to travel long distances to access specialist health or disability services
b. incur high travel costs as a result of frequent visits to specialist health or disability services
c. have significant financial needs that might otherwise prevent them accessing necessary specialist health or disability services.

Any person who is referred by a publicly funded health and disability specialist to another publicly funded health and disability service (as described in section 2.1 of the NTA Policy 2009) may be eligible for travel assistance under the NTA scheme, provided they meet one or more of the distance/frequency criteria. People can find out more about the eligibility criteria by:

a. calling MoH's Sector Operations (the NTA payment agency) on 0800 281 222 (option 2) or
b. emailing travel@moh.govt.nz or
c. visiting http://www.moh.govt.nz/travelassistance.

People can confirm eligibility to register for travel assistance by contacting a DHB's patient transport coordinator.

4.12.1.1 Overseas visitor

Overseas visitors[52] are generally not eligible for travel assistance, as they do not meet the criteria of 'home' defined in the NTA policy[53].

4.12.2 Emergency transport

Regulation 3 of the Ancillary Services Regulations 2002 states Emergency transport means transport that:

a. starts within 24 hours of a claimant suffering a personal injury or being found after suffering a personal injury, whichever is the later; and
b. is necessary for the purpose of obtaining treatment urgently for the claimant's personal injury.

ACC is responsible for emergency transport (air, and road including water) within 24 hours of a patient/client being injured or being found after being injured. This includes emergency inter- hospital transfers (that is, within 24 hours) where the patient's/client's condition has deteriorated or the hospital is not able to provide the level of specialist care required[54]. All emergency transport, including emergency inter-hospital transfers, must be dispatched by an ambulance communications centre.

[52] Some overseas visitors (eg some students and New Zealand citizens whose usual place of abode is in the Cook Islands, Niue or Tokelau) may qualify for the NTA because they are entitled to access public health services. See MoH website for details on the publicly funded health services eligibility criteria.
[53] 'Home' is currently defined in the NTA policy as the person's normal place of residence, where the person has been living continuously for more than three months.
[54] Inter-hospital transfer because of space constraints within the acute period are funded via PHAS.

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The contracted price for emergency transport includes the paramedic crew. Any additional crew or medical escort(s) provided by a DHB or required as part of an emergency transport service, including inter-hospital transfers within the first 24 hours, is the responsibility of the DHB and is included within PHAS funding.

4.12.3 Inter-hospital transfers within the first 24 hours and clinical crew

a. Emergency ambulance providers (road and air) are funded to cover the cost of paramedic level clinical crew for inter-hospital transfers that are within the first 24 hours of a patient/client being injured or found injured.

b. Inter-hospital transfers may require the patient/client to be escorted by an appropriate hospital clinical team from bed (originating hospital) to bed (receiving hospital). DHBs are funded for this through Regulation 4(1) of the IPRC (PHAS) Regulations 2002.

c. There may be arrangements in place between emergency ambulance providers and DHBs for the operational management of clinical crew for these inter-hospital transfers. However, please note these are outside of obligations under the emergency ambulance service agreements and IPRC (PHAS) Regulations 2002.

4.12.4 Transfer of patients between hospitals

a. Inter-hospital transfers funded by ACC are part of emergency transport. The transfers must be within the first 24 hours only of the patient/client being injured or found injured and they must be dispatched by an ambulance communications centre.

b. A DHB only funds inter-hospital transport within 24 hours if a patient/client requires transferring because the hospital's normal services are not available (eg if the ICU is full or the specialist is on leave).

c. A public hospital to public hospital transfer relating to an acute event, and taking place more than 24 hours after a patient/client has been injured or has been found injured, is covered by PHAS. These are the funding responsibility of the DHB of domicile

d. A private hospital to public hospital transfer is the responsibility of the referring hospital or ACC, depending on whether the transfer to acute treatment is due to a health need or a personal injury/treatment injury need.

Additional information on the transfer of patients/clients is covered in Table 24 in section 4.12 of this guide.

4.12.5 Non-emergency travel and accommodation assistance

The DHB is responsible for funding travel and accommodation assistance for injured patients/clients who are receiving public health acute services. The NTA policy applies to ACC clients on the same eligibility grounds as patients who are ill or have a disability. Assistance by the DHB is not automatic; it is dependent upon criteria such as distance to travel, income levels, age and frequency of treatment.

ACC is not responsible for providing any assistance where the NTA policy does not provide for assistance to an injured person who is receiving public health acute services, until the DHB's responsibility for travel and accommodation ceases. This is when the patient/client is no longer receiving public health acute services, eg after being transferred to a non-acute inpatient rehabilitation facility or after the patient/client has travelled home following the completion of six weeks of medical outpatient services.

ACC is responsible for providing non-emergency transport for its clients to travel to treatment (excluding the majority of public health acute services – see Table 24 in section 4.12 of this guide) and to travel to the specified types of social and vocational rehabilitation listed in the Ancillary Services Regulations 2002.

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The criteria for receiving payment from ACC for transport and accommodation costs related to treatment and rehabilitation are specified in the Ancillary Services Regulations 2002:

a. Non-emergency scheduled surface public transport costs (Regulation 7)
b. Non-emergency transport by private motor vehicle (Regulation 8)
c. Non-emergency transport by air (Regulation 9)
d. Non-emergency transport ambulance transport (Regulation 10)
e. Non-emergency other transport (Regulation 11).

It must be noted that the transport to treatment criteria only relates to medical practitioner outpatient appointments as per PHAS rules, and not allied health and nurse consultations or community-referred radiology. ACC's prior approval is required in some cases (eg for non-emergency transport by air and non-emergency ambulance transport).

ACC can also pay the cost of non-emergency ambulance transport and non-emergency transport by air to *rehabilitation* (excluding the majority of public health acute services – see Table 24 in section 4.12 of this guide), which is available to clients where the client's injury is such that no other form of public or private transport is appropriate.

To access one of these services, a client must have obtained a certificate from their doctor that validates the need for an ambulance. The service can be arranged by the requesting treatment provider by contacting the ambulance communications centre. Prior approval from ACC is required.

ACC contracts for the provision of this service with their emergency ambulance providers. It should be noted that non-emergency transport by ambulance is not subject to the same access criteria as apply under the Ancillary Services Regulations 2002 to most other forms of non-emergency transport to rehabilitation.

4.12.6 Escort costs

Under Regulation 12 of the Ancillary Services Regulations 2002, ACC is responsible for decisions on payment for travel and accommodation assistance for an escort, but only when an escort is accompanying the client in non-emergency transport to treatment or rehabilitation that is not part of PHAS (see Table 24 in section 4.12 of this guide for more detail).

ACC is liable for escort costs for non-emergency transport under the following circumstances:

a. the injured person is under 18 years of age; or
b. the medical condition or pre-existing disability of the injured person is such that they need an escort; or
c. the person or organisation providing the transport that is used requires the injured person to be escorted.

ACC pays accommodation costs for escorts for as long as the availability of transport services prevents the escort returning home. ACC does not pay accommodation costs for an escort if they are sharing the accommodation with the client. Prior approval should be sought from ACC to check if escort costs can be paid in a particular case. An individual cannot receive 'double' payment for acting as both an escort and a support person.

4.12.7 Support person costs

Under Regulation 13 of the Ancillary Services Regulations 2002, ACC is responsible for decisions on payment for travel and accommodation assistance for support persons, but only when a support person is visiting a client who is receiving ACC-approved inpatient or residential rehabilitation that is not a public

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health acute service. When a client is receiving a public health acute service, any support person's costs are managed under the DHB's responsibility and determined by the NTA criteria.

If the client is aged 18 years or older, ACC pays the regulated amounts for up to one return journey and two nights' accommodation per week, if the support person would have to travel over 80 kilometres in a one-way journey to visit the client. If the client is under the age of 18 years, the client travel rules apply to support person travel.

ACC pays accommodation costs for support persons for as long as the availability of transport services prevents them returning home (or up to a maximum of two nights' accommodation per week if the client is aged 18 years or older). ACC does not pay accommodation costs for a support person if they are sharing the accommodation with the client or escort.

An individual cannot receive 'double' payment for acting as both a support person and an escort. Prior approval should be sought from ACC to check if support person costs can be paid in a particular case.

4.13 Relief care (carer support)

So that a regular carer can take a break, ACC is responsible for the assessment of the need for and the provision of personal care services by another carer – this is known as relief care.

ACC expects that relief care will be needed from time to time as it is not possible for one person to provide 24-hour hands-on care safely by themselves.

There are two types of relief care:

a. family caregiver requires a break
b. crisis care (when a client's safety and health would be at risk without services).

Relief care can be provided in the following ways:

a. the client can be admitted to a residential facility to receive the care
b. an alternative caregiver can go to the family home to provide the care
c. the client can go to an alternative provider's home, such as the home of another family.

An assessment of relief care is done during a support needs assessment. Should a family feel that they require relief care beyond that which is provided for in the assessment, they should contact ACC as soon as possible.

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Section 5: Administrative processes

5.1 Notification of acute admission due to personal injury

ACC (or the accredited employer) should be notified as early as possible (through the ACC45 form) when a person is admitted acutely due to a personal injury. If a client's diagnosis changes, the DHB should update ACC via the ACC18 Medical certificate form to ensure that appropriate cover is provided and post-discharge treatment or rehabilitation services can be arranged as required.

5.2 ACC forms

Copies of ACC forms most frequently used by DHBs are available online or by contacting ACC.

Table 25: ACC forms frequently used by DHBs

ACC number	Name of form	When to use the form
ACC18	Medical certificate	If a client is unable to work at their normal employment because of their injury, the medical practitioner completes an ACC18, which describes how the client's injury affects their capacity for work. It can also be used to add to the original injury diagnosis or to clarify the diagnosis
ACC32	Treatment extension request	This is completed by the treatment provider when initial treatments have been provided and the client needs more treatment.
ACC42	Dental injury claim form	This is a specialised form of the ACC45 Injury Claim form that dentists use to provide more specific details about client's dental injury
ACC45	Injury claim form	This form must be completed *and signed* by the person who has had a personal injury (or their authorised representative) for the first attendance or admission. It can be lodged electronically. See section 5.2.1 of this guide
ACC46	Injury claim form	This form contains the same information as the ACC45 form and is used to collect claim information before entering it into a practice management system (PMS). The ACC46 is not sent to ACC to lodge a claim
ACC271	Medical practitioner cover questionnaire	This form must be completed by the treating medical practitioner of a person who has lodged a claim for a personal injury caused by work-related gradual process, disease or infection. This information is used by ACC when deciding whether to accept the claim
ACC705	Referral for support services on discharge	DHBs are to use this form to notify ACC about support needs post discharge. The form should be submitted at least 48 hours before the proposed discharge date. Clients requiring short-term support (up to a maximum of six weeks) can be referred directly to a Home and Community Support Services provider. For eligibility criteria, please see section 5.6.1.2 of this guide.

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ACC number	Name of form	When to use the form
ACC706	Early notification of complex case	DHBs are to use this form to provide early notification to ACC of a client who will have complex support needs on discharge, so that joint discharge planning can commence. The form should be submitted to ACC within a week of admission
ACC1151	Referral to TBIRR service form	DHBs are to use this form to request prior approval from ACC when a client with a moderate to severe Traumatic Brain Injury (TBI) requires emerging consciousness rehabilitation services.
ACC1171	Request for pharmaceutical funding	This form is used to seek funding approval for non-subsidised pharmaceuticals
ACC2152	Treatment injury claim form	This form notifies ACC of treatment injury and is filled out by the provider (preferably the provider who provided the treatment concerned). The client *must* be aware of the claim. The form *must* be used in conjunction with the ACC45 form
ACC4249	Short-term equipment (needed post six weeks discharge) request	This form is used to request ACC funding for short-term equipment needed by clients for more than six weeks post discharge.
ACC7422	Early cover application form	DHBs use this form when a client with TBI, multi-trauma or spinal cord injury requires an early cover decision so that ACC can assign a case manager to assist with discharge planning

5.2.1 ACC45 Injury claim form

This form gives ACC the first notification of an injury caused by an accident. It is used to determine ACC cover on a person's claim. In the case of a dental injury an **ACC42 Dental injury claim form** must be completed.

An ACC45 form must be completed and signed by the client (or their authorised representative) for the first attendance or admission, including clients:

a. treated under PHAS

b. whose work-related personal injury cover is the responsibility of an accredited employer.

Where a form is lodged electronically, a copy, signed by the client, must be retained by the treatment provider. Information on how to complete, sign and lodge a claim using the ACC45 form is available on ACC's website.

5.2.1.1 ACC46 Injury claim form

Some DHBs also use the ACC46 form. This form is designed to assist with transferring data from a paper form to ACC's web-based lodgement portal or into a PMS. Although the ACC46 is filled in by the client and provider in much the same way as the ACC45, it cannot be used as a form to lodge claims directly with ACC.

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5.2.1.2 ACC45 form initiated by another provider

Where another provider, eg urgent care clinic, has ensured that an injured person has completed an ACC45 form before the person's treatment at a DHB, the DHB should use that claim number.

Where another provider has **submitted** a completed ACC45 to ACC and the **DHB's injury diagnosis is different** from the diagnosis made by that provider, the DHB should advise ACC using an **ACC18** (Medical certificate), quoting the original ACC45 number.

Where a patient is delivered to hospital by ambulance but then is not assessed or treated by the DHB (for example, where a patient leaves before being seen in ED), the DHB cannot complete an ACC45 form for that person.

5.2.1.3 ACC45 forms and Accredited Employers

General information on accredited employers and TPAs can be found in section 1.2.3.2 of this guide.

Accredited employers under the ACC Accredited Employer Programme accept the responsibilities that ACC would accept in relation to the work-related injuries of their employees. Some accredited employers use TPAs to manage their employees' claims. Accredited employers pay ACC a fee to cover the free provision of PHAS to employees, and DHBs cannot invoice accredited employers for these services.

The ACC45 form asks for the name of the injured person's employer. If a DHB or client knows the employer is an accredited employer, the DHB should send the accredited employer (or their TPA) a copy of the ACC45 form. If relevant, any invoices for non-public health acute treatment should be sent directly to that employer.

If a DHB is unsure whether the client's employer is an accredited employer or if they use a TPA, then the DHB should send the ACC45 directly to ACC.

If an ACC45 for an employee of an accredited employer is sent to ACC in error, ACC will forward it to the appropriate recipient.

See section 5.4 of this guide for information on accredited employers and the lodgement of sensitive claims.

5.2.1.4 ACC32 Treatment extension request

Under the provisions of the AC Act 2001, no approval is required from ACC when providing acute treatment (as defined in section 7 of the AC Act 2001) or PHAS. ACC purchases non-acute care via contracts and regulations, which may carry their own entry criteria such as prior-approval requirements. Please refer to the details of the contracts with ACC that your DHB holds.

If prior approval is required, either the appropriate form for entry into a particular service (eg active rehabilitation) or an ACC32 will need to be submitted to ACC before the treatment that requires this approval takes place.

Additional information on the ACC32 form can be found on ACC's Treatment and recovery web page. In some instances, for example physiotherapy, prior approval using the ACC32 may be required after a certain number of treatments for a particular injury.

If contractually required prior-approval conditions are not met, payment may be declined by ACC. In cases where prior approval is not required, ACC monitors service provision and investigates any apparent excessive service provision.

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5.3 Treatment injury

5.3.1 What is treatment injury?

Treatment injury is a personal injury caused as a result of treatment from one or more registered health professionals. The person must have been actually injured during treatment, not just suffered symptoms. The personal injury cannot be a necessary part or an ordinary consequence of the treatment provided.

'Treatment' includes diagnosis, the actual treatment itself, a lack of treatment that should have been provided, a failure to obtain consent to treatment, a failure of equipment or the application of support systems. For the legislative definition of treatment injury, see sections 32 and 33 of the AC Act 2001. Section 32 defines treatment injury and section 33 lists what constitutes treatment in terms of treatment injury.

Table 26: Treatment providers covered under treatment injury

Treatment providers whose treatment is covered under treatment injury		Treatment providers whose treatment is not covered under treatment injury
Chiropractor	Midwife	Acupuncturist
Clinical Dental Technician	Nurse	Audiologist
Dental Technician	Occupational Therapist	Counsellor
Dentist	Optometrist	Osteopath
Medical Laboratory Technologist	Pharmacist	Speech Therapist
Medical Practitioner (Doctor, Surgeon, Anaesthetist etc.)	Medical Radiation Technologist	
Physiotherapist	Podiatrist	

5.3.2 When treatment injury occurs and the client requires acute treatment

All treatment injury claims need to be lodged with ACC (using the ACC45 and an ACC2152; see below) as soon as possible after it is identified that a treatment injury has occurred.

If, as a result of a treatment injury, a client requires acute treatment at a DHB, this treatment is funded under PHAS. When the record is loaded into the NMDS, the ACC45 number should be included and the accident flag set to 'N' (the client was not admitted as a result of the accident). Report the treatment injury in the clinical coding along with external cause codes that are dated between the admission and discharge dates.

5.3.2.1 When a treatment injury occurs at a private facility

If a treatment injury has occurred at a private facility section 74(2) of the AC Act 2001 allows acute care to be delivered in a non-public hospital if the clinical decision is that a transfer from the private facility to the DHB for treatment is unsafe due to the client's condition, or it is more clinically appropriate to treat the treatment injury immediately.

The client should be transferred to a DHB within 24 hours of the treatment injury occurring (or being identified as a treatment injury).

ACC will fund the:

a. cost of the acute surgery
b. hospital stay up to the point that it is practicable to transfer the client to a DHB
c. emergency transport from the private facility to the DHB.

ACC will review the funding of the treatment at the private facility when the cover decision is made to accept the claim and a request for funding is received.

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5.3.3 Treatment injury claims

Every treatment injury claim needs to be lodged with an ACC45 (or ACC42 for a dental injury) and a provision of an ACC2152 form will assist ACC in making a timely decision. A treatment injury claim can be made by any registered treatment provider able to submit an ACC45 form. However, **the injured person must have knowledge of the claim being lodged and must have given consent**. Treatment providers are paid for the completion of the ACC2152 treatment injury claim form.

Treatment injury claims are considered complicated claims, and section 57 of the AC Act 2001 allows for up to nine months to assess and determine cover, depending on the ease of accessing relevant clinical information. However, in most cases, where clear, relevant information has been provided to ACC, cover can be decided much more quickly (in days or weeks). ACC's intent is to make robust cover decisions as quickly as possible so that the patient/client can access the scheme for treatment, rehabilitation and entitlements.

In some instances, an injured person will require treatment, elective surgery or rehabilitation related to the treatment injury prior to the treatment injury claim being determined. In these cases, the treatment provider or funder, eg MoH, will be reimbursed by ACC once the claim for treatment injury has been accepted. For more information, see section 5.7.4 of this guide.

5.3.4 Review of treatment injury claim decisions

Only the patient/client (i.e. the injured person) or their authorised representative may seek a review of a decision on a treatment injury claim. The review application must be made within three months of the date of ACC's decision on the treatment injury claim. Should a patient/client seek to have a decision reviewed they should contact ACC directly. In some circumstances a patient/client may decide to appeal a review decision through the District Court.

5.4 Sensitive claim lodgement

ACC accepts a sensitive claim when there is a mental injury caused by a certain criminal act, for example sexual abuse or assault. To lodge a claim, a medical practitioner completes the ACC45 injury claim form stating that this is for a sensitive claim following sexual abuse or assault.

ACC doesn't accept cover for a mental injury based on these ACC45 forms, but ACC's Sensitive Claims Unit contacts the patient and discusses what pre-cover and cover assessment services are available for sensitive claims through the Integrated Services for Sensitive Claims (ISSC).

If the patient decides to go through the mental injury assessment process in order to have a covered claim, the Sensitive Claims Unit will request clinical notes from the DHB for the purpose of the assessment.

Note:
Where the injured person is employed by an accredited employer and the injury is a sensitive claim, the patient/client can request that the case be managed by ACC directly. In this case, no ACC45 form or claim details should be sent to the employer; they should go directly to the ACC Sensitive Claims Unit.

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5.5 Information supply provisions related to ACC claims

5.5.1 Information supply provisions for PHAS

The MoH incorporates information supply provisions in their funding agreement with DHBs, including:

a. the completion of ACC forms and medical certificates for individuals
b. the submission of data to MoH's Client Insights and Analytical Group for all inpatients, outpatients, day patients and ED patients receiving PHAS
c. reporting on the volume of, and expenditure on, public health acute services provided by DHBs in outpatient and emergency departments:
    i. by the purchase unit
    ii. recording ACC claim information
    iii. whether the injuries were work related or non-work related
d. the supply of copies of relevant audit and monitoring reports related to the purchase of PHAS.

Note:
At present there is no set process for reimbursement by ACC to other agencies (for example MoH), and therefore there is no set format for what information needs to be supplied to facilitate this reimbursement. Generally, the process is managed between MoH's Client Insights and Analytical Group and ACC.

5.5.2 The NMDS

Clinical coding submitted to the NMDS plays a major part in identifying accident cases treated by hospitals and is used in calculating the amount ACC pays for PHAS. Accident cases are normally coded with principal and/or other diagnosis codes within the ICD-10-AM ranges of S00-T98 (injury, poisoning and certain other consequences of external causes) and U50-Y98 (external causes of morbidity and mortality). Note though that not all such diagnoses are covered by ACC and covered cases may also have principal and/or secondary diagnoses outside this range.

Note:
The NMDS is the national collection of inpatient and day-case hospital events. The National Non-Admitted Patient Collection (NNPAC) holds data for ED and outpatient attendances. Both collections include the Accident flag and ACC45 fields. NNPAC does not currently include ICD-10-AM clinical coding. NNPAC data may be used in the future for funding purposes. To enable this to happen DHBs, ACC and MoH will need to work together to agree on the data to be collected and address data quality issues. The current file specification for NNPAC can be found on the MoH website.

5.5.2.1 Identification of potential ACC-covered cases

DHBs are required to identify potential ACC-covered cases by using the following fields:

a. Accident flag
b. ACC claim number
c. Clinical coding – use of diagnosis, procedure and external cause codes.

For further information, see the NMDS Data Dictionary.

The 'principal health service purchaser' code is used to identify the purchaser of treatment. In most cases, accident acute admissions will be coded '35' as they are funded through the Minister of Health's funding arrangements for PHAS (the exception is code '20' for MoH purchasing of services for injured overseas visitors). Principal health service purchaser codes for ACC (code 'A0') and other accident payers, eg accredited employers (code '17'), should be used only for treatment directly purchased by ACC or accident payers (eg elective admissions for elective surgery or non-acute/rehabilitative care).

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It is acknowledged that there are inconsistencies in coding cases in the NMDS between different DHBs, but DHBs, MoH and ACC are working together to get a more standardised approach.

Table 27: Reporting of accident cases by DHBs to NMDS

NMDS field	Acute admissions	Elective admissions and non-acute transfers
Accident flag	Y	Y
ACC form number	ACC45	ACC45
Admission type (see NMDS Data Dictionary for further information)	AA or AC	WN or AA
Principal health service purchaser	35 = all accident cases (except specific classes of overseas visitor) 19 = overseas ineligible 20 = overseas eligible	A0 = ACC 17 = Accredited employer

5.5.3 Codes used on ACC forms

5.5.3.1 Injury diagnosis codes

ACC has endorsed the use of common diagnosis codes. Injury diagnosis code information will also be collected by the Government to monitor that ACC is meeting its obligations for treatment.

Read is the diagnosis and procedure coding system to be recorded on ACC45 forms lodged by the primary healthcare sector. The secondary healthcare sector, including DHBs, may choose to use either Read or **ICD-10-AM on the ACC45 form. However, only ICD-10-AM codes can be reported to the NMDS**.

ACC is in the process of migrating from Read coding to SNOMED CT for reporting the diagnosis on submissions to ACC including the claim form (ACC45/6) and the Medical Certificates (ACC18). Implementation will be phased in over a period of time. Stakeholders wanting to move to SNOMED CT coding to replace Read codes should contact ACC.

5.5.3.2 Provider codes

ACC needs a number that identifies each DHB as a health provider. All health and relevant disability providers should use their Health Practitioner Index (HPI) number (including the Common Person Number), which can be sourced from each registration authority. It is acknowledged that further work is required to improve coding standards (eg National Health Index [NHI] and HPI number).

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5.6 Discharge planning

Planning for discharge should be continually evaluated along the continuum of care to ensure that:

a. the injured person has care appropriate to their needs
b. the transitions between services are well organised, efficient and effective
c. the injured person and their family/whānau are involved in decision-making wherever possible.

Good communication between the MoH, DHBs, ACC and suppliers is vital in discharge planning, especially where there is a pre-existing disability or dual/multiple diagnosis.

Discharge planning requirements include the provision of a discharge summary sent on the day of discharge to the patient's/client's GP and referring consultant (if different from the operating surgeon/attending physician). The discharge summary should include, as appropriate, the diagnosis, treatment provided, prognosis and recommended treatment plan.

ACC may request a copy of the discharge summary or letter following receipt of the ACC45 form, but does not require a copy routinely.

The funding agreement between the MoH and DHBs require that DHBs grant such access to ACC to information relating to any client receiving treatment in that hospital for a personal injury covered by the AC Act 2001, and to those health professionals necessary for arranging post-discharge treatment, care, rehabilitation or other services. Client consent for this is included on the ACC45 form.

Accredited employers are entitled to the same provision of and access to information as ACC.

Refer to Appendix 1 - 'a guideline for transfer of funding responsibilities from DHBs to ACC'.

5.6.1 Early notification for complex injury/support needs post discharge

Where a patient/client has a complex injury/support needs (eg TBI, burns unit, multi-trauma, or spinal cord injury), and requires either rehabilitation in a residential facility or ongoing support upon discharge, it is important that the DHB:

a. reviews the diagnosis on the ACC45 (and updates via an ACC18 where necessary) to ensure that the patient/client has the appropriate cover
b. provides clinical notes to support the cover decision
c. notifies ACC as soon as possible (within three days of admission) using an ACC706 Early Notification of Complex Case form to allow ACC and rehabilitation suppliers to engage early with the patient/client and their family/whānau. An ACC706 or ACC7422 Early cover application form must be completed and emailed to the nearest ACC Contact Centre.

ACC will liaise with the DHB and, where appropriate, will arrange an assessment of the patient's/client's needs and arrange appropriate post-discharge support.

5.6.1.1 Transfer to residential rehabilitation services[55]

In addition to 5.6.1, and where a patient/client requires rehabilitation in a residential setting, the DHB will notify the ACC case owner as soon as the need for residential services becomes apparent.

In some cases, ACC will need to approve residential rehabilitation for a patient's/client's covered injury, and the DHB and rehabilitation supplier will assess the patient/client against the relevant contractual criteria to determine eligibility for the service. The DHB needs to provide the appropriate clinical information to ACC and rehabilitation suppliers to enable good decision-making.

[55] The Traumatic Brain Injury Residential Rehabilitation (TBIRR) contract started on 1 April 2014; the process described here reflects changes to this service.

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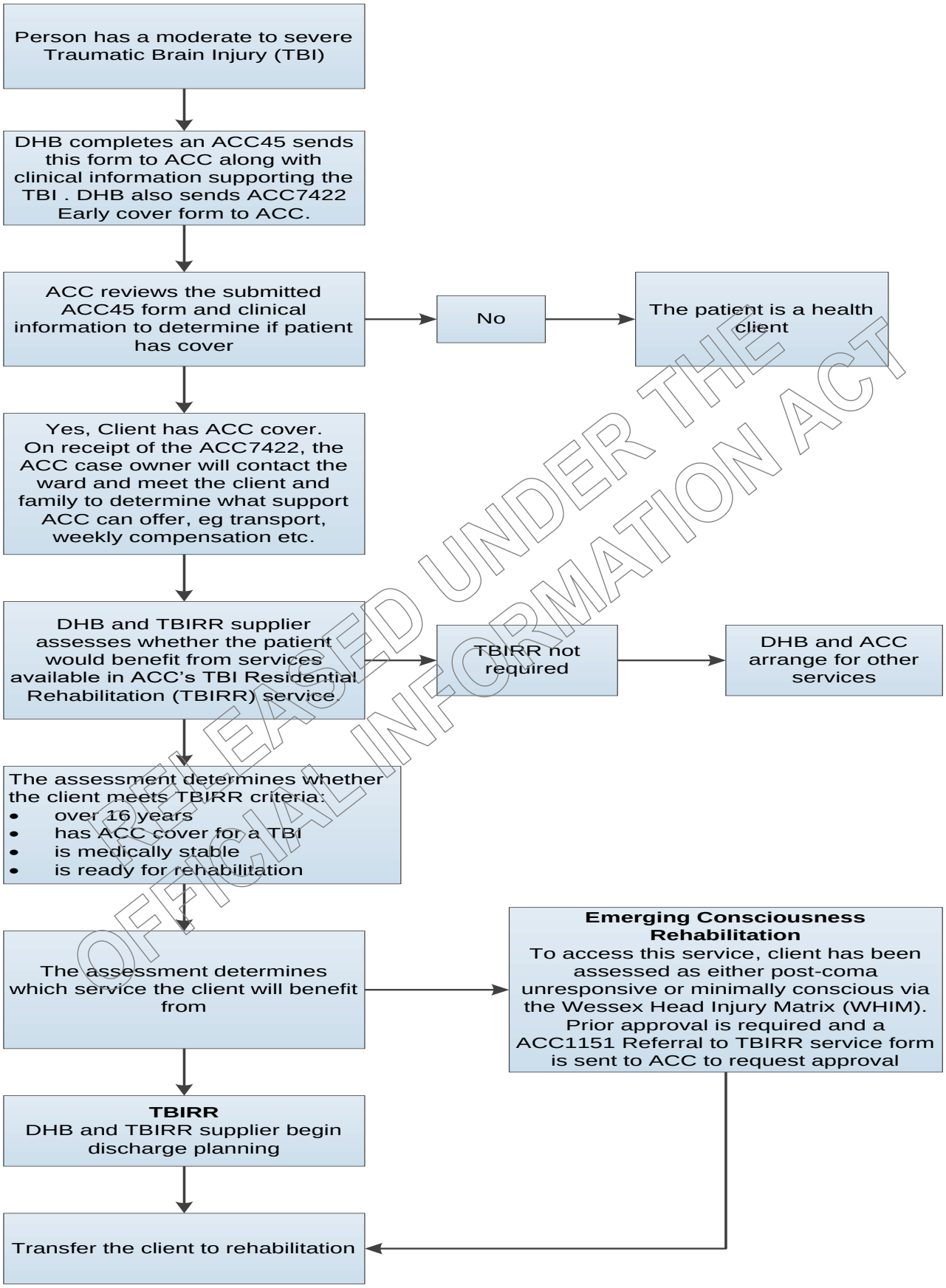
Figure 2: Process for referring a patient for Traumatic Brain Injury Residential Rehabilitation services



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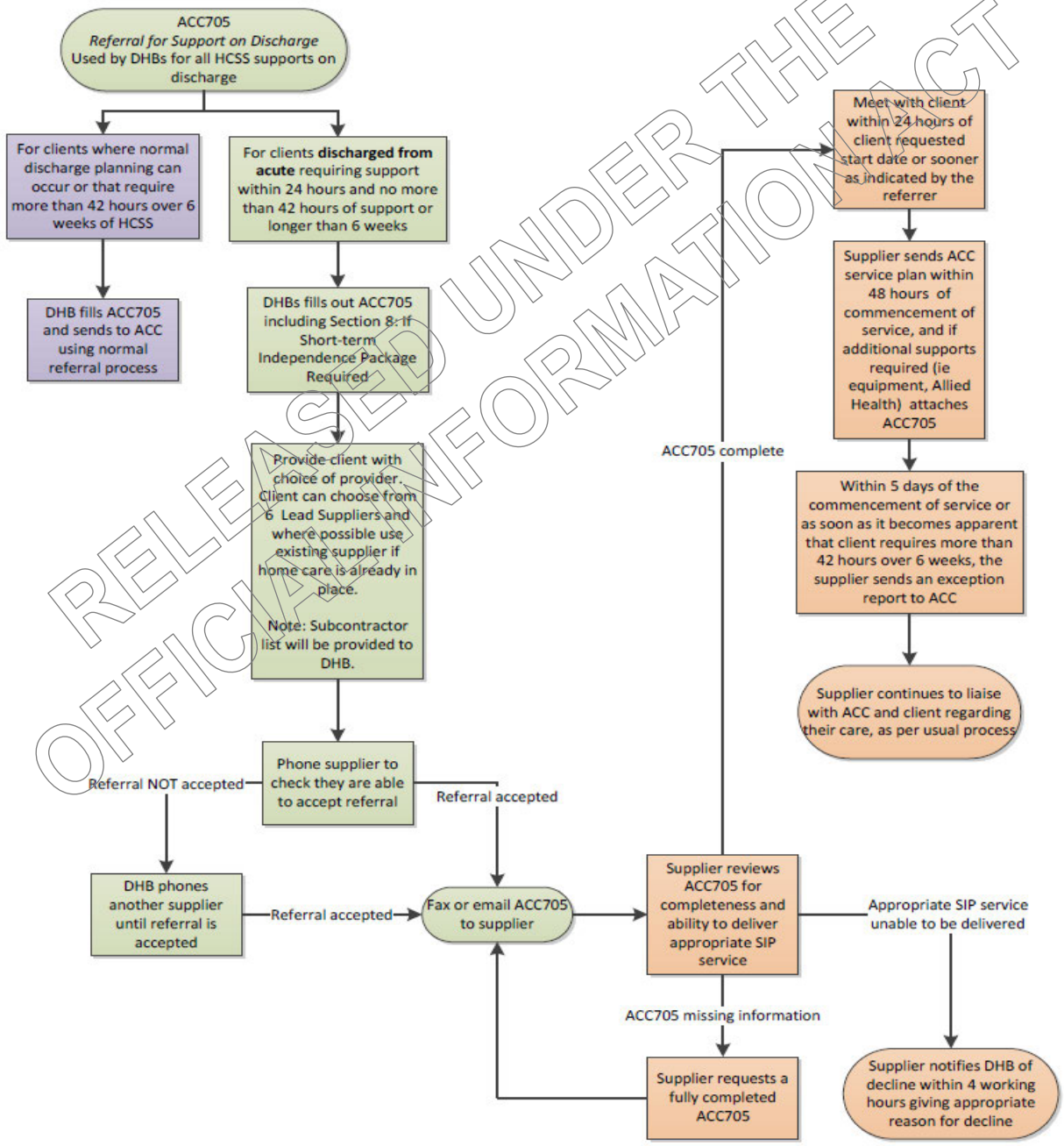
5.6.1.2 Home and Community Support Services

If a client is likely to require more than 42 hours' support or more than six weeks' support, the DHB should complete an ACC705 Referral for Support Services on Discharge form and forward this to the ACC Contact Centre at least 48 hours prior to discharge. The ACC Contact Centre will make the decision on the appropriate action to be taken and will notify the DHB as to whether a package of care can be implemented without a prior assessment, or an assessment is required.

If the client requires less than 42 hours of support over a six-week period, the DHB can make a referral directly to a Home and Community Support Service (HCSS) supplier by completing an ACC705. The Short-term Independence Package is available 24 hours a day, seven days a week – see Figure 3 for further information.

Figure 3: Process for referring a patient for HCSS Short-term Independence Package



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5.7 Invoicing for treatment and services

5.7.1 Invoicing ACC for treatment that is not included in PHAS

ACC will only make a payment for treatment of an injury if:

a. a claim has been registered with ACC via an ACC45 injury claim form
b. the claim has been accepted by ACC
c. prior approval has been obtained where required.

Invoicing for non-acute services is via the DHB bulk-billing form or on a case-by-case basis.

Further information is available on ACC website under Invoicing us.

5.7.2 Electronic transactions

eLodgement lets you send your ACC45 Injury Claim forms to ACC using the ACC webpage. eInvoicing lets you invoice ACC for treatment that is not covered by PHAS electronically, either via an application called the XML Builder (ACC provides this for free) or via an upload mechanism on the ACC eBusiness Gateway Invoicing webpage.

You can check the payment status of sent invoices, query the status of a claim (ACC45) and access and download your payment advice details. You can also submit discharge notices, clinical notes and reports to ACC using HealthLink or MMEx. For more information:

a. see the ACC website under Getting set up online; or
b. contact the eBusiness team on 0800 222 994 (option 1).

5.7.3 Invoicing an Accredited Employer

DHBs need to invoice accredited employers for non-acute services provided to employees for work-related injuries (eg allied health outpatient services, rehabilitation, post-six-weeks medical outpatient services and elective surgery).

If an invoice for payment by an accredited employer is sent in error to ACC, ACC will send the invoice back to the DHB, together with a letter advising of the accredited employer's details.

If a DHB has consistent difficulty with an accredited employer or their TPA (eg in receiving timely payments for invoices, obtaining prior approvals for treatment or arranging support services for discharge), the DHB should contact the ACC account manager for assistance.

5.7.4 Invoicing ACC for non-PHAS treatment where funding responsibility is unclear and a decision has been delayed

If there has been a delay of more than 12 months between the commencement of services to a person and that person's claim being accepted by ACC, the agency will need to provide supporting documentation with their invoice to ACC. Delays can happen with instances of complex treatment injury or multiple or dual diagnosis. Queries regarding invoicing should be directed to the ACC Provider Contact Centre.

If sending a late invoice, a provider must include additional information[56] that demonstrates:

a. the ACC45 claim number for the personal injury that the service relates to
b. that the service relates to the personal injury specified on the ACC45 and the service was necessary and appropriate for that personal injury. Information that demonstrates this might include clinical records and treatment notes
c. full management of the personal injury to date (eg assessment reports, clinical records).

[56] It is the provider's responsibility to ensure that the information demonstrates that the service was necessary and appropriate for the personal injury etc. ACC may audit the information at any time.

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5.8 Audit and monitoring

The PHAS agreement includes provisions relating to the quality of service provision and audit procedures that apply to the services purchased on behalf of ACC. The MoH and ACC will work with service providers to further develop a compliance regime that will monitor service provision with a focus on quality of delivery and optimal health outcomes, and will identify over-servicing or fraud.

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Section 6: Process for resolving Health/ACC boundary Issues

6.1 Principles for resolving boundary issues

The following principles are to be used as a guide:

a. All parties should work together in good faith to resolve issues

b. Disputes should be resolved at the lowest possible level of management that is appropriate given the nature of the dispute and taking into account legislative and contractual requirements.

As a general principle, ACC is responsible for paying (either directly or through PHAS) for services required by a client as a result of personal injury covered by the AC Act 2001. Funding for and the provision of services outside the AC Act 2001 are the responsibility of DHBs and/or MoH.

6.2 Agreed steps where there is a dispute over boundaries

a. **DHB staff** should first talk to the ACC case owner or relevant team manager if possible/appropriate. Where a claim has not yet been accepted, DHB staff should contact ACC's Provider Contact Centre on 0800 222 070.

   If the issue is not resolved (or if the actions above are not possible/appropriate), DHB staff should discuss this with their DHB's ACC Contract Manager. The Contract Manager will work with ACC's Engagement and Performance Manager to resolve the issue.

   ACC staff should, in the first instance, talk to the DHB staff member involved and as necessary, escalate the matter to a Team Leader. If this is not possible or appropriate, contact the Engagement and Performance Manager who will work with the DHB's ACC Contract Manager to resolve the issue.

b. If the dispute is not able to be resolved between the DHB's ACC Contract Manager and ACC's Engagement and Performance Manager, they will escalate the issue to the DHB/ACC Operational Management Group.

c. If the issue remains unresolved, it may be appropriate to follow the relevant agency's escalation pathway.

6.3 Funding while boundary disputes are resolved

Where responsibility for payment is disputed, the following will continue until the issue is resolved:

a. services and, for the avoidance of doubt, items inherent to the provision of the services (eg consumables, equipment, pharmaceuticals) to individuals will be maintained by whichever agency is currently providing the service

b. payment for the above will continue to be made by whichever agency is currently paying.

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Section 7: Provider Performance

ACC is committed to guiding providers towards best-practice behaviour and contract compliance to improve client outcomes.

7.1 Engagement and Performance Managers

Engagement and Performance Managers (employed by ACC) work in the community primarily with contracted suppliers and providers, including DHBs, and also those who work under the CoTR 2003, such as general practice staff (medical practitioners, nurses and practice managers), physiotherapists, osteopaths and acupuncturists.

The role of Engagement and Performance Managers includes:

a. working with suppliers and providers in an educative and supporting role

b. implementing monitoring activity in accordance with ACC policy and annual performance plans, and tracking those suppliers and providers whose service provision against their contract causes concern

c. developing, negotiating and implementing performance improvement plans for suppliers and providers as required

d. managing and resolving escalated supplier and provider issues that affect client outcomes.

7.2 ACC Resources available to providers

ACC produces a number of resources for providers. These include:

a. reports summarising the utilisation of ACC-subsidised treatment across treatment provider groups

b. 'frequently asked questions' sheets

c. electronic resources, which are available using the resources section of the ACC website, or by contacting ACC.

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Glossary

Accident – For the full definition of 'accident' and types of personal injury, see sections 25-30 of the AC Act 2001.

Accident Compensation Corporation (ACC) – The Crown entity responsible for paying for the provision of treatment, rehabilitation and other entitlements for clients with personal injury for which they have cover under the AC Act 2001. ACC makes payments to the Crown to enable the Minister of Health to arrange the purchase of PHAS, and directly purchases treatment and rehabilitation services that are not part of PHAS.

Accredited Employer – An employer (or group of companies) that, after meeting defined criteria, has signed a contract with ACC to become part of the ACC Accredited Employer Programme. The accredited employer accepts responsibility for a specified time period for managing and directly purchasing most of the statutory entitlements of their employees who suffer a work- related personal injury.

Acute admission – As defined in section 4 of the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 and section 74 (4) of the AC Act 2001.

Acute treatment – As defined in section 7 of the AC Act 2001 and, in relation to an injured person, means:

a. the first visit to an appropriate treatment provider for treatment for a personal injury for which the claimant has cover
b. subsequent treatments by that treatment provider if, in their reasonable clinical judgement, the need for the treatment is urgent (given clinical safety issues)
c. referral by the first treatment provider to another provider (this provider may not be a DHB) for that same injury, if the first provider believes the referred treatment is urgent (given clinical safety issues).

Ancillary Services Regulations 2002 – The Accident Compensation (Ancillary Services) Regulations 2002, which specify contributions towards the costs of specified ancillary services related to specified kinds of rehabilitation (including treatment) that must be made by ACC and accredited employers. Specified ancillary services are: emergency transport, non-emergency scheduled surface public transport, non-emergency transport by private motor vehicle, non-emergency transport by air, non-emergency ambulance transport, non-emergency other transport, accommodation, escort transport and accommodation, and support person transport and accommodation.

Annual Service Agreement – Section 301 of the AC Act 2001 requires the Minister, on behalf of ACC, to enter into an annual service agreement with the Minister of Health for the purchase of PHAS, pharmaceuticals and laboratory tests for ACC claimants (the annual service agreement). Funding for PHAS is distributed to DHBs via Vote: Health Crown Funding arrangements.

The full title of the agreement is: Annual Service Agreement for the Purchase of Public Health Acute Services, Pharmaceuticals, Therapeutic Devices, Laboratory Tests and Renal Dialysis Services between the Minister for ACC and the Minister of Health (Under Section 301 of the Accident Compensation Act 2001).

Claimant – Patient/Client.

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Community Health Trusts (also referred to as Community Trust Hospitals) – are funded through DHBs via MoH funding. These provide some health services to smaller communities, and may provide PHAS.

Complex injury – An ACC term meaning an injury that involves one or more injury and/or factors that could complicate or delay the patient's/client's rehabilitation, eg injury severity, age, non-injury health issues, infection.

Date-time of discharge (within the NMDS; in NNPAC collections this is called event end date-time) – The date and time when a patient/client is safely discharged from a hospital. The date-time of discharge can also be the date-time of discharge home or discharge to non-acute rehabilitation services, for example from a medical/surgical ward to rehabilitation. A patient/client returning home 'on leave' from a hospital does not constitute a permanent discharge, eg weekend leave for a seriously injured patient/client. For more information on the NMDS event end date please see the NMDS data dictionary.

Disability Support Services – Disability services funded by MoH and DHBs.

District Health Board (DHB) – An organisation established under section 19 of, and named under Schedule 1 of, the New Zealand Public Health and Disability Act 2000.

Emergency Department (ED) – There is no definition within the AC Act 2001 or associated regulations of what constitutes an 'emergency department'. It is interpreted in this context to mean any area in a DHB or other publicly funded provider that provides treatment services that would generally be considered part of a normal ED operation of a public hospital.

Individual Rehabilitation Plan (IRP) – As defined in section 6 of the AC Act 2001, a plan that ACC and a claimant develop in consultation with the claimant's family, employer and treatment provider within 13 weeks of the acceptance of the claim for cover. The IRP outlines the injured person's need for rehabilitation, the assessments to be done, the services appropriate to meet those needs and which of the services ACC will provide, pay for or contribute to in order to restore the claimant's health, independence and participation to the maximum extent practicable.

Mental injury – As defined in section 27 of the AC Act 2001. Cover for mental injury caused by certain criminal acts is discussed in section 21 of the AC Act 2001 and the relevant sections of the Crimes Act are listed in Schedule 3 of the AC Act 2001.

MoH Client Insights and Analytical Group – On 1 July 2008 the New Zealand Health Information Service was merged into MoH's Information Group. This group was disestablished in 2012 and the information collection functions largely sit under the Ministry's Client Insights and Analytical Group.

National Minimum Data Set (NMDS) – A national collection of public and private hospital discharge information, including clinical information, for inpatients and day patients. Unit record data is collected and stored. All records must have a valid National Health Index (NHI) number. Additional information on the NHI can be found at National Health Index | Ministry of Health NZ. The NMDS is used for policy formation, performance monitoring, research and review. It provides statistical information, reports, and analyses about the trends in the delivery of hospital inpatient and day patient health services both nationally and on a provider basis. It is also used for funding purposes.

National Non-Admitted Patient Collection (NNPAC) – A system introduced on 1 July 2006 that provides nationally consistent data on non-admitted patient activity (eg outpatient and ED events). Unit record data is collected and stored. All records must have valid National Health Index (NHI) number. Additional information on the NHI can be found at National Health Index | Ministry of Health NZ.

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The availability and use of the data in NNPAC will improve sector knowledge and enable more informed planning, resource allocation and advice. The collection provides statistical information, reports, and analyses about the trends in the delivery of non-admitted patient services both nationally and on a health provider basis. The collection will be expanded over time and may be used in the future for funding purposes. Further information about NNPAC including the file format, can be found at National Non-Admitted Patient Collection File Specification | Ministry of Health NZ

Ordinarily resident in New Zealand – As defined in section 17 of the AC Act 2001.

Outpatient – As defined in Regulation 3(2) of the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002 to mean –

"3(2) A person is an **outpatient** in relation to a healthcare facility if –

(a) the person receives from a medical practitioner a pre-admission assessment, a diagnostic procedure, or treatment at the facility; and

(b) the person has not been admitted to the facility; and

(c) the medical practitioner intends that the person will leave the facility within three hours after the consultation begins."

Personal injury – As defined in section 26 of the AC Act 2001. The terms mental injury, work-related personal injury, personal injury that is both work related and motor vehicle injury, personal injury caused by work-related process, disease or infection, and treatment injury are individually defined in sections 26-30 of the AC Act 2001.

Pharmaceutical – As defined in section 6 of the AC Act 2001:

"pharmaceutical means **--**

(a) a prescription medicine, a restricted medicine, or a pharmacy-only medicine, as listed in Parts 1, 2, and 3 of the Schedule 1 of the Medicines Regulations 1984; or

(b) a controlled drug as defined in the Misuse of Drugs Act 1975."

PHAS regulations – The Injury Prevention, Rehabilitation and Compensation (Public Health Acute Services) Regulations 2002 in Public Health Acute Services.

Physical injury – Evidence of actual damage to the body and an actual diagnosis of the injury is needed before it can be said that a patient has sustained a 'physical injury'. A diagnosis of pain is insufficient for establishing there has been physical injury.

Prior approval – When approval from ACC for a service or treatment is required prior to the commencement of the service. If prior-approval conditions are not met, or prior approval is declined, ACC will not pay for the service or treatment. Prior approval is not required for acute treatment or PHAS. Most other non-acute treatment and rehabilitation services require the prior approval of ACC.

Public Health Acute Services (PHAS) – Specialist acute accident services required by clients. These services are purchased by the Minister of Health on behalf of ACC and are provided through DHBs.

Publicly funded provider – A provider that is funded by a DHB or the Minister of Health to provide PHAS. Providers can include Community Health Trusts, also referred to as Community Trust Hospitals.

Purchasing arrangements for public health acute services – The arrangements whereby PHAS are purchased through the Minister of Health's funding arrangements with DHBs and other publicly funded providers (such as Community Trust Hospitals). The Minister of Health funds these services through Vote:

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Health, and subsequently ACC makes payments to the Crown for PHAS received by ACC clients. These payments are in the form of an annual regulated levy payment from ACC to the Crown (agreed via an Annual Service Agreement for the purchase of public health acute services and other health services as per section 301 of the AC Act 2001).

The calculation for PHAS is based on a data match between ACC and DHB data.

Registered health professional – As defined in section 6 of the AC Act 2001:

"**registered health professional –**

(a) means a chiropractor, clinical dental technician, dentist, medical laboratory technologist, medical practitioner, medical radiation technologist, midwife, nurse, occupational therapist, optometrist, pharmacist, physiotherapist or podiatrist, and

(b) includes any person referred to in paragraph (a) who holds an interim practising certificate but only when they are acting in accordance with any conditions of such interim certificate, and

(c) includes a member of any occupational group included in the definition of 'registered health professional' by Regulations made under section 322 of the AC Act 2001."

Rehabilitation – A process of active change and support to assist a person with a covered injury to regain their health and independence and therefore their ability to participate in their usual activities as far as practicable. It comprises treatment, social rehabilitation and vocational rehabilitation. ACC purchases many rehabilitation services by way of contracts with public and private organisations, outside the public health acute services period.

Sector Operations – The group within MoH that is responsible for making and monitoring payments to various health providers. The group used to be known as Health Payments Agreements & Compliance (HealthPAC) until a restructure in 2008. More information is available at Sector Operations | Ministry of Health NZ; see also the glossary entry for MoH Client Insights and Analytical Group.

Serious injury – An internal ACC classification that applies to people who are likely to have long-term requirements for support funded by ACC. This covers those with spinal injury, moderate to severe brain injury or other significant injuries such as severe burns, multiple amputations and comparable injuries.

Systematised Nomenclature of Medicine - Clinical Terms (SNOMED CT) - SNOMED CT is the standard international system of clinical terminology used to record precise, structured and actionable information about a person's health and disability status and the care and support they receive. SNOMED CT provides the core general terminology for electronic health records.

Treatment Cost Regulations – The Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003, which specify the contributions towards the cost of specific treatment services that must be made by ACC and accredited employers.

Treatment injury – A personal injury occurring in the context of treatment by one or more registered health professionals – but is not a necessary part or ordinary consequence of the treatment.

Treatment providers – A range of health providers recognised in section 6 of the AC Act 2001 as able to provide acute treatment for personal injuries (see section 2.4 of this guide).

Work-related personal injury – As defined under section 28 of the AC Act 2001. Work-related personal injury involving a motor vehicle is defined in section 29 of the AC Act 2001. Personal injury caused by a work-related gradual process, disease or infection is defined separately under the AC Act 2001 in section 30.

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Appendix 1: A guideline for transfer of funding responsibilities from DHBs to ACC

Purpose

This document describes the services, responsibilities and ACC purchasing options that may apply for the transfer of patients/clients from acute care to rehabilitation using scenarios. This document is part of the *Accident Services – a guide for DHB and ACC staff (2018).*

Principles that guide ACC's funding decisions

1. ACC only funds support needs directly related to a covered injury
2. All decisions are made in the client's best interest
3. Discharge destination decision is made by clinicians, but ACC makes the cover and associated funding decisions.
4. Discharge destination decision must support optimal rehabilitation outcome
5. Weight bearing status can be an indicator in some situations that the patient/client is ready to participate in active rehabilitation. However, weight bearing status should not be the only determining factor of the patient's/client's readiness for rehabilitation.
   Note: there is risk of the patient/client deconditioning due to prolonged immobility which subsequently prolongs the recovery period. A patient/client may be able to actively participate in rehabilitation/physical activity despite being non-weight bearing, which should be decided on a case by case basis.

Transfer of funding responsibility from DHB to ACC

The transfer of funding responsibility for patient's rehabilitation and/or additional support needs from DHB to ACC is at the point of a patient's discharge from hospital. Discharge is defined as when the clinical responsibility for the patient is transferred from the DHB Clinician to the patient's General Practitioner.

The timeliness of ACC's cover and entitlement decisions is dependent on the quality of the patient information provided by the DHB.

Note, the PHAS six week rules apply e.g.: equipment, DHB medical outpatient appointments and ancillary services such as non-emergency travel etc. may remain the responsibility of the DHB for six weeks following an emergency department attendance or an acute admission.

Refer to Section 2 of the *Accident Services - a guide for DHB and ACC staff (2018)* to view the PHAS rules and how to calculate the PHAS period.

Process for resolving Health/ACC boundary issues

Where responsibility for funding between DHB and ACC for a client is, unclear or disputed:

- **DHB staff** should contact the ACC Case Owner or relevant team manager. If the claim has not yet been accepted, DHB staff should contact ACC's Provider Contact Centre on 0800 222 070.
  If the issue is not resolved, DHB staff should contact the DHB's ACC Contract Manager. The DHB's ACC Contract Manager will work with ACC's Engagement and Performance to resolve or escalate the issue.

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- **ACC staff** should, in the first instance, talk to the DHB staff member involved and as necessary, escalate the matter to a Team Leader. If this is not appropriate or the issue remains unresolved, contact the Engagement and Performance Manager who will work with the DHB's ACC Contract Manger and ACC's Acute Care Services Portfolio to resolve the issue.

Refer to Section 6 of the *Accident Services - a guide for DHB and ACC staff (2018)* for further details.

Acute Care to Rehabilitation Scenarios

The following scenarios are to be utilised as a *guide* to support decision making. Decisions should be made on a case by case basis taking into consideration any entry requirements for a ACC purchased service. There will be occasional exceptions to the patient pathway and purchasing options described below.

Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Home 2) Injury only 3) Home	Ms D is 30 years old and has children under her care. Ms D fractured her arm at home. She was treated non-operatively at ED/Orthopaedics ward and discharged home the same day. Ms D has a follow up appointment at the Orthopaedics clinic post discharge.	✓ **ED through to discharge home from acute ward** ✓ **Outpatient appointment** to see medical practitioner (if within 6-weeks post discharge) If required: ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Outpatient appointment** to see medical practitioner (from 6-weeks post discharge from acute care) ✓ **Home and Community Support** services (domestic support, child care and personal cares) upon discharge home from acute admission. ✓ **Allied Health** services (eg physiotherapy) ✓ **Equipment** (from 6-weeks post discharge from acute care)
1) Home 2) Injury only 3) Home	Mr H is 60 years old and has fractured his lower leg at home. Mr H presented to ED and is admitted into an acute ward. Mr H has surgery performed for his lower leg and after a few days, he is clinically safe to be discharged home with crutches. He requires help with personal hygiene, cooking and cleaning. Mr H has a follow up appointment at an outpatient Orthopaedic Clinic four weeks later where it is decided that Mr H will participate in community rehabilitation.	✓ **ED through to discharge home from acute ward** ✓ **Outpatient appointment** to see medical practitioner (if within 6-weeks post discharge) ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Home and Community Support** services (domestic support and personal cares) upon discharge home from acute admission ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)

[57] Scenario outline: (1) describes the patient/client's living situation at time of injury, (2) describes the patient/client's need for hospitalisation is related injury only or injury as well as comorbidities, (3) describes the discharge location

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Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Home 2) Injury only 3) Rest home	Mrs B is 67 years old and sustains bilateral wrist fractures at home. Mrs B was taken to ED and is treated with both arms in a cast. She is discharged from hospital but requires rest home level of care as she needs full supports with activities of daily living. She is otherwise clinically stable. Once the casts are removed, Mrs B will receive community rehabilitation (e.g. physiotherapy).	✓ **ED and through to discharge into rest-home** ✓ **Equipment** (up to 6-weeks post discharge from acute care to rest home). × The DHB is not responsible for the rest home stay as patient is clinically stable and only requires supports with activities of daily living due to the injury.	✓ Support services in client's home if additional family members available and able to provide natural supports for security and safety reasons. ✓ **Short-term Residential Supports** if natural supports at home are not available. ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)
1) Home 2) Injury only 3) Home but rest home supports requested	Mr C is 80 years old and has sustained a lower leg fracture at home. Mr C was admitted in the acute ward and his fracture fixed externally (in a cast). The DHB clinician has made the decision to discharge Mr C home however, Mr C's family has requested that Mr C is placed in a rest home so that he can be better supported.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Short-term Residential Support** services: ACC makes a contribution towards rest home care (similar to amount of contribution that ACC would make if patient is discharged home) and the patient/patient's family makes a contribution. ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)
1) Rest Home 2) Injury only 3) Hospital level rest home	Mrs K is 76 years old and has sustained a fractured ankle and wrist whilst in her rest home. Mrs K presented to ED and is admitted into an acute ward. Due to her injury, Mrs K requires additional supports for activities of daily living. Mrs K is discharged to hospital level rest home care.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Short-term Residential Support** services: ACC pays the difference between the rest home level of care and hospital level of care at rest home as the additional supports required are related to the covered injury. ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care)

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Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Home 2) Injury only 3) Hospital level rest home	Mr R is 96 years old and has sustained a fractured ankle at home. He presented to ED and is admitted to the acute ward. He is treated non-operatively (fracture plastered). Mr R is unable to manage the crutches due to his frailty, which is exacerbating his injury related needs. Mr R is discharged needing a higher level of care (hospital level) at a rest home.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (for up to six weeks post discharge from acute care).	✓ **Short-term Residential Support** services: ACC funds the placement at a hospital level rest home (usually up to six weeks). ✓ **Allied Health** services (eg physiotherapy) ✓ **Training for Independence Advisory** service ✓ **Equipment** (from 6-weeks post discharge from acute care). Note: ACC will fund the equipment from the point of discharge if the equipment is required for more than 6 months post discharge.
1) Home 2) Injury & comorbidities 3) Non acute rehabilitation	Mrs A is 82 years old with Congestive Heart Failure (CHF) recently discharged from hospital. Mrs A falls and sustains a fractured neck of femur at home. She is taken to ED and is admitted into an acute ward. Her CHF is stabilised over 1 day and she has surgery which is successful. The clinical decision has been made that Mrs A will benefit from inpatient/non acute rehabilitation. However, she requires a period of management of CHF before she is ready to participate in inpatient/non acute rehabilitation	✓ **ED through to discharge into inpatient/non acute rehabilitation** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Non Acute Rehabilitation** service ✓ **Equipment** (from 6-weeks post discharge from acute care) ✓ **Home and Community Support** services (domestic support and personal cares) upon discharge home from non acute rehabilitation service ✓ **Training for Independence Advisory** service

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Scenario outline[57]	Injury Scenario	DHB Responsibility (funded under PHAS for ACC clients)	Purchasing options for ACC
1) Rest Home 2) Injury that requires ongoing clinical/medical management 3) Non acute rehabilitation	Mr E is 78 years old and has fractured his pelvis in three places at the rest home where he lives. Mr E was treated non-operatively in an acute ward. Mr E requires bed rest for the fracture to be fixed and stabilised. He requires four staff to perform cares. After six weeks, a clinical decision is made that Mr E will participate in inpatient/non acute rehabilitation.	✓ **ED through to discharge in to inpatient/non-acute rehabilitation** Note: the DHB may transfer the patient to a DHB contracted rest home for the bed rest period. This remains DHB responsibility as the patient's fracture is not fixed and they remain under the care of DHB clinicians. ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Non Acute Rehabilitation** service ✓ **Equipment** (from 6-weeks post discharge from acute care from the hospital/rest home into Non Acute Rehabilitation service). Note: ACC will fund the equipment from the point of discharge if the equipment is required for more than 6 months post discharge.
1) Home 2) Injury only 3) Hospital level rest home until ready for non acute rehabilitation	Mrs J is 86 years old and has sustained a humerus fracture at home. She receives acute care, with the fracture being fixed externally (in a heavy plaster cast). Pre-injury, Mrs J used a walking frame to aid in her mobility. However, due to her cast she is unable to use the walking frame and requires supports with dressing, bathing and toileting. She also has some dementia, and is admitted for three days for investigations. Due to a lack of natural supports at home (as Mrs J lives alone), the clinician has requested Mrs J is placed under hospital level care in a rest home until the cast is removed. After which, Mrs J may require inpatient/non acute rehabilitation.	✓ **ED through to discharge from acute ward** ✓ **Equipment** (up to 6-weeks post discharge from acute care)	✓ **Short-term Residential Support** services: ACC funds the placement at a hospital level rest home for up to six weeks as: - the need is a consequence of the injury and - the need is not due to underlying medical conditions and - the fracture is fixed externally or internally and - the client is safe to discharge under GP care (at rest home) NOTE: If she requires longer-term Residential Support it may not be due to the injury. ✓ **Equipment** (from 6-weeks post discharge from acute care). ✓ **Allied Health** services (eg physiotherapy) ✓ **Non Acute Rehabilitation** service Note: rehabilitation may be provided in the rest home by Non Acute Rehabilitation Community services or Training for Independence for adults with other injuries service.

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Intensive Service Coordination Guidelines for NASCs funded by the Ministry of Health

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Disability Services Directorate
Ministry of Health

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1. INTRODUCTION

The Disability Services Directorate (DSD) of the Ministry of Health (the Ministry) contracts organisations to provide the facilitation of support needs assessment; information on disability supports; support and service planning and coordination; and allocation of Disability Support Services (DSS) for those people with a lifelong impairment, usually under 65 years of age.

District Health Boards (DHBs) fund similar needs assessment and service coordination processes for older people, usually over 65 years of age.

These guidelines are intended to describe, and give guidance to, best practice in relation to that section of the Ministry of Health service specification for needs assessment and service coordination (NASC) which specifies Intensive Service Coordination (ISC) (Section 5.5).

Background

- Intensive Service Coordination (ISC) has been a service component of NASC contracts with the Ministry of Health (the Ministry) since approximately 2000.
- It has been developed in different ways and to a different extent by individual NASC.
- Intensive Service Coordination is also a service component of the Regional Intellectual Disability Care Agency (RIDCA) contracts in the work of those agencies with civil clients who are not subject to the legislative requirements of the IDCCR Act.[1]
- It can be a shared function in the transitioning of people between RIDCA and NASC services
- ISC is also a service component in the resettlement of people in the community from long term institutions ("deinstitutionalisation"), i.e. as part of the transition process for people who have been living at Kimberley Centre, Levin.
- There are also contracts with some NASC in specific areas in which ISC is a core component of flexible family support.

Objective of ISC

ISC is to provide coordination of supports, be they natural resources and/or formal paid services, for the small number of people within the NASC client population who have high and complex needs, usually requiring the involvement of multiple providers and ongoing problem solving. ISC will involve an ongoing relationship between the person, their whanau, aiga, carers where relevant, and the coordinator for the period that ISC is needed.

Purpose of these Guidelines

These guidelines are primarily for professional staff, their team leaders and managers responsible for providing service under the contractual service specifications between NASC and the Ministry. They seek to support best practice, and should be read alongside the requirements to work to Standards as specified in the contracts, Guidelines for Service Coordination (1995), and "Support Needs Assessment and Service Coordination – Policy, Procedure and Information Reporting Guidelines" Feb 2002. They should also provide the base for best practice in greater collaboration in needs assessment and service coordination processes of the future.

Intensive service coordination is not a default service for other types of support work. Nor should it detract from, or confuse, the extent and depth of work undertaken as generic service coordination[2] (SC).

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[1] Intellectual Disability Compulsory Care and Rehabilitation Act 2003

[2] "generic" is used in this document simply to make distinction between existing service coordination and the practice of intensive service coordination. It is not a new service component.

Additionally, separate work on boundary and definition issues, eligibility, referral and transition processes, quality, training and qualifications development will also inform these guidelines.

Note:

1. these guidelines should be read in conjunction with the NASC service specifications and service provider agreement terms and conditions.
2. subsequent references in this document to "the person" or "people" should be understood as referring to a person/people eligible for ISC.

Definition

Consistent with the Ministry's NASC service specifications, in these guidelines ISC is understood to mean and/or include:

- a relationship, role and responsibilities which are essentially the same as Service Coordination, but differ from Service Coordination in the level of involvement rather than in the nature of the core functions
- support for coordination provided to a small number of the NASC's people/client population
- coordination for people who have high and complex needs
- situations where there are multiple means of support and/or service providers
- higher levels of creative problem solving and/or more complex support packages than with generic service coordination, while working within existing budget management requirements
- sustained involvement between the person/family/whanau and the Intensive Service Coordinator (IS Coordinator)
- involvement which may be primarily face to face meetings
- regular and planned formal and informal review both for the person, their whanau/family/informal supports and service providers
- planning for return to generic service coordination is included wherever possible
- understanding by the NASC that this level of coordination should be for a specified period
- implementing best practice principles of service coordination
- core competencies, as for generic service coordination, are enhanced as needed and well supported
- best practice supported by supervision/mentoring and peer support.

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Things to remember about ISC:

- ISC should support, not replace, natural support systems
- ISC should observe all the requirements and best practice guidelines which relate to NASC in all its functions of facilitating assessment of needs, coordinating access to supports, allocating services and managing an indicative budget for the Ministry
- IS Coordinators should have the necessary level of competencies and demonstrated experience to undertake the role
- NASC need to ensure competencies are present and developed, and support provided through supervision or mentoring, and ongoing training
- There should be a clear connection between individual strengths/goals/needs, the services proposed to meet those needs, and the need for, and role of, the Intensive Service Coordinator
- The applicability of these guidelines to specific contracts with individual NASCs for services which include a ISC function (such as Flexible Family Options) is to be determined with the DSD Service Manager.

2. INTENSIVE SERVICE COORDINATION - FREQUENTLY ASKED QUESTIONS

2.1 What is ISC and what are the components of the service?

The components of service are those of generic service coordination, ie:

- the process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the person and, where appropriate, their family/whanau and carers.
- identification of which needs can be met by government funded services and other services
- exploration of all options and linkages for addressing prioritised needs and goals
- monitoring the delivery of the support plan, review of needs and revision of the support plan at regular specified intervals
- supporting independence.

with

- a higher degree of problem solving
- ongoing contact and relationship for the period of ISC
- contact and coordination provided in such a way, and with the frequency, as indicated by the extent and complexity of needs of the person, and, where appropriate, their family/whanau and carers.

Note:

ISC should follow requirements for national consistency, resource allocation and budget management as in the NASC service specification, internal NASC requirements, and any DSD requirements as advised by Service Managers.

ISC may include:

- Discretionary Funding. Where this is the case all the requirements of the NASC service specification and any NASC internal processes must be followed

- negotiating the most appropriate means for achieving the outcomes and responsibilities with service providers and other sectors e.g. education, justice, police. Intersectoral protocols may apply

- arranging interim and crisis service provision pending further assessment (Note: this is also a generic service coordination function)

- involvement with specialised services e.g Mental Health teams for assessment and treatment planning, integrated with facilitated needs assessment and service co-ordination for people with a dual diagnosis of intellectual disability and mental illness

- convening or participating in meetings as required with the person and those involved in the development and/or implementation of a support plan

- specialised assessments and specialist services (following the same process as for generic SC). Referrals would be made by the NASC and it would normally be expected that the specialised assessment would have taken place before determination that ISC was required. Assessments by specialists should not be part of the proposed support package.

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2.2 Who is the service for?

ISC is for the small number of people within the NASC client population who need, and agree to[3], more intensive support and coordination in the accessing of appropriate and available resources in response to their assessed and prioritised disability support needs.
This will be consistent with the operational eligibility definition of the NASC:

"A person with a disability is someone who has been assessed as having a physical, intellectual or sensory disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required."

As with generic NASC processes, the person needs to have knowledge of, and give consent to involvement and any responsibilities of ISC, without unnecessarily complicating understanding of a process which involves a greater level of coordinator involvement rather than any different sort of activity.

There are a number of people who, as a result of high and complex needs and as part of, or following, transition from institutional to community based living may require ISC. ISC, however, is not a service exclusively for people leaving long-term institutional settings as a result of de-institutionalisation programmes.

- Eligibility for ISC will be determined by a service co-ordinator following assessment.
- Each NASC will have established, known, and regularly reviewed protocols for ISC, including determination of eligibility.
- Each NASC will ensure service coordinators know and competently implement eligibility criteria for ISC.
- Protocols and practice will include ongoing review of the need for this level of coordination and transition to generic service coordination.

2.3 Are there any areas or functions not included in ISC, and why?

- **Social Work:**

  While social work is often situation and outcome specific, it is a service and profession in and of itself[4]. Social work has a broader focus on, and analysis of, society, alongside its therapeutic engagement with individuals and groups of people. Social work provides support different from that of ISC.

  There are times when a person or child's situation is such that a social worker's involvement could assist and progress the situation. Examples to consider could be:

  - There is neglect or abuse involved
  - The whanau/family situation needs assistance to enhance their ability to support the person. This may include responses to incidents, issues of attachment and separation, parenting knowledge and skills
  - The need for advocacy in relationship to other issues, agencies, departments and/or to maintain the relationship between the person and their various support providers
  - Support and skill development in decision making
  - Work with some significantly presenting issues that need to be resolved so that the person or whanau/family can engage fully with the needs assessment/service

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[3] Consent will follow normal NASC practice and include a formally designated agent or family member where this is required (e.g. children)

4 There are many definitions of social work An example is 'To promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing'.
From the Social Work Notice Board

coordination process. These could include support/ referral for income maintenance, budgetary assistance etc.

NASCs need to be mindful of the timing and possible consequences of yet another person being involved in the lives of people who are possibly already dealing with many professionals, service
providers and others. NASC need to work together with the person/whanau/family to be clear about what is offered and refer with permission.

- **Case Management**

The term "case management" has various definitions, and is used in various situations, including in some services for older people and people with disability. Case management can confer differing mandates to manage or direct with differing levels of responsibility for, and influence on, the wider environment impacting upon the person.

One example in New Zealand is that of the Accident Compensation Corporation (ACC) model of case management. In this model the case manager budget holds and has the authority to engage health providers, social or vocational rehabilitation providers, Specialist Assessors etc. Case managers hold the oversight and non-clinical management of the rehabilitation of a person for ACC. Other models in the literature include brokerage, "social entrepreneurship", and combinations of clinical and case management functions such as in nurse case management or social work case management.

The contract NASCs currently have with the Ministry does not include this type of case management. There is a need for further work in order to understand the various definitions and determine whether, in disability oriented needs assessment and service coordination, it is a necessary, appropriately unique or potentially duplicative concept and function. That work will need to embrace disabled people's views on terminology as well as the function, form and location of assessment, service coordination and intensive service coordination.

- **Personal Advocacy**

Personal advocacy is a service to support an individual person, or possibly family/whanau. A person in an advocacy role may speak for the person, but would also be supporting the person in understanding themselves, developing and sustaining the abilities to make themselves heard and represent their own needs and situation.

Neither NASC in general, nor the ISC role, offers a personal advocacy service at the individual level. To advocate at that level is not compatible with the responsibility to allocate supports consistently and equitably across a given population.

Are there any other things NOT included in ISC?

Intensive Service Coordination is also **NOT**:

- solely for any one type of impairment/disability
- solely for any one type of support or service
- confined to people of any particular age
- necessarily indicative of, nor authority for, use of NASC discretionary funding
- an ongoing entitlement
- a 24 hour service
- a crisis service.

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2.4 What are the significant variables applying to ISC?

It is likely there will be more than one of these variables present. Their nature and extent will impact significantly on the level of involvement and expertise required in the ISC process and relationship. For example:

- **Significant times/ Transitions, such as**

  - Children (and their whanau/family) aged from birth to 21 years, particularly during times of transition to school, between schools and through the teenage years to adult life
  - In adult life transitions to employment, parenthood, retirement.

- **The nature and extent of impairment/disability,** including **complexity**, **dual diagnosis** and the involvement of **multiple agencies** e.g. Child Youth and Family (CYF), DHB, Dual Diagnosis team, Mental Health services, Department of Corrections, Group Special Education (GSE) etc.

- **Whanau/Family circumstances, such as**

  - more than one family member with an impairment/ disability
  - substance use and issues
  - care and protection issues and CYF involvement
  - history of poor service or negative experiences with providers
  - where it is difficult to satisfy the person/caregiver's support requests
  - where there are no, few or reluctant natural supports, from family or significant other people
  - the family is under chronic stress and/or frequently experiences crises
  - new or challenging relationships e.g. blended families
  - where significant unmet needs remain.

- **Issues of Rural and Personal Isolation**

  - There are many small and remote communities within New Zealand with few community resources. Contracted providers can have greater difficulty providing support outside of urban centres
  - Some whanau/families are isolated by having no phone or personal transport and limited options of public transport.

- **Issues of Culturally appropriate support**

  In some areas it can be difficult to engage culturally appropriate supports and/or carers or providers to the extent to which they are needed. This can have consequences for the person/ whanau/aiga/family.

- **Provider/ service development issues**

  - Given the higher level of need and coordination, usually across providers, providers need to work closely with the NASC
  - Person/family may decline particular service provider options, perhaps because of previous experience, expectations, or perceived lack of "good fit" with aspirations and goals
  - Provider workforce issues, such as lack of satisfaction on the part of the person; health and safety issues for provider staff; availability of staff skilled and experienced to provide individualised supports for people with high and complex needs
  - There may be insufficient social work services to assist in resolving personal/family issues which may be potential barriers to achieving positive service coordination and service provision outcomes

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- The need to initiate and develop individual support solutions where there is no Ministry contracted service provider can be time consuming. It may also require considerable skill and experience
- Similarly, there may be need for individual solutions where contracted services cannot provide because they are working to capacity
- There may be a gap in development/contracting of services to meet particular needs e.g. young people needing to live in older people's residential care

- **Time**

Common to all the above is that the process of ISC can take significantly longer and may have an end point which is difficult to plan. At other times ISC can be episodic, with each episode being very time intensive. In both instances frequent review will ensure the efficiency, efficacy and appropriateness of ISC.

2.5 What is the NASC process to determine the use of ISC?

- A needs assessment is completed

- Service coordination may be started and support planning may be undertaken

- The Needs Assessment Facilitator may indicate and/or Service Coordinator determine the need for Intensive Service Coordination, according to the NASC's protocols

- ISC is explained to the person, and family/whanau/carer as appropriate, including at least:

  - Intention of ISC
  - How it works
  - Respective roles and responsibilities
  - The ongoing review component and
  - Process for transition back to generic Service Coordination. (Depending on the model used by the NASC this may simply mean a reduction in the level and frequency of contact and reviews)

Note: This explanation needs to be in a manner appropriate to the person's immediate situation (e.g. if in crisis) and may need to be repeated. The emphasis is on the realities for the person. It is not about ISC being a different experience or function.

- With agreement, the person is transferred to an IS Coordinator

- Where the applicability of ISC is not clear, the generic Service Coordinator will follow the NASC's protocols and practices for peer review, consultation and decision making on whether ISC is needed and/or continues to be needed

Note: All people involved in ISC should receive the same information as other people with whom the NASC works. It needs to include, at least, information on:

- Supports and services available to them
- Consumer Rights and Responsibilities
- The NASC's Comment and Complaint Policy and Procedures
- Appeal/Review processes

For further information on the NASC process refer to "Support Needs Assessment and Service Coordination – Policy, Procedure and Information Reporting Guidelines" Ministry of Health, 2002.

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2.6 What is the interface between ISC and support service providers?

- The IS Coordinator needs to advise all service providers of the ISC agreement with the person and what this will involve
- ISC will, with permission, provide sufficient information for service providers to respond to the person's needs and goals
- The NASC will support the provider to provide support/services to the person which meet the person's needs and goals, including in flexible and person centred ways which may not be the standard form of delivery of service by the provider
- The NASC will expect the provider to provide service according to those agreements, and advise promptly if there is any variation in the provider's ability to provide the agreed kind and level of support
- Services will be provided by provider staff with appropriate competencies, with flexibility of response as required
- Where there are multiple people in coordination roles, especially when these are across sectors, there needs to be agreement as to a lead coordinator/organisation
- Methods of communication and liaison need to be agreed between all parties, including the person. There needs to be particular agreement on any communication responsibilities of the lead coordinator/organisation
- All parties need to commit to sharing of information on progress, changed need and/or concerns, with permission.
- All the above should be consistent with existing Memoranda of Understanding (MOU) between NASC and service providers. Where these exist, they should be reviewed to ensure the memorandum covers the specific aspects of ISC and works for people involved in ISC. New MOU being developed, as required in the NASC service specification, should be inclusive of ISC work and provider interfaces.

Note: Many of these points are not specific to ISP only

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2.7 What is the role of the Ministry of Health?

- The primary relationship for the NASC manager is with the DSD Service Manager.

The Ministry:

- approves/declines exceptional support packages according to current protocols and/or as determined by the Ministry at the time
- monitors NASC performance and expenditure
- monitors service providers' performance
- reports service utilisation and expenditure to NASCs
- develops a purchase strategy, tender processes etc
- develops and revises service specifications

- supports development of quality
- contracts routine audits, and where necessary, issue based audits
- supports NASC and provider development
- responds to complaints to the Ministry.

2.8 What are the challenges for NASCs?

The predominant challenges include:

- **Time**

  Greater time on the part of the IS Coordinator is intrinsic to the function of ISC and the achievement of best outcomes.

  Time needs to be well managed, with staff understanding and competently managing the role. There need to be good support, including that from team leaders and management and robust reporting systems.

  A significant amount of time may be spent in travel to see people. Visits and meetings may be necessary with wider family, providers and other support people. Multiple and/or ongoing visits may be necessary. Attending whanau hui or fono may need more than one staff member to meet expectations and protocols relating to these meetings.

  There needs to be good deployment of staff, and constant monitoring to ensure other service coordination work does not fall behind contracted times and standards.

- **Skilled and Experienced Staff**

  ISC requires highly skilled and experienced staff. It requires an interest in, and commitment to, this form of coordination work on the part of all staff who undertake it. This includes commitment to work with the same people over an extended period.

  An IS Coordinator needs the knowledge, skills and values of a S Coordinator, with particular attention paid to cultural competencies**,** plus knowledge and competencies, at least, in the areas of:

  - family/whanau dynamics
  - supporting people to have valued and meaningful lives
  - gaining trust
  - working at the person's pace
  - working collaboratively with providers to agreed outcomes
  - individual service design and development
  - supporting and managing change
  - being alert to, and managing, issues of dependence
  - self management and self care.

  Note: This is not an exhaustive list.

  NASC managers need to provide for their ISC staff's professional health and safety, as well as support and development opportunities. Professional boundaries, such as between social work and ISC roles and functions are important and need to be understood and maintained. The same is true for professional standards.

  Across the four Regional Intellectual Disability Care Agencies (RIDCA) services there are well developed Position Descriptions which could be adapted for similar NASC Intensive Service Coordination work and roles.

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- **Expectations of other Sectors or Providers**

Other sectors, funders and providers sometimes expect the NASC ISC to take the key worker role. IS Coordinators can end up doing this by default. When this happens, it can generate confusion, and even compound the impression in other sectors that "key worker" is a generic NASC role and responsibility. To avoid this, clear understandings, preferably recorded in MOU, need to be jointly developed. An agreed format for doing this across NASCs would support consistency on ISC across regions.

- **Eligibility**

NASC have a responsibility to ensure that intensive service co-ordination is offered only to people with high and complex needs. They need processes to regularly review the needs of the person and the purpose of intensive service co-ordination to ensure that it is appropriate.

All NASC will need to manage the number of referrals that are made to ISC. Personnel designated for the role will be able to work well with a finite number of people at any one time. Workload and professional demands will need to be carefully managed by the Manager.

More work needs to be done between NASCs and funders on definitions/ eligibility/ workloads. Benchmarking between NASCs would support this work, and ensure that exercise of this function within NASC also demonstrates national consistency and equity of access and allocation.

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2. 9 What does a NASC manager need to have in place to support best practice in ISC?

Policies and Protocols:

- Process for needs assessment facilitators and service coordinators to recognise and advise when ISC may be needed
- Material for referrers and providers so that they can make referrals which clearly outline, with permission, the nature and extent of needs
- Processes for determining ISC eligibility, approval, allocation and workload.
  NASC Managers may need to work with their generic Service Coordinators to describe eligibility for the ISC service within their NASC. This will depend on factors unique to their NASC, staff resource and skills. It will also be important that a designated person, likely to be the manager, states and describes clear boundaries between generic service coordination and intensive service coordination; circumstances such as when referral to a social worker is indicated, and when there is responsibility belonging to other organisations.
- Set practice guidelines, for example, so that staff know when to refer a person for social work, how to work with dependency, set review periods etc
- Identify and/or secure social work services, with agreed referral criteria and processes
- Consider staff mix and skill and redesign work flow if required
- Establish staff supervision, mentoring and training policies and practice to support and develop those staff undertaking ISC work.
- Collect data and report on ISC to the Ministry of Health in monthly and quarterly reports.

A Model for ISC:

The NASC contract does not specify a model or a structure for any of the NASC components of service, including ISC.

Options include:

- a dedicated person who does only ISC, or
- the function and role spread across several SC staff.

Existing expertise, experience and interest in the team will influence this. Intensive service coordination does require specific skills, attributes and sensitivities. Not every one is interested in working in this way, and not everyone who is interested in ISC may be sufficiently skilled to undertake the role.

Staff training and support:

Training needs to include:

- disability awareness
- knowledge about na/sc and NASC
- professional skills
- technical knowledge and skills relating to protocols, tools, networks etc
- values, with a commitment to implementing the objectives of the NZ Disability Strategy and to increasing the opportunities for Maori and Pacific peoples to access services.

When staff are working with people in an intensive way it is very important that they are receiving good support and supervision to keep themselves, and the people they work with, safe. Clinical or professional supervision[5] is a separate professional skill. Therefore, it is important that NASC managers do not go outside their skill base in undertaking clinical/professional supervision.

Other models might be usefully explored or preferred. Knowledge of different models, preferences and benefits should inform the manager's decision making about supervision, peer review, mentoring etc.

Reporting to the Ministry of Health

It is important that:

- there is agreement with the Ministry as funder about definitions and practice of ISC, consistent with service specifications
- statistics for ISC are captured and reported to the funder in monthly reports and trends and other aspects in quarterly reports.

3.0 ISC Referral

NASC will currently have in place referral processes which may need to be modified in relation to ISC. One option is a one page sheet that is completed as part of, or shortly after, the needs assessment has taken place, as an internal process to alert the NASC team. Information that is to be captured and shared needs to be agreed with the person and the NASC needs to decide where this information is filed. For example, it may be in a separate section on the person's file or included in a service coordination section. This ISC Sheet needs to have some alerts, as related to the vulnerability of the person, whanau/family and/or the situation concerned.

4.0 Model/Process

One process is:

When the factors indicating eligibility for ISC are confirmed in the needs assessment, or are apparent early in generic service coordination, they are highlighted on a ISC Sheet. The Service Coordinator then obtains the team leader/manager's approval for ISC to begin.

How ISCs are allocated would depend on how the NASC chooses to staff the ISC component of the NASC service and would be developed after that decision is made.

A Pathway showing a flow for ISC through the NASC is in Appendix 1.

[5] One definition of supervision is: 'an intensive, interpersonally focused, one-to-one relationship in which the 'supervisor' facilitates the development of practice competence in the other' Hawkins and Shohet.

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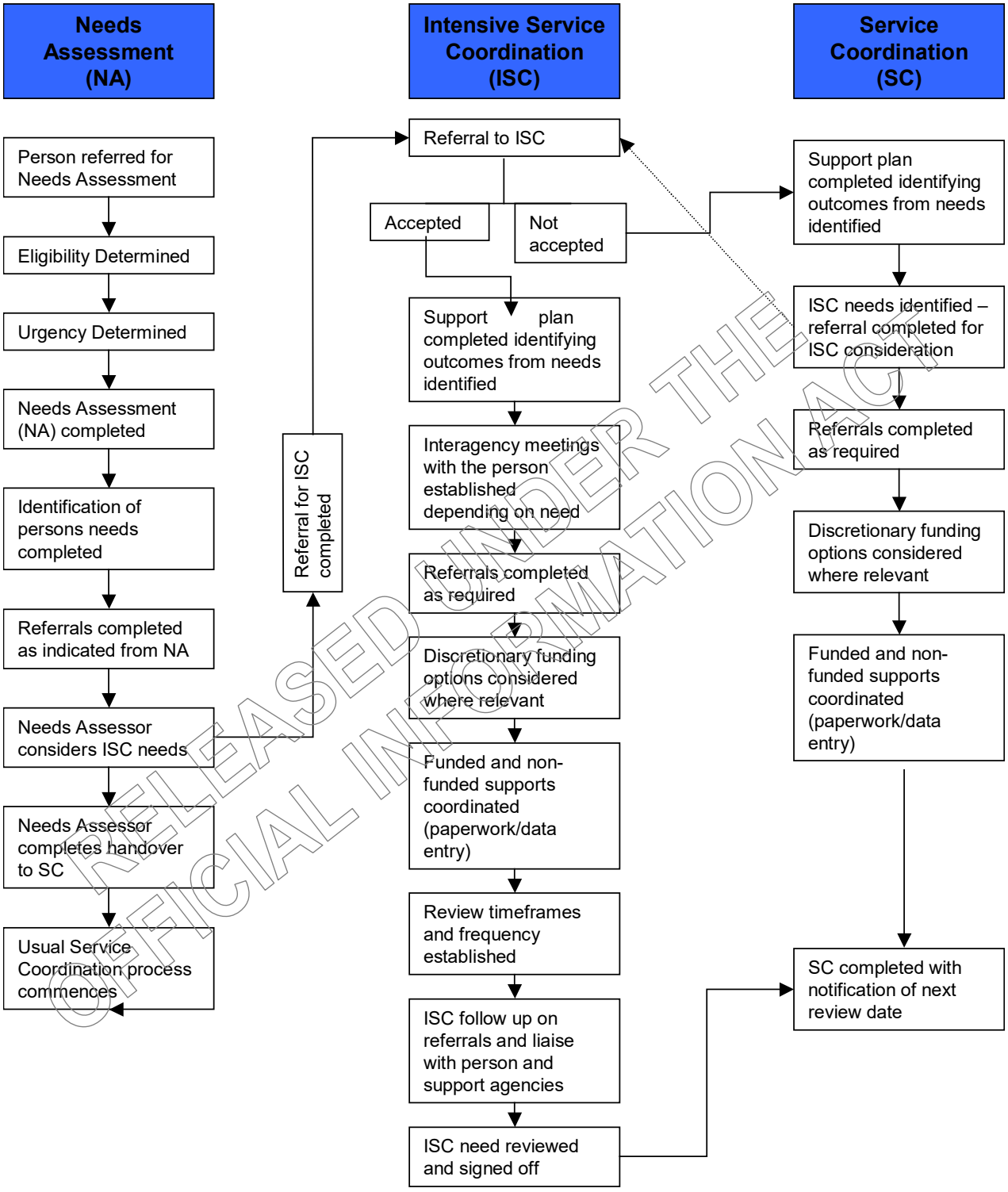
Pathway to Intensive Service Coordination



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Note: This depicts process and function and does not necessarily suggest there must be separate ISC and SC roles.

Supported Independent Living Guidelines for NASCs and Providers

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Disability Services Directorate
Ministry of Health
Implemented March 2001

Updated December 2004

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1. Introduction

The Disability Services Directorate (DSD) funds a continuum of services for disabled people ranging from minimal support in people's own homes to very high levels of support and care in residential settings. Supported Independent Living is one of the services in this continuum and is funded in response to the growing number of people with disabilities who wish to live independently in their own homes.

Population
The significant groups for whom this service is attractive are:

- those living with their parents and at an age where it is appropriate for to transition to an independent living situation such as a shared flat or their own house;
- those who acquire a disability later in life and require an increased level of support to continue living independently;
- Those people who are currently in residential settings who wish to live independently.

This service was developed to assist those people who may require a significant amount of support to get established in an independent living situation. For some people this level of support may reduce over time, however, other people may always require a significant level of support to maintain them in independent living. Their needs are of a nature that will require ongoing planning and review.

Objective
The objective of supported living services is to assist a person with a disability to live safely in the community with an appropriate level of support. Key outcomes are to maximise the person's choice about where and how they live, develop the skills to access their community and to prevent, or delay the need for admission into a residential care service.

It should be noted that the main component of Supported Independent Living is support for skill development and maintenance. It is not intended to be a 24-hour support service and was not designed as a "hospital in the home" service. If a person wishes to pursue a "hospital in the home" service then DSD would only partly fund the support required i.e. that which is based on DSD's ability to meet assessed need.

Service packages
The SIL service funded by the Ministry of Health DSD is based on a person's support needs to meet their lifestyle choices in living independently. Support needs are determined through the NASC process and form the basis for the service Support Package that is agreed between the person, SIL provider and the NASC agency.

It is unlikely that support for all the person's goals will be funded by the DSD as part of the Support Package. There are likely to be options that are either funded by other agencies or provided through informal networks. These should be used wherever possible as they enhance the independent nature of the person's choices. Choices that relate to lifestyle, rather than support need, are not funded as part of the Supported Living Package but never the less will form part of the Individual Plan of the person. For example, if a person chose to join a sports club, fees, sporting equipment and transport to events would not be funded as part of the Supported

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Living Package, but their personal support to enable them to participate could be. In this example it could be possible for this personal support to be provided over time by informal networks that develop within the sports club.

The DSD will continue to work toward ensuring equity of service access across New Zealand.

Note: these guidelines should be read with reference to the Supported Independent Living service specification and service provider agreement terms and conditions.
Note: Subsequent references in this document to "the person" or "people" should be understood as referring to an eligible person/people for SIL services.

2. Supported Independent Living Frequently Asked Questions

2.1 What are the components of the service?

- **Individual Plan**: is based on the support needs identified through the NASC process and outlines the person's development and lifestyle goals. The IP is the basis for the development of a Support Plan.

- **Personal Care / Household Management:** as described in home based support service agreements. These services may be included as part of the support package administered by the provider where appropriate. Personal Care and Household Management support generally does not include a development component. It is expected that in most cases Home Based Support services will not form part of the Supported Independent Living service and that these services will be provided by Ministry of Health contracted providers Home Based Support services.

- **Community support worker:** Provides oversight of the day-to-day needs of the person and works with the person to develop the skills identified in the Individual Plan, i.e. budgeting, motivating, supervision, assisting the person to build community linkages and networks and assisting with co-ordination of the support package. Supervision is intended to mean support of a person's development rather than "keeping an eye" on them in case some unplanned event occurs.

- **Service Plan Set-up and Review**: Proposing and co-ordinating a care package including the initial brokering of service linkages, review and revision of the package at agreed intervals, or when a persons needs change. It is expected this will occur at defined intervals over the life of the support package where there is a requirement for intense supervision and management of service changes.

- The provider may be contracted to provide all these components. In some circumstances the provider may choose to sub-contract personal care and household management to an MOH contracted home support agency. If the SIL provider does directly provide personal care and household management they must meet the same standards of service provision as if they were a Ministry of Health contracted provider of Home Based Support services. However, in terms of the SIL service, the SIL contracted provider will have overall responsibility for the provision of these services where they form part of the Support Package and are agreed by the NASC agency.

- There is also work being done with agencies who provide services for people with Intellectual Disabilities and complex needs who require a higher level of

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supervision than most people on the programme. An administrative component may need to be contracted for separately. This will be done on a case-by-case basis with individual providers as appropriate.

2.2 Who is the service for?

Supported Independent Living services are available for those people with a disability who have been referred to the Provider for service by a contracted Needs Assessment Service Co-ordination Service (NASC) Agency.

A person with a disability is someone who has been assessed as having a physical, intellectual or sensory (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.

- People who wish to live in their own home, or in a flat either by themselves, or with others and who may require a level of support or supervision that is beyond normal personal assistance / household management services. Some boarding arrangements may be included.
- People who wish to move from their parental home into supported independent living.
- People who wish to stay in their own home but require additional support because of increased needs.
- People who are in a residential care facility that wish to move into supported independent living.

Note: The level of support will be determined through the NASC process.

2.3 What SIL is not intended for

- SIL is not intended to be a fully staffed 24-hour 7-day per week support service.
- SIL is not residential care.
- SIL is not a "hospital in the home" nursing service.
- SIL cannot be provided in a residential care facility.
- SIL does not fully fund all support to meet a person's goals. Other supports may be provided by other agencies and/or through informal networks.
- SIL cannot be provided in a person's parental home unless as part of the transition from parental home into independent community living.
- SIL is not intended to provide ongoing high levels of service to ensure safety. This refers specifically to managing public and personal safety with high levels of behaviour support or medical components of care. These types of services are available to individuals through separate contracts DSD holds with other providers and may be used on a time-framed basis.

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- SIL is not intended to provide "day-care" services or support for the children of disabled people who are on the SIL program. This is the responsibility of the disabled person as a parent.

2.4 What is the role of the NASC in the SIL Process?

- Completes an initial needs assessment
- Explores and discusses all of the support options available for the person based on DSD's ability to meet the assessed need.
- Ensures that SIL is the preferred option of the person
- Ensures the person is well informed of the SIL options available to them and that they understand what is funded by the DSD of the MOH i.e. that funded support is needs based, not based on lifestyle choices.
- Makes an appropriate referral to the SIL provider selected by the person.
- Negotiates and approves the proposed support package up to the funding limit indicated by the SPA tool, or up to a total of $40,000 per annum. If the total DSD funding required to fund the support package (including all MoH funded ongoing support cost but excluding the cost of equipment or any one-off costs) exceeds $40,000 per annum the NASC Manager will defer to the DSD Service Manager for the Locality
- Ensures the support package meets the goals identified through the NASC process and documented in the Individual Plan.
- Ensures the financial resources are available to meet the proposed support package within the overall budget management responsibilities of the NASC.
- Responds to the need to review or revise a service package if support needs change.
- Provides regular re-assessment and review of service users' needs as required by NASC Service Specifications and Guidelines.
- Provides notification of service changes (or exit) to the MOH in a timely manor to ensure service payment is made as agreed by the NASC agency.

Note:

Later in these guidelines (Section 2.14 Operational Protocol for Supported Independent Living services) the need for each NASC to develop a protocol that would include processes around the resolution of disputes between the provider and the NASC is outlined. It is important to remember that the potential service contract is between the NASC and the provider, not the person and the NASC. Consequently service users should not be directly involved in the negotiation of the package, although clearly the person will be totally involved in the identification of needs and development of the package.

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For further information on the NASC process refer to "Support Needs Assessment and Service Coordination – Policy, Procedure and Information reporting Guidelines" developed by the MOH 2002.

2.5 What is the role of the provider?

- Completes a proposed support package, which will meet the goals outlined in the Needs Assessment and documented in the Individual Plan.

- Ensure the support package submitted to the NASC includes only those things that are needs based and funded by the DSD. This may not include all of the goals identified in the Individual Plan as some of the goals may either be funded through other Government agencies, e.g. participation in vocational programmes, support while in hospital, or are personal goals of a nature not funded by the DSD e.g. overseas travel, engaging in the same social activity every night of the week.

- Submits the proposed support package to the NASC for approval.

- Implements the approved support package. Note: The provider must notify the NASC if there are any changes to hours of service provided to that specified in the approved support package.

- Manages the day-to-day support needs of the person as outlined in the Supported Independent Living service specification.

- Provides information to the MOH to ensure prompt payment for services delivered.

- Monitors and reviews the Support package. The service specification indicates this should occur at least every 6 months.

- Involves the NASC agency in the review if there has been a significant change in support needs.

- Ensures support staff have a sufficient level of training to meet the persons support needs, are aware of the service philosophy, organisation process and have adequate role supervision/orientation.

- Ensures the person has access to an external (to the provider) advocate.

- Submits a support package review at time intervals agreed with the NASC.

2.6 What is the role of the Ministry of Health?

- Negotiate contracts with providers to whom the NASC may refer

- Approve/decline exceptional support packages. Exceptional support packages are those support packages that are outside SPA bands or support packages (including all MoH funded ongoing support cost but excluding the cost of equipment or any one-off costs) that exceed a total cost to Ministry of Health of $40,000 per annum.

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- Monitor NASC expenditure and performance
- Monitor providers' performance
- Report service expenditure to NASC agencies
- Develop a purchase strategy, RFPs etc
- Develop and revise service specifications
- Contract for audits
- Provider development
- Respond to complaints to the Ministry

2.7 What components should be in a proposed support package?

- Relevant history
- Statement of goals
- Current and future needs
- The person (and family/whanau where appropriate) preferences
- Appropriate and realistic options
- Resources required to meet needs
- Individual risk management plans when appropriate.
- Specialist clinical reports when appropriate
- Timeframes for implementation and review
- Service exits – if a person wishes to exit a service this will prompt a provider review of the support plan and package, the provider will immediately inform the NASC agency and will propose a transition process in the support package review, timeframes will be agreed between the provider, the person and the NASC agency. Each participate is responsible for the timeframes and actions agreed in the transition Support Plan. The overall process will be managed by the NASC agency.

2.8 Things to remember when developing a support package:

- The support package should support, not replace, natural support systems
- The support package does not include hotel costs (i.e. rent, food, and utilities. These are expected to be paid for out of personal income such as employment or benefits). Therefore the person will not be income and asset tested
- The Community Support worker hourly rate includes all overhead costs of the service provision including; management, supervision, training and travel costs.

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Community Support Worker hours should account for all of the direct contact hours with a person where there is an element of personal development and supervision in line with the goals identified in the Individual Plan.

- Support plan set-up and periodic reviews are likely to occur at set times within a support package. These will be agreed with the NASC organisation. Support plan set up and review is not expected to be an ongoing weekly component of the service.

- There should be a clear connection between goals/needs/and the services proposed to meet those needs

- It is often a fine line between personal choice and support need. For each person this will be different. The DSD funds need based support. The question that will be asked is "what is reasonable in this case" in light of the service described in the service specification and the needs outlined through the NASC process.

- A support packages may include a level of provider discretion within the service package delivery if agreed by the NASC agency. A person's changing needs can then be managed within the SIL service with fewer referrals back to the NASC agency and a reduced need for funding level changes. If implemented there needs to be an acknowledgement by both NASC and SIL provider that over the term of the support package there will be periods where cost is higher than weekly funding and visa versa. The provider takes responsibility for ensuring the agreed goals are met within the funding agreed over the agreed term. Providers and NASC agencies have to be proactive ion reviewing service packages.

- Supported Living is not twenty-four hour, seven days per week, residential care.

- The more relevant information included the better

- A person's support proposals is not to be considered a "contestable" process i.e. NASCs should not send a referral to more than one provider

2.9 Reviewing/revising the support package

- The support package should timeframe a date for review - this will depend how dynamic the person's situation is.

- The provider is responsible for the 6 monthly reviews as described in the Supported Independent Living service specification.

- The support package should be reviewed if there is a significant change in the person's needs, goals or circumstances. It is the provider's responsibility to identify this.

- The NASC agency is to be informed of the support package review. Information including goals met by the person and new objectives set should be forwarded to the NASC agency.

- The NASC agency will acknowledge receipt of the reviews and ensure that the objectives set are in line with the Needs Assessment and Individual Support Plan.

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- The NASC agency should be involved in the review if there is a significant change in the persons support needs or at other times as agreed with the NASC agency and as required by NASC Service Specifications and Guidelines.

2.10 Can a provider invoice separately for time spent on developing the proposal?

While, the Support Plan set-up time is to be included in the package that is approved by the NASC, the initial Support Plan set-up cannot be charged as a separate service component**.**

It does require a level of trust and positive relationships between NASC and provider. This may present a challenge in some complex situations. However in working through these issues, it requires a different level of working together than the traditional assessment/residential placement process.

Clearly there would be an initial meeting with the person and family/whanau to discuss their situation, and to discuss what the provider can offer. As in residential care, the MoH would expect that this is a preliminary information gathering/provider marketing meeting. We would not expect that the MoH would pay for this time, as this is part of the process of identifying an appropriate provider.

2.11 What happens if the provider and the NASC cannot agree on a package?

Supported independent living services require a strong relationship of trust between providers and NASCs. This will develop over time. The relationship will need to be managed in a more active way than more traditional residential care services have required.

If the provider and NASC cannot agree on a package it will be referred to the DSD Service Manager for the Locality for consideration.

2.12 If a provider has a contract for Supported Independent Living: Intellectual Disability, can they provide services to a person whose primary disability is physical, and vice versa?

No. Unless approved by the Disability Services Directorate prior to acceptance of the NASC referral.

SIL services were contracted with two separate service descriptions, one for intellectual and one for physical disability.

The service specifications were separated so that there would not be an automatic assumption that a provider can provide SIL services to both client groups.

The Disability Services Directorate has moved away from the approach of having separate Supported Independent Living service specifications for people (previously one for services to people with support needs related to Intellectual disability and one support needs related to physical disability). The primary focus of the service specification is to ensure the service meets the needs of the person as identified through the NASC process.

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People with intellectual and physical disabilities can have very different needs. This will be acknowledged through the NASC process and in the Support Plan for the person. Some clients will have both an intellectual and physical disability. In this situation, as in all situations, it is more important to find the provider who best meets the needs of the individual.

Where a provider provides services to people with an Intellectual disability only this will be specified in the provider specific terms and conditions of the service agreement. Likewise if a provider provides services to people with a Physical disability only this will be specified in the provider specific terms and conditions of the service agreement.

2.13 Should specialist services and assessments by specialists be part of the proposed support package, and who will pay for them?

If approved by the NASC specialist services would be paid through the flexible funding stream, not under the SIL code. Referrals for assessments by specialists should be made by the NASC and it would normally be expected that this would have taken place before the referral for SIL has been made. Consequently assessments by specialists should not be part of the proposed support package.

2.14 Can the provider also provide accommodation for SIL clients?

In some situations providers have entered into tenancy arrangements with Housing New Zealand for a house in the community. If an SIL client lives in this house they can be charged rent, or a board payment. These payments are not included in the SIL support package. The rent or board payment is made to the landlord (the provider). There is no client contribution for SIL services. SIL services do not cover the cost of rent, utilities, food and other hotel costs.

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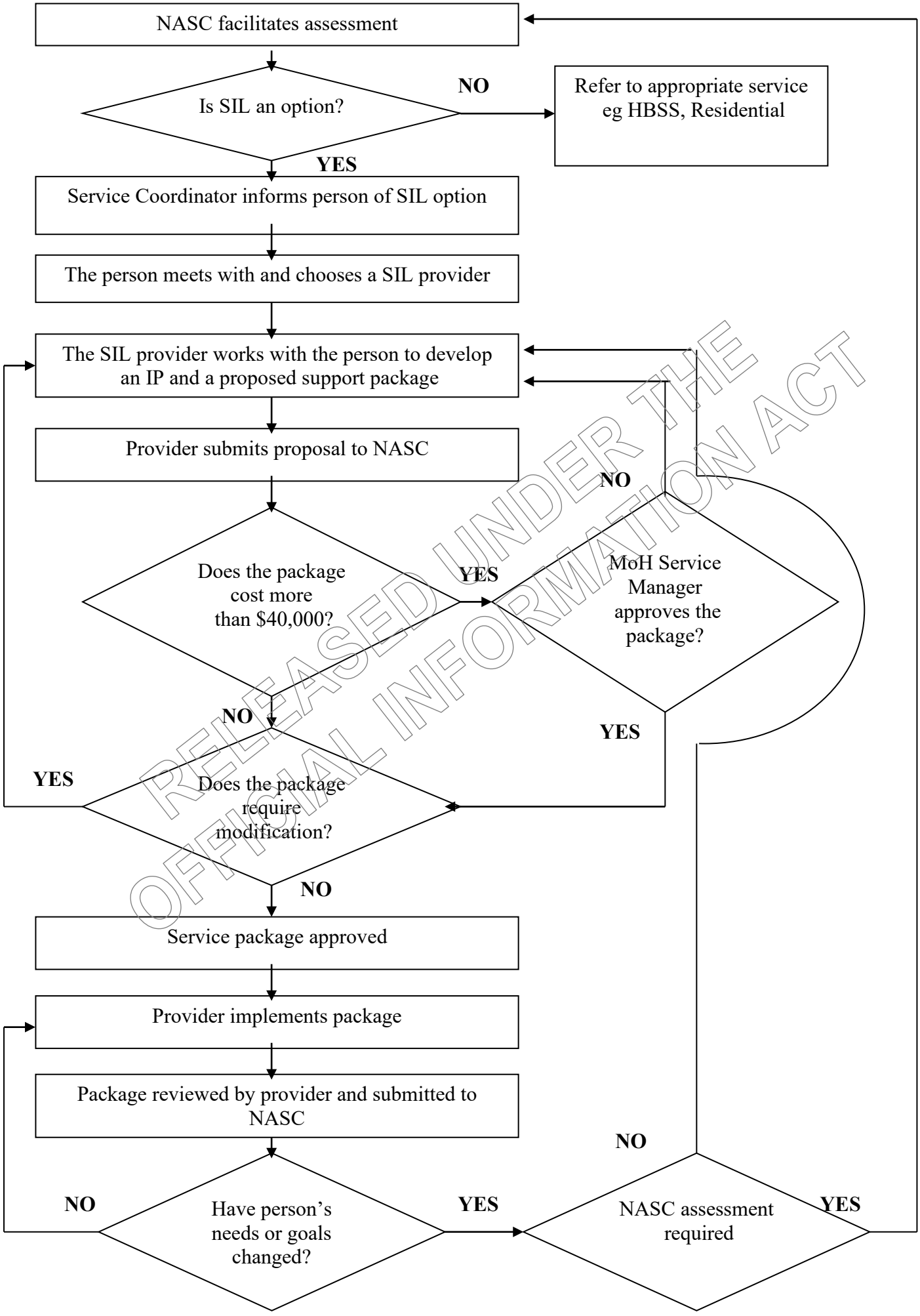
3 Operational Protocol for Supported Independent Living services

Each NASC is encouraged to develop an operational protocol which sets out the ground rules for how the NASC and contracted SIL providers will work together to implement the service.

Most of the contracted providers cover more than one NASC area, so there is a strong argument for the development of a joint protocol between all NASCs. This will support a consistency in how services are delivered. As a suggestion, the protocol could set out:

- Referral processes
- Assessment processes
- Expectations for negotiating a proposed support package
- Principles for prioritisation
- Decision review procedures

FLOWCHART OF SIL PROCESS



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Designed for Ministry of Health Needs Assessment and Service Coordination (NASCs)

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2016 Support Package Allocation (SPA) Guide

This guide is an update to the 2010 Handbook

Version: Final (1-04-HDDD) 11/10/2016

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I. Summary

The purpose of the SPA is to assist in the determination of a person's disability related need level, equitable service allocation within and across NASC.

Overtime the SPA has evolved and been applied differently by NASC services. The remodeled 2016 SPA is being introduced to

- Improve consistency in application of the tool
- Allow for a measure of a person's disability needs before and after natural supports have been considered

II. Introduction

The SPA document is a tool provided by the MoH to support NASCs resource management solution that is used for all DSS NASC allocated services. The application of the SPA is part of the service coordination functions that occurs following the completion of a needs assessment. This guide is to provide the reader with an understanding of the 2016 remolded SPA tool and its application.

III. Background and History

Following the introduction of NASCs in 1995, service coordinators did not have a nationally consistent means for making a support needs level decision based on identified needs and desired outcomes of a person. Instead individual skill and

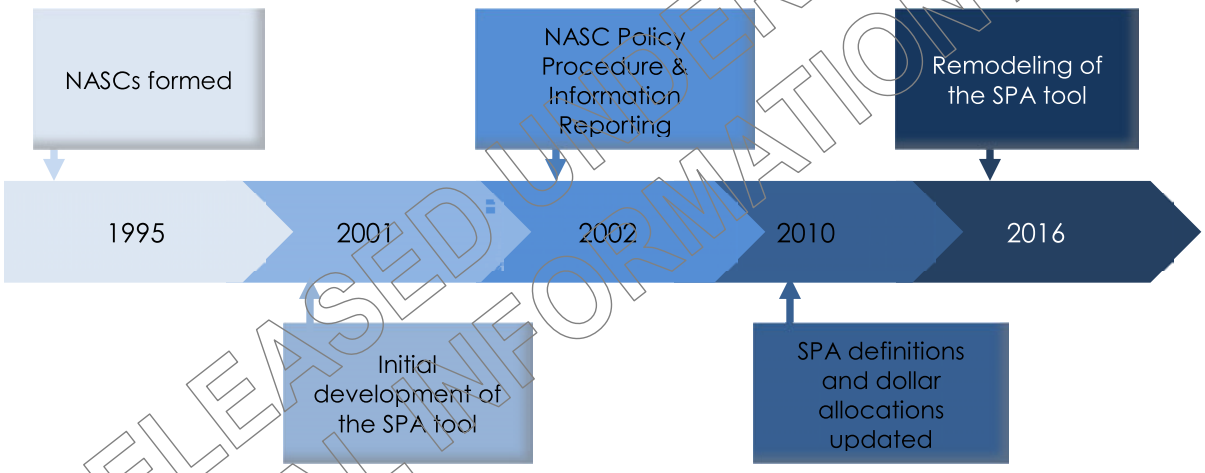
experience coupled with the expertise of a NASC practice model guided the decision Naturally this led to variations of resource allocation.

The MOH thus committed to the development of the SPA, not only did the SPA provide a platform for consistent practice and a means of allocating resource in a transparent and equitable manner but also provided a natural resource for budget management.

The 2002 "*Support Needs Assessment and Service Coordination Policy Procedure and Information Reporting Guidelines*" included information on how to apply the SPA.

The SPA tool was next reviewed in 2010 which included updated definitions, application process, and dollar allocations.

It is however, apparent that variability remained in the application of the tool; this has resulted in further remodeling of the tool this year.



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IV. 2016 Remodeled Tool

The remodeled 2016 model is being introduced to support NASCs to further strengthen consistency in the application of the tool.

The changes include:

- The introduction of 2 measures (previous SPA tool only had 1 measure)
  i. First measure before natural supports are considered
  ii. Second measure after natural supports are considered

- Reducing the number of age brackets to 3 (the previous SPA tool had 4 age brackets)
  The age bracket for school leavers and 65 years+ descriptors have been combined; the SPA dollars for these 2 groups will continue to remain separate.

- The existing outcome indicators and descriptors for each level of the SPA were reviewed and strengthened, the additional descriptors have been combined to support and reflect consistency of practice.

The remodeled tool has been designed to define both; a person's total DSS eligible need and the level of funded support they may require; thus measuring and acknowledging the informal supports a person receives.

This step is intended to enhance information about the DSS population, with the ability to recognise the most vulnerable as well as noting variations to informal supports for a person following each assessment.

V. Applying the SPA

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Step 1 Information Gathering

Assemble and read all of the person's available information used to inform the assessment; this should include the latest needs assessment and any additional reports. Identify key components of information to ensure a complete picture of the person and their disability support related need is able to be accurately established.
If information is incomplete, seek the missing components before proceeding.

Step 2 Apply Total Disability Support Level

(This refers to a person's needs which are DSS eligible ref: *DSS Operational guidelines*).

Support needs descriptors have to apply specifically to those arising from the disability needs of the person being assessed and no other conditions, such as mental health.

Focus on the person's abilities and how their independence is affected as a result of their disability, in doing so consider appropriate age and stage milestones impactors.

Focus on the person's functionality when completing an activity.

1. Select the age appropriate document. school-leaver to 65
2. Using information from the assessment and provided reports, highlight the descriptors that best reflect the person's situation and disability support needs
3. Determine which level best describes the person

Step 3 Begin Support Planning

Identify and confirm how the person's identified disability support needs may be met by:

1. Natural supports and resources. This might include but is not limited to family/whānau, friends, church connections, club members etc.
2. Community based supports and services. This might include but is not limited to field officers, disability resources centres, support groups, disability organisations, budget advisory services etc.
3. Non DSS funded services. This might include DHB services such as Community based therapy services, Rehabilitation, Mental Health, Housing NZ, Group Special Education etc.

Step 4 Apply the SPA

(This measure clarifies disability support needs of the person that may require DSS funded support)

After considering step 3, identify any remaining disability support needs of the person then:

1. Select the age appropriate SPA e.g. school-leavers and adults
2. Using information from the assessment and provided reports highlight the descriptors that best reflect the person's situation and support needs
3. Determine which level best describes the person
4. Identify the Support Package Allocation from very low through very high
5. If the proposed support package is over the average or maximum SPA level exception processes remain applicable.

Step 5 Complete Service Coordination

Once the plan has been approved (if necessary), and agreed with the person compete the planning and service coordination.
This might include the application of other funding tools, e.g. ICARe.

VI. Conclusion

The purpose of the revised version of the SPA is to ensure all NASCs apply the tool in the same way, that of promoting consistent and equitable service coordination for people; to consistently describe a person's total disability related needs and to equitably allocate DSS resource as needed.

Appendix 1, 3 SPA tools supporting NASC practice.

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Name: (auto populated)
Date of Needs Assessment: (auto populated)

NHI: (auto populated)

TDS/SPA Development Date: (auto populated)
Service Coordinator: (auto populated)

'Focus on best start'

*Select **one** of the following categories (i.e. Very Low, Low, Medium, High or Very High) that best describe the child's disability support needs. Consider movement, play interaction, emotions, behaviour, milestones for self-care management, night time behaviour/care, preverbal and verbal communication.*

Very Low	**Low**	**Medium**	**High**	**Very High**
The disability related needs of the child are ***minimal,*** and their safety and wellbeing is not compromised.	The disability related needs of the child are ***increasing,*** and are over and above that of children of a similar age. The additional support needs/input is ***minor.***	The disability related needs of the child are ***becoming more apparent,*** and are over and above those of children of a similar age. The additional support needs/input is ***moderate.***	The child's disability/development delay is significant and the ***impact is significant***. The additional support needs/input over and above children of a similar age is ***significant.***	The child's disability/developmental delay is very significant and the ***impact is very significant.*** The additional support needs/input over and above children of a similar age is ***intensive.***
The child: ☐ Has limitations and/or challenges over and above children of similar ages and stages which are marginal, and are not seen as significant.	The child: ☐ Is most likely not achieving developmental milestones. ☐ May require additional support/input over and above what is usual for their age. ☐ May be involved with a specialist service e.g., speech language therapy, physiotherapy or early intervention services. ☐ May have frequent health and specialist appointments.	The child: ☐ Has limitation and/or challenges which mean that there is risk of isolation from their community ☐ Is likely to be under investigation regarding their potential for development e.g., physical health, cognitive level, communication skills and/or behaviour. ☐ Is likely to be involved with specialist services e.g., child development services. ☐ May present with behaviour that is becoming challenging.	The child: ☐ Is likely to have either high physical or behavioural needs, or a combination of both. ☐ May require support in management of health needs and/or behaviour support. ☐ Is likely to be involved with specialist services e.g. child development services. ☐ Is likely to display challenging behaviour.	The child: ☐ Has either very high physical or behavioural needs, or a combination of both. ☐ May require support in management of health needs and/or behaviour support. ☐ May not be able to express needs and be non-verbal. ☐ Is likely to be involved with specialist services e.g. child development services. ☐ May be exhibiting extreme challenging behaviour.
Rationale and Comments:	Free text section that extends			

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UNMET NEED AFTER NATURAL AND COMMUNITY SUPPORTS CONSIDERED

*Select **one** of the following categories (i.e. Very Low, Low, Medium, High or Very High) to best describe the child's current situation*

Very Low	**Low**	**Medium**	**High**	**Very High**
The family/whānau need to be provided with ***resources and information*** to continue to manage the child's disability related needs.	The child ***requires support***, in excess of what is naturally provided, to ***participate in their environment*** and to develop independence and skills to participate more independently in their community.	The child requires ***a combination of family/whānau and natural networks combined with formal support*** for their disability related needs to be supported within their environment and community.	The child's ***disability needs cannot be managed solely by family/ whānau and natural supports.*** Formal support may be required to enable the child to have meaningful relationships with their family/whānau and natural networks.	The child and family/whānau ***require development of a support package that ensures safety and wellbeing.*** Without this formal support, ***the child may be at risk of harm to themselves or others.***
☐ Minimal support to access information on early intervention and, to be connected to community supports. ☐ Should the situation change, the family/whānau knows how to access NASC services.	☐ Family/ whānau and natural networks may need periodic support and/or minimal support to enable them to carry out their carer's role and retain their resilience. ☐ Specialised assessment and treatment services may need to be accessed.	☐ Natural supports and networks may need to be strengthened and/or developed, or there may be few/intermittent natural networks. ☐ There may need to be an interface with other agencies e.g., health, education. ☐ Specialised assessment and treatment services may need to be accessed. ☐ A clear and practical long term support plan promoting development of natural supports is required. The plan needs to be regularly reviewed.	☐ Caregivers may require breaks and/or support to build resilience and support family/whānau in their caring role. ☐ NASC may need to facilitate inter-sectorial collaboration to identify sustained solutions for the child and their family/whānau. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. ☐ A clear and practical long term plan that includes opportunities for development is required. The plan needs to be reviewed regularly to meet the long-term needs of the child and family/whānau. ☐ May require intensive service coordination.	☐ Networks need to be developed and regular planned breaks provided to build up resilience and to sustain a caregiving role. ☐ NASC may need to facilitate inter-sectorial collaboration to identify sustained solutions for the child and their family/whānau. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. ☐ A clear and practical long term plan, that includes opportunities for development, is required. The plan needs to be reviewed regularly to meet the long-term needs of the child and family/whānau. ☐ Intensive service coordination and collaboration with other agencies involved is required.
Rationale and Comments:	Free text section that extends			

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TOTAL DISABILITY SUPPORT LEVEL
less NATURAL AND COMMUNITY SUPPORTS
equals SUPPORT PACKAGE ALLOCATION

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Total Disability Support Level	After Natural and Community Supports Considered	Support Package Allocation (Birth to 5 years) ☐		
Very Low ☐	Very Low ☐	**Only in exceptional circumstances. NASC Manager authorisation required.**		Max: $15 per week
Low ☐	Low ☐	**Only in exceptional circumstances. NASC Manager authorisation required.**		Max: $21 per week
Medium ☐	Medium ☐	**$0 to $52 per week**	Average: $35	Max: $52
High ☐	High ☐	**$0 to $110 per week**	Average: $110	Max: $165
Very High ☐	Very High ☐	**$0 to $250 per week**	Average: $250	Max: $375
Support Package including costs:	Free text section that extends			

Name: (auto populated)
Date of Needs Assessment: (auto populated)

NHI: (auto populated)

TDS/SPA Development Date: (auto populated)
Service Coordinator: (auto populated)

'Focus on personal goals and development'

*Select **one** of the following categories (i.e. Very Low, Low, Medium, High or Very High) that best describes the child/ young person's disability support needs.*
Consider movement, play, interaction, emotions, behaviour, milestones for social interaction, self-care management, night time behaviour/care and verbal communication.

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Very Low	**Low**	**Medium**	**High**	**Very High**
The disability related needs of the child/young person are ***minimal,*** and their safety and wellbeing is not compromised.	The disability related needs of the child/young person are ***increasing***, and are over and above those of children of a similar age. The additional support needs/input is ***minor.***	The disability related needs of the child/young person are ***becoming more apparent*** and are over and above those of children of a similar age. The additional support needs/input is ***moderate.***	The child/young person's disability is significant, and the ***impact is significant.*** The additional support needs/input are over and above children of a similar age is ***significant.***	The child/young person's disability is very significant, and the ***impact is very significant.*** The additional support needs/input over and above children of a similar age is ***intensive.***
The child/young person: ☐ Has limitations and/or challenges over and above children of similar ages and stages that are marginal, and are not seen as significant.	The child/young person: ☐ Is most likely not achieving developmental milestones. ☐ May be involved with a specialist service e.g., speech language therapy, physiotherapy or early intervention services. ☐ Is able to access appropriate education i.e., school. ☐ May have frequent health and specialist appointments.	The child/young person: ☐ Has limitations and/or challenges which mean that there is risk of isolation from their community. ☐ Has limited opportunity for independent personal growth. ☐ May be affected by a lack of ability to have meaningful relationships and develop social roles. ☐ Is likely to be involved with specialist services e.g., child development services. ☐ Is able to access appropriate education i.e., school. ☐ May present with behaviour that is becoming challenging.	The child/young person: ☐ Is not accessing, or able to access, opportunities for personal growth and development. ☐ Is likely to have either high physical or behavioural needs, or a combination of both. ☐ Is limited in their ability to participate in activities of daily living. ☐ May require complex care regimes e.g., therapeutic, drug, dietary. ☐ Is likely to be involved with specialist services e.g., child development services. ☐ Is compromised in their ability to attend school. ☐ Is likely to display challenging behaviour.	The child/young person: ☐ Is not accessing, or unable to access, opportunities for personal growth and development. ☐ Has high and complex needs. ☐ Has very high physical or behavioural needs or a combination of both. ☐ Is limited in their ability to participate in activities of daily living, across several domains. ☐ Is likely to be involved with specialist services e.g., child development services, Ministry of Vulnerable Children Oranga Tamariki , Strengthening Families. ☐ May be in crisis. ☐ May be excluded or unable to attend school. ☐ May be exhibiting extremely challenging behaviour.
Rationale and Comments:	Free text section that extends			

Created by: (auto populated)
Date: (auto populated)

NASC (auto populated)

UNMET NEED AFTER NATURAL AND COMMUNITY SUPPORTS CONSIDERED

*Select **one** of the following categories (i.e. Very Low, Low, Medium, High or Very High) to best describe the child's current situation*

Very Low	**Low**	**Medium**	**High**	**Very High**
The child/young person, and their family/whānau and natural supports, need to be provided with ***resources and information*** to continue to manage the child/young person's disability related needs.	The child/young person ***requires support***, over what is naturally provided, **to *participate in their environment*** and to develop independence and skills to participate more independently in their community.	The child/young person requires ***formal support across the course of the week*** to complete activities of daily living. To be able to remain safely in their own environment, carers need to be supported considering both short-term and long-term needs. Formal support sustains participation in their environment and opportunity for developing skills for independence.	The child/young person ***requires regular formal support to complete activities of daily living.*** Existing natural supports may have been eroded and without formal support, the child/young person's environment is becoming unsafe or unstable. Formal support is required to enable a sustainable environment and promotes independence and social values.	The child/ young person **requires regular formal support to complete activities of daily living.** There may be no or limited natural supports. The child/young person's ***disability impacts to the extent that it compromises their ability to remain in their current environment*** and sustainability of the family/whānau is at risk.
☐ Minimal support required to access community supports. ☐ Should the situation change, the family/whānau knows how to access NASC services.	☐ Family/ whānau and natural networks may need some periodic and/or minimal support to enable them to carry out their carer's role and retain their resilience. ☐ Specialised assessment and treatment services may need to be accessed. ☐ A clear and practical long term support plan is required. This needs to be regularly reviewed.	☐ Intermittent breaks for carers may be needed. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. Support to access/engage may be required. ☐ There may need to be an interface with other agencies e.g., health, education. ☐ A clear and practical long term support plan promoting development of natural supports is required. This needs to be regularly reviewed.	☐ Regular breaks may be required for caregivers. ☐ NASC may need to facilitate inter-sectorial collaboration to identify sustained solutions for the child/young person and their family/whānau. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. Support to access/engage may be required. ☐ A clear and practical long term plan that promotes growth, stability and community participation is required. This needs to be regularly reviewed. A transitional plan is required for school leavers. ☐ May require intensive service coordination.	☐ Networks need to be developed and regular planned breaks provided to build up resilience and to sustain a caregiving role. ☐ NASC may need to facilitate inter-sectorial collaboration to identify sustained solutions for the child/young person and their family/whānau. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. Support to access/engage may be required. ☐ A clear and practical long term plan is required promoting growth, stability and community participation. This needs to be regularly reviewed. A transitional plan is required for school leavers. ☐ Requires intensive service coordination.
Rationale and Comments:	Free text section that extends			

OIA RELEASED INFORMATION ACT

TOTAL DISABILITY SUPPORT LEVEL
less NATURAL AND COMMUNITY SUPPORTS
equals SUPPORT PACKAGE ALLOCATION

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Total Disability Support Level	After Natural and Community Supports Considered	Support Package Allocation (5 years to school leavers) ☐		
Very Low ☐	Very Low ☐	**Only in exceptional circumstances. NASC Manager authorisation required.**		Max: $15 per week
Low ☐	Low ☐	**Only in exceptional circumstances. NASC Manager authorisation required.**		Max: $31 per week
Medium ☐	Medium ☐	**$0 to $101 per week**	Average: $68	Max: $101
High ☐	High ☐	**$0 to $288 per week**	Average: $198	Max: $288
Very High ☐	Very High ☐	**$0 to $900 per week**	Average: $600	Max: $900
		Only in exceptional circumstances with NASC manager approval is residential care considered. The cost of residential care may exceed the max allocation.		
Support Package Including Costs:	Free text section that extends			

Name: (auto populated)
Date of Needs Assessment: (auto populated)

NHI: (auto populated)

TDS/SPA Development Date: (auto populated)
Service Coordinator: (auto populated)

'Focus on personal goals, development, independence and interdependence'

*Select **one** of the following categories (i.e. Very Low, Low, Medium, High or Very High) that best describe the person's disability support needs. Consider functional abilities, emotions, behaviour, self-care management, night time behaviour/care and communication.*

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Very Low	**Low**	**Medium**	**High**	**Very High**
The disability related needs of the person are ***minimal,*** *and their safety and wellbeing is not compromised.*	The disability related needs of person is ***increasing***. The additional support needs/input is ***minor.*** While managing, the person is compromised in their ability to participate in opportunities, develop and/or maintain life skills.	The disability related needs of the person are ***becoming more apparent.*** The additional support needs/input is ***moderate.*** The ability for the person to manage without support or oversight is compromised.	The person's disability is significant, and the ***impact is significant.*** The additional support needs/input is ***significant.*** There are multiple challenges with daily living activities which may affect the person's ability to remain in their own home.	The person's disability is very significant, and the ***impact is very significant.*** The additional support needs/input is ***intensive.*** There are multiple and significant challenges with daily living activities affecting the person's ability to remain in their own home.
The person: ☐ Has limitations and/or challenges that are marginal, and not seen as significant. ☐ Is able to live in the community and attend to daily living activities safely at home.	The person: ☐ May take longer to complete tasks, or equipment may be used to assist. ☐ Is likely to need direct support of another person, over the course of a week. ☐ May experience some challenges with some components of daily living activities. ☐ May have some difficulty accessing transport e.g., physical access, reading timetables. ☐ May have difficulty mobilising. ☐ May have a limited or declining level of physical activity.	The person: ☐ Is likely to require support from another person over the course of the week, to undertake or navigate some activities of daily living, and to participate in community activities. ☐ May require direct support, or equipment, to assist with daily functions to maintain independence. ☐ Is able to communicate, but independent communication is compromised in more complex situations.	The person: ☐ Requires support of another person over the course of a day, directly or indirectly, for activities of daily living. ☐ Has only partial control over their immediate environment as a result of their impairment. ☐ May require assistance with day to day communication (sign, gesture, visuals to assist with, or instead of speech). ☐ May require support in management of health needs; and/or behaviour support. ☐ May require the continuous presence of another for safety needs or behavioural support.	The person: ☐ Requires support of 1-2 people for at least 80% of all activities of daily living e.g., personal hygiene, dressing, eating, managing continence, mobilising in their home, community settings, and managing health needs. ☐ Most likely requires assistance with communication. ☐ Most likely requires continuous support from another in relation to safety and behaviour needs in order to prevent injury to self or others.
Rationale and Comments:	Free text section that extends			

UNMET NEED AFTER NATURAL AND COMMUNITY SUPPORTS CONSIDERED

*Select **one** of the following categories (i.e. Very Low, Low, Medium, High or Very High) to best describe the person's current situation*

Very Low	**Low**	**Medium**	**High**	**Very High**
The person and their family/whānau and natural supports need to be provided with ***resources and information*** to continue to manage the person's disability related needs.	The person ***requires support***, periodically or across the course of the week over what is naturally provided, to maintain their level of functioning and participate in their community. Capacity of the family/whānau and natural networks to provide effective support is impacted.	The person requires ***formal support across the course of the week*** to complete activities of daily living. The person is able to remain within their environment and community with a combination of family/whānau and natural networks, combined with formal support. Natural supports and networks may need to be strengthened and/or developed.	The person ***requires regular formal support.*** Their ability to remain in their current environment is compromised, without formal support across the course of the day. The person may require access to a stable environment. Family/whānau and natural networks' resilience and ability to provide on-going support is significantly compromised.	The person ***requires regular formal support.*** Their ability to remain in their current environment is significantly compromised without frequent formal support across the course of the day. Without this support, the person may be at risk of harm to themselves or others. There may be no or limited natural supports.
☐ Minimal support required to access or be connected to community supports or information. ☐ Should the situation change, the family/ whānau knows how to access NASC services.	☐ May require support to connect with community organisations and activities and /or sustain meaningful relationships. ☐ Specialised assessment and treatment services may need to be accessed. ☐ A clear and practical long term support plan is required. This needs to be regularly reviewed.	☐ Intermittent breaks for carers may be needed. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. Support to access/engage may be required. ☐ There may need to be an interface with other agencies e.g., health, education. ☐ A clear and practical long term support plan promoting development of natural supports is required. This needs to be regularly reviewed.	☐ Regular breaks may be required for care-givers. ☐ NASC may need to facilitate inter-sectorial collaboration to identify sustained solutions for the person. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. Support to access/engage may be required. ☐ A clear and practical long term plan is required promoting stability and community participation. This needs to be regularly reviewed. ☐ May require intensive service coordination.	☐ Support from 1-2 people for at least 80% of activities of daily living is likely. ☐ Regular breaks for care-givers are likely to be required. ☐ NASC may need to facilitate inter-sectorial collaboration to identify sustained solutions for the person. ☐ Multi-disciplinary team of specialised assessors and treatment services may need to be accessed. Support to access/engage may be required. ☐ A clear and practical long term plan is required promoting safety and wellbeing, and opportunity for development and/or skill maintenance. This needs to be regularly reviewed. ☐ Requires intensive service coordination.
Rationale and Comments:	Free text section that extends			

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TOTAL DISABILITY SUPPORT LEVEL
less NATURAL AND COMMUNITY SUPPORTS
equals SUPPORT PACKAGE ALLOCATION

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Total Disability Support Level	After Natural and Community Supports Considered	Support Package Allocation (School leavers to Age 65 years) ☐			Support Package Allocation (65 years+) ☐		
Very Low ☐	Very Low ☐	**Max: $15 per week**	**Only in exceptional circumstances with NASC Manager authorisation**		**Max: $15 per week**	**Only in exceptional circumstances with NASC Manager authorisation**	
Low ☐	Low ☐	**Max: $55 per week**			**Max: $52 per week**		
Medium ☐	Medium ☐	**$0 to $225 per week**	Average: $150	Max: $225	**$0 to $195 per week**	Average: $130	Max: $195
High ☐	High ☐	**$0 to $900 per week**	Average: $600	Max: $900	**$0 to $860 per week**	Average: $575	Max: $860
Very High ☐	Very High ☐	**$0 to $1500 per week**	Average: $1200	Max: $1500	**$0 to $1500 per week**	Average: $1050	Max $1500
Support Package including costs:	Free text section that extends						

Operational Manual for Needs Assessment and Service Co-ordination Managers

Volume 2
Appendices

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Issued by

Disability Services Directorate
Ministry of Health

May 2005

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1 DSD NASC Service Specification

Service name:	DSS1004 and DSS1005 and DSS1004D
Service description:	Needs Assessment and Service Co-ordination

DSD PHILOSOPHY

The aim of Disability Services Directorate (DSD) of the Ministry of Health (the Ministry) is to build on the vision contained in the New Zealand Disability Strategy (NZDS) of a fully inclusive society. New Zealand will be inclusive when people with disabilities can say they live in:

'A society that highly values our lives and continually enhances our full participation.'

With this vision in mind, DSD aims to promote a person's quality of life and enable community participation and maximum independence. Services should create linkages that allow a person's needs to be addressed holistically, in an environment most appropriate to the person with disability.

Disability support services should ensure that people with disabilities have control over their own lives. Support options must be flexible, responsive and needs based. They must focus on the person and where relevant, their family and whānau, and enable people to make real decisions about their own lives.

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1 DEFINITIONS

Disabled person/person with disability

NASC should ensure services are provided only to those disabled people who are eligible to receive them, as required by the Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand. For the purposes of this service specification a person with a disability is someone who has been identified as having a physical, intellectual, sensory disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.

Note: Subsequent references in this document to 'the person' or 'people' should be understood as referring to a disabled person/person with disability.

Throughout this document the term 'person' is taken to include, where appropriate, family/whānau/aiga and/or full-time carer. When the NASC is working with a child, that child is always considered within the context of the family/whānau/ aiga.

Carer

For the purposes of this specification, a full-time carer is someone who has principle, active responsibility for the ongoing and frequent care of a person, usually on an unpaid basis and according to the above definitions.

For the purposes of this specification needs assessment or service co-ordination is a process provided by a Needs Assessment Service Co-ordination (NASC) on behalf of the Ministry of Health. This process is based on *The New Zealand Framework for Disability Service Delivery,* Ministry of Health, August 1994. Needs assessment and service co-ordination provides the means for a person to identify their prioritised disability support needs within the context of their own natural resources and existing supports, receive information on support options, including those which are government funded, and receive assistance with co-ordination of support services. NASC also manage DSS budgets for the funder.

The three key functions of NASC are:

- **Facilitated Needs Assessment.** Needs assessment is a process of determining the current abilities, resources, goals and needs of a person and identifying which of those needs are the most important. The purpose of the process is to decide what is needed to maximise a person's independence so that they can participate as fully as possible in society, in accordance with their abilities, resources, culture and goals. A person's needs will also include, where appropriate, the needs of their family/whānau and carers; their recreational, social and personal development needs; their training and education needs; and their vocational and employment needs. This does not assume Ministry responsibility for funding of supports in relation to all of these needs, and particularly when they are the funding responsibility of other agencies.

- **Service Co-ordination.** Service co-ordination is a process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the person and, where appropriate, their family/whānau and carers. Service co-ordination also determines which of the assessed needs can be met by government funded services and which can be met by other services, and will explore all options and linkages for addressing prioritised needs and goals.

- **Budget Management.** The NASC manages, on behalf of the Ministry, a defined indicative budget based upon an annual allocation. Performance against the budget will be reviewed, at least, on a monthly basis by the NASC and the Ministry.

  The NASC needs to ensure that people with the highest priority needs receive access to services first. The NASC must also ensure that commitments made to fund service packages for people are such that they will not exceed the indicative budget for the current and out years.

  Budget management involves allocating cost effective packages of services within the indicative budget, according to the Support Package Allocation tool, and within Benchmark Indicators determined by the Ministry for the identified population for a region.

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2 OBJECTIVES

2.1 General

A fundamental objective of the NASC is to maximise and support the abilities of people by facilitating a process for them to identify their needs and goals, and make decisions on how these can best be met. To achieve this objective the NASC must maintain a clear vision of NASC as the dynamic combination of a service working in partnership with people and the Ministry to achieve the best possible outcomes within the available resources.

For people with disability and full-time carers NASC is the means by which their strengths, resources and needs can be identified, their support options explored and support services accessed. In order to achieve these objectives a NASC needs to, at a minimum:

- be responsive to people and their communities
- be community focused
- support the enhancement of the person's own natural strengths, resources and independence
- have minimal waiting times by adhering to timeframes set out in this specification.

Needs assessment and service co-ordination processes must be separated from the provision of support services. A NASC may not be the provider of support services, to ensure that no actual or perceived conflict of interest exists.

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2.2 Responding to Communities

The NASC will have mechanisms in place to gain the input of people and their communities. In line with the objectives of the Māori Disability Action Plan, He Ratonga Tautoko I Te Hunga Haua, the input of Māori in particular as mana whenua should also be sought. Examples of mechanisms that could appropriately demonstrate and achieve responsiveness to the community include community representation at the governance level of the provider and/or an advisory group to the NASC.

2.3 Māori Health and Disability

The Crown Statement of Objectives outlines the Government's medium term objectives for, and expectations of, the Ministry. In response to the Crown's Objective for Māori health and in line with its purpose statement, the Ministry has developed a Māori Health Strategy, *He Korowai Oranga*, and a Māori Health Action Plan, *Whakatataka*.

He Ratonga Tautoko i Te Hunga Haua, the DSD Māori Disability Action Plan identifies four strategic goals aimed at increasing responsiveness to Māori. The NASC is required to contribute to the implementation of *He Ratonga Tautoko i Te Hunga Haua* and the four strategic goals.

The four strategic goals are:

- remove barriers for disabled Māori
- increase Māori participation in the disability sector
- develop effective disability services
- work across sectors.

Mauriora (positive life essence) is a key principle for Māori with a disability as opposed to Oranga (health) as described in He Korowai Oranga. Mauriora and the four strategic goals may be achieved through the application of Tikanga (practice and process) ie, the use of te reo, appropriate protocols, participation in marae activities and regular whānau, hapū or iwi initiatives.

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3 SERVICE USERS

3.1 Inclusions

- People eligible according to the *Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand* who have been assessed as having a physical, intellectual or sensory disability (or combination of these) that is likely to continue for a minimum of six months; result in reduction of independent function; and require ongoing support.[1] People with these disabilities constitute the Ministry's main client group, which largely consists of people aged under 65, many of whom have lifelong impairments.

  People with physical, intellectual or sensory disability that co-exists with a personal health condition, mental health condition and/or injury, in relation to their disability support needs.

  The NASC will consult with the Ministry for prior agreement in relation to people under 65 whose needs may have historically been recognised as disability-related within the parameters of the definition of disability.

3.2 Exclusions

- People who are covered under the Injury, Prevention, Rehabilitation and Compensation Act 2001. ACC has been responsible since 1974 for funding support services for people whose disability is caused by injury or accident.[2]
- People aged 65 years and over who do not have a long term impairment (ie, physical, sensory, intellectual or cognitive disability that was acquired before the age of 65 years)

[1] Although people with psychiatric disability and 'age-related' disability with support needs can be assessed for access to support services they are excluded from the Ministry's operation of the definition.

[2] Injury, Prevention, Rehabilitation and Compensation Act 2001 refers.

- People aged 65 years and over with a long term impairment who have been Ministry funded but who have been clinically assessed by a DHB or needs assessor as requiring age related residential care.
- People aged 50–64 years who have been assessed by a DHB or DHB needs assessor as 'close in interest' to persons aged 65 years and over and whose needs would be best met by DHB integrated health and disability services.
- People who require an assessment solely as a result of a mental health need or addiction condition – these assessments are contracted for by the DHB through Mental Health Assessment Services or Community Mental Health teams.
- People who require assessment as a result of a personal health need. A personal health need is defined as when a person's level of independent function is reduced by a condition that requires ongoing supervision by a health professional.

3.3 Interface with NASC for people 65 years and over

The NASC will maintain working relationships and agreed protocols with DHB NASC working with older people.

3.4 Interface with Mental Health

For those people with a dual diagnosis, that being a co-existing mental illness and disability, the NASC will work in collaboration with the relevant Mental Health Service.

3.5 Interface with Personal Health

Following an acute illness and the completion of post-discharge care and treatment, a disabled person can be referred to a NASC for their disability support needs.

3.6 Interface with Other Agencies

Depending on the needs of the person it may be appropriate for the NASC to jointly facilitate needs assessment with other appropriate agencies.

4 SERVICE ACCESS

The NASC is expected to:

- encourage and enable the person to take an active role in the needs assessment and service co-ordination process
- ensure that there is full consideration of the person's chosen lifestyle in all aspects of the assessment and service co-ordination process
- determine with the person the appropriate level of NASC involvement. This may require full involvement by the assessment facilitator through to minimal involvement and advice where the person wants to take more responsibility for the process themselves, including accessing services which are funded or purchased outside the NASC process.

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Needs assessment and service co-ordination will be conducted with the person in an environment comfortable to them. The NASC will:

- provide information about the NASC service and work to ensure people, providers, GPs, other community groups and potential referrers are aware of NASC referral processes
- promote access to services by Māori and Pacific peoples
- identify, and build into the service, strategies to overcome known barriers to access for Māori, Pacific peoples, and other population groups with specific needs
- operate from premises that are appropriate, accessible and welcoming.
- have NASC premises open during normal business hours.

4.1 Referrals

The person may self refer to the NASC. Any other person or organisation can make referrals.

Initial contact will be made within two working days of receipt of the referral. This contact may be by phone, letter or visit. The type of contact and response will be determined by the nature of the referral (ie, urgency).

4.2 Prioritisation

The NASC will promote self-determination, quality of life and an environment that maximises community participation and independence for people. The NASC's role is to co-ordinate effective utilisation of disability support resources.

The NASC has a role in facilitating access, prioritising and allocating DSD funded resources. To achieve this the NASC will:

- acknowledge and support the person's own natural resources and existing supports
- give the person accurate information on eligibility and the limitations and boundaries of DSD funded services
- meet the safety needs of the person and community wherever possible
- promote equity for people to achieve similar outcomes for similar needs and circumstances
- work to safely reduce any disparities in equity between population and disability groups
- recognise the need for, and support access to, appropriate supports for groups with specific disability needs.
- support the continued needs based shift to supported community-based options for people previously living in institutional care or unsupported in the community
- support the continued needs based shift from service based to support based delivery

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- be efficient, including creative and innovative use of resources to meet needs
- establish greater trust and credibility in the NASC process
- work within the funding and policy boundaries of the Ministry when allocating public resources.

The NASC will implement, and adhere to, consistent and transparent processes for priority setting and associated resource allocation. These processes need to adhere to the Ministry's relevant Disability Services Directorate policies and processes.

4.3 Inter-NASC Transfers

The NASC will provide service to all eligible people wherever they live, or subsequently shift to, within the NASC's specified geographic area.

The NASC will establish protocols and procedures with fellow NASC in other areas of New Zealand to ensure continuity of service for people moving into, and out of, the region. Such protocols should include but are not limited to:

- the timely transfer of relevant information including assessment, service and support planning records to the new NASC, subject to the provisions of the Health Information Privacy Code (Office of the Privacy Commissioner 1994)
- immediate commencement of services by the new NASC according to the person's transferred support plan until such time as a reassessment or review of the support plan are undertaken by the new NASC
- a process for, and agreement on, a transition plan developed by both NASC in conjunction with the person. This is particularly important in situations where different services are required and/or where particular services are not available in the new area
- a process for reporting changes to the Ministry for payment and planning purposes
- a process for temporary moves between areas (eg, for education, holiday, study). Note: In this situation the original NASC retains responsibility for ensuring that the person's disability support needs continue to be met while away and as outlined in the support plan.

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5 SERVICE COMPONENTS

5.1 Screening

The NASC will ensure that it has personnel and systems in place to determine the eligibility of people being referred to the NASC using the definition of Service Users in 3.1, the functions of NASC in 1.0, and consistent also with the *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002).

The NASC will advise those who make referrals that are not appropriate to NASC and assist with information to effect appropriate on-referral.

5.2 Facilitated Needs Assessment

The role of the needs assessment facilitator is to work directly with the person to identify the person's current abilities, resources, goals and prioritised needs. The outcome of the process is a comprehensive needs assessment report. The level of detail required in the needs assessment will depend upon the situation of each person.

The objectives of the assessment process are to:

- confirm eligibility – including the nature of the person's disability, if appropriate
- work with the person to identify their current abilities, resources
- work with the person to identify prioritised needs and goals arising from their impairment
- refer to appropriate specialised assessment services including Assessment Treatment and Rehabilitation (AT&R) where appropriate.

The NASC will have a clear auditable separation in their business between the function of assessment facilitation and service co-ordination. The purpose of this separation and transparency is to demonstrate objectivity and show identification of the person's needs irrespective of resource availability.

The NASC will demonstrate that:

- they have in place qualified and competent staff or sub-contracted assessment facilitators to provide choice of assessment facilitators and adequate coverage of the entire geographic area contracted for, including remote and rural areas
- access is facilitated to specialised assessment and/or referral for treatment and followed up to ensure timely response from that assessor.

Outcomes of the needs assessment process may be either:

- a needs assessment is completed and service co-ordination commenced
- a needs assessment is partially completed and service co-ordination commenced to arrange access to urgent support needs
- a needs assessment is partially completed awaiting the outcome of specialised assessment.

At the end of the assessment process the person, or their delegated advocate/ representative, will sign off the completed assessment and receive a copy for their records.

Further information on the process and requirements for delivering facilitated needs assessment is provided in *Standards for Needs Assessment* (Ministry of Health 1994) and (Ministry of Health 1999) and *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002).

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5.2.1 Cultural Component of Facilitated Needs Assessment

The purpose of the cultural component of assessment is to jointly identify, the person's cultural needs. This may include issues of social/cultural, spiritual, psychological and physical need, and strengths, assets, and support systems to assist in planning support.

The NASC will have the capacity to include a cultural component into the facilitated needs assessment process.

5.3 Specialised Assessment

The assessment facilitator may refer the person to a specialised assessor for a specialised assessment. The purpose of a specialised assessment is to obtain detailed information and knowledge to accurately assess the person's need and identify a range of possible options including treatment. Such assessments are generally funded directly by the Ministry (in most instances provided by a DHB) and will not be a charge on the NASC budget. Occasionally, in the absence of any Ministry funded specialised service, the NASC may need to access privately provided specialised assessment. Purchase of such assessments will be a charge against the budget managed by the NASC for purchase of services and must be in line with the prioritisation principles set out in section 4.2, and within available resources.

Specialised assessments include, but are not limited to, clinical, diagnostic or other assessment, the purpose of which is to:

- establish the physiological basis, extent and implications of the disability (eg, testing, diagnosis and medical/physical prognosis)
- gain access to medical treatment and/or rehabilitation or habilitation (eg, AT&R, corrective surgery, exercises, treatment or child development)
- determine the person's suitability for a specific service or type of assistance, including environmental support
- make recommendations on how specific needs of the individual can be met (eg, communication support, activities of daily living (ADL), mobility assistance)
- provide advice on how support services can assist in furthering the rehabilitation process.

The NASC will also identify and facilitate access to assessors funded by other government departments (eg, education, vocational).

5.4 Service Co-ordination

The NASC is required to undertake service planning and service co-ordination, and agree a support plan with the person that indicates how prioritised needs will be met.

The service co-ordinator will ensure that, wherever possible, the person has a choice of service options, including involvement of family, community, voluntary or private (personally funded) services. The service co-ordinator will support and/or arrange innovative and flexible individually focused service packages. Where appropriate

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services are not available the service co-ordinator and the person will consider other possible options for meeting the support needs.

Consideration of natural supports will be included in assessment and co-ordination processes for all people, including Hunga Haua (people with disability). Natural supports include but are not limited to friends, both outside and in service settings; immediate and extended whānau members including hapū and iwi; community activities/groups/education and courses; neighbours; workplaces.

The place of natural supports in a person's life is likely to be an important part of Mauriora. Hunga Haua should be encouraged to think about who or what these supports might be and should be supported to have contact with them, or, where no supports exist, should be supported to explore the possibilities of developing them.

Service co-ordination will:

- commence immediately following completion of the needs assessment. However, as the NASC is accountable for meeting the safety needs of the person, service co-ordination may need to commence before the completion of the assessment. Access to support services that maintain the safety and/ or dignity needs of the person should not be delayed where the completion of the needs assessment is subject to delays (eg, time involved in accessing or completing specialised assessments)
- confirm financial eligibility for disability support services
- provide information to the person on all their options, including available service providers. The person should have the opportunity to choose the support service provider from whom they will receive services. The NASC will then refer the person to the chosen service provider
- develop an individualised support plan with the person, focusing on support for prioritised needs and goals
- prioritise access to publicly funded services
- ensure that the service package is cost effective, affordable and equitable and can be provided within the NASC defined budget and the Ministry's guidelines. The Ministry will work with the NASC to develop price and allocation guidelines during the course of the NASC contract
- ensure that all aspects of the package of services are co-ordinated and that services made available through the NASC budget are accessible by the person. The NASC should ensure, to the extent possible, that services provided by external agencies are co-ordinated and not duplicated.

Further information on the process and requirements for delivering service co-ordination is provided in the *Guidelines for Service Co-ordination* (Ministry of Health1995), *Standards for Service Co-ordination* (Ministry of Health 1999) and *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002), including the Support Allocation Tool (SPA).

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5.5 Intensive Service Co-ordination

The NASC is responsible for providing intensive service co-ordination for the small number of people with high and complex needs, usually requiring the involvement of multiple providers and ongoing problem solving. Intensive service co-ordination requires an ongoing relationship between the person and the co-ordinator. The decision that intensive service co-ordination is needed will be made by the service co-ordinator following assessment.

The tasks of intensive service co-ordination include:

- negotiating the most appropriate means for achieving the desired outcomes and respective responsibilities with service providers and other sectors (eg, education, justice, police, High and Complex Needs Unit MSD for children)
- arranging interim and crisis service provision pending further assessment
- involvement with specialised services (eg Mental Health), for assessment and treatment planning, including joint needs assessment and service co-ordination for people with a dual diagnosis of intellectual disability and mental health
- convening or participating in meetings as required with the person and those involved in the development and/or implementation of a support plan
- monitoring the delivery of the support plan, review of needs and revision of the support plan at regular, specified intervals.

The NASC will:

- ensure that intensive service co-ordination is offered only to people with high and complex needs
- work with others involved in supporting the person to ensure all participants have a common understanding of the needs and goals of the person and are working together to achieve these
- regularly review the needs of the person and the purpose of intensive service co-ordination to ensure that it is appropriate.

5.6 Review and Reassessment

Review: The NASC is responsible for determining an appropriate time frame with the person to review their support package. The interval will be indicated by the person's needs and the package of supports. Generally it is expected that a person's supports will be reviewed at least annually. However, a person may at any time seek a review if the service is not meeting their needs or their eligibility has changed or expired eg, eligibility for community services card, carer support. Review periods for people with high or complex needs or those in a crisis period may be considerably shorter.

Reassessment: Should the person's needs or circumstances undergo significant change and the support plan no longer meets their needs, a reassessment of needs will be required.

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If it is likely that a person's support needs will increase or decrease over an identified period of time, a reassessment may also be required. This can be indicated when setting a timeframe for review.

The NASC will facilitate a reassessment at least every three years if the person has not been reassessed in the interim.

5.7 Crisis Response

The NASC will provide a crisis response service when required. It will have a 24-hour emergency call system available through which people, families, or carers experiencing genuine emergencies can access services such as respite care when required.

To fulfil this function the NASC will need to be able to source crisis response options.

5.8 Māori Service Components

The NASC will recognise health as all encompassing as depicted in the Whare Tapa Wha model:

- Te Taha tinana – physical body
- Te Taha wairua – spirit
- Te Taha whānau – the family
- Te Taha hinengaro – the mind.

The NASC will establish and implement a Māori Service Plan that covers governance, management, organisational competencies, Māori health and disability gain, assessment and co-ordination practices, and how these will contribute to improving outcomes for Māori through the needs assessment and service co-ordination process.

In developing the plan the NASC will take into account the Ministry's strategic direction for Māori health and disability. This plan should incorporate the minimum requirements for Māori health and disability based on the Treaty of Waitangi, the Crown objectives for Māori health and disability and any specific requirements negotiated from time to time with the Ministry.

The NASC will specify how it intends to implement this plan. In particular, the NASC will identify those services it will deliver as explicit contributions to reducing inequalities and other additional opportunities that may exist for improvements for Māori with disabilities.

The NASC will be an Equal Employment Opportunity organisation and will ensure that they recruit, train and develop Māori, and in so doing ensure provision of a more culturally competent service appropriate to Māori.

The NASC will:

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- have the capacity to include a cultural component in the facilitated needs assessment
- facilitate improved access for Māori to disability support services by ensuring the equitable distribution of resources
- provide the NASC service in Te Reo Māori where necessary or appropriate or specifically requested by the person.

The NASC is required to ensure:

- that needs assessment facilitators and service co-ordinators have a basic understanding of Māori cultural values and beliefs, in particular Te Reo Māori and Tikanga Māori
- that people have access to needs assessment facilitators and service co-ordinators who have a strong understanding of the Māori holistic concept of health (taha wairua, taha tinana, taha hinengaro and taha whānau) and are able to articulate this understanding in service implementation
- that needs assessment facilitators and service co-ordinators have appropriate cultural competencies and/or support from cultural experts and resources
- that people have access to kaumātua (respected elder) who can be instrumental in cultural assessment and application of tikanga
- that Māori are offered the choice between Kaupapa Māori services and generic services, or a combination of both
- that the NASC can demonstrate progress toward implementation of cultural competencies to be developed by the Ministry during the term of this contract.

5.9 Pacific Service Components

The Pacific Health and Disability Action Plan (the Action Plan) sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders.

The Action Plan is a working document. It provides a foundation for priorities now and sets the direction for the future. The NASC is required to recognise the key principles of the Action Plan:

- dignity and the sacredness of life are integral in the delivery of health and disability services
- active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

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The NASC is required to ensure:

- they can demonstrate progress toward implementation of cultural competencies to be developed by the Ministry during the term of this contract.

5.10 Other Cultures

NASC are expected to provide facilitated needs assessment and service co-ordination in a manner culturally appropriate for people of other cultures in their populations, including new migrants who meet eligibility criteria and people with the status of refugee. Interpreters will be engaged as necessary.

5.11 Information Management

Access to information is a vital function to support people's independence and is an integral component of the NASC business. The NASC will have the dual role of both providing information and acting as an information broker.

It is expected that the NASC will capture and store data according to specifications provided by the Ministry and will use any system, designated funded and supported by the Ministry or its agents, that is developed during the course of the contract.

The outcome of the management of information will be:

- effective service outcomes for people
- people's privacy is maintained
- efficient systems for quality, budget management and reporting
- equitable and consistent allocation of available resources.

NASC are responsible for providing and facilitating a range of information to and from a number of sources. Information managed by NASC will include:

- information about individuals (eg, needs assessment and service co-ordination information)
- information for individuals regarding NASC processes (eg, information on NASC service users' rights and complaints processes)
- information on service availability (eg, contracted providers for disability support services and occupancy information)
- information for business management (eg, information for provider payment, and information for budget management)
- information on service issues including service gaps and/or boundary issues, quality issues regarding contracted providers.

5.11.1 Individual Information

Management of information on individuals is a core function of NASC. NASC must comply with the *Health Information Privacy Code* 1994.

NASC are required to work to key principles and practices under the code.

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At a minimum:

- information must be:
  - necessary
  - collected lawfully
  - stored securely
  - accurate, up to date, complete, and not misleading
- people must be informed:
  - of what information is collected
  - of the purpose of collecting the information
  - of and agree which agencies will receive the information collected
  - how to access information kept on them
  - that they have the right to correct inaccurate information about themselves.

NASC should not keep personal information for longer than necessary and information should be disposed of in a secure manner.

Further information on the collection and management of personal information is provided in *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting* (Ministry of Health 2002).

5.11.2 Disability Sector Information

NASC have the role of referring on to, and advising people and their families/whānau on, sources of further information. It is expected that general information will be readily available to the person and their family/whānau, at least, on:

- disabling conditions
- eligibility and entitlement to financial assistance, and benefit information
- details of the nature, type and quality of services available – both services accessed through NASC and services available from other sources, including how to access those services, expected outcomes and approximate costs of services
- referral paths for people who are not eligible for DSD funded support services but have support needs (eg, medical conditions which result in long term support needs)
- other agencies where further specific and detailed information may be obtained regarding their impairment.

The NASC is not expected to compile and duplicate specific detailed information already available from other disability information agencies in their area. However the NASC will maintain effective networks and linkages with a wide range of appropriate organisations resulting in current, reliable information from which to advise and make referrals.

The Ministry considers it important that people:

- are supported through the process by having relevant information

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- have a co-ordinated and comprehensive method for accessing information.

5.11.3 Provider Information

The NASC will provide support services with sufficient information to enable them to provide service to people referred to them. To ensure this happens NASC must provide the minimum information detailed in *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002), consistent with the requirements of the *Health Information Code* (Office of the Privacy Commissioner 1994).

Additionally, NASC must have Memoranda of Understanding with providers to cover such things as:

- specifying what information is to be provided by NASC
- timeframes in response to service requests
- timeframes for notification of a change to people's service, change in service levels, and/or the amount of service
- processes for passing on information regarding a change in need of a person.

This includes the transfer of personal and service information that may be used by support service providers as they plan their services (eg, information on unmet needs and service gaps etc).

As part of maintaining effective networks the NASC will provide information to other disability support service providers on trends, unmet needs etc, for the purpose of fostering creative, innovative, flexible services.

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5.12 Monitoring of Support Service Delivery

The NASC will report quarterly to the Ministry on service delivery by support service providers contracted by the Ministry. It is expected that the NASC will implement a process of monitoring:

- negotiated and actual delivery timeframes
- actual delivery of the support plan as negotiated between the NASC and support service provider
- whether services being delivered are able to meet the needs of the person. The NASC might comment on the willingness of the service provider to understand the person's needs and be flexible, within reason, on how these are met
- gaps in services available from providers, particularly services that are being purchased in significant volumes outside of Ministry contracted providers (using discretionary funding for example). The Ministry will meet with the NASC at least annually to jointly plan the possible development by the Ministry of services to fill the identified gaps
- any unresolved issues, problems or complaints and significant risks with service delivery by contracted providers.

The NASC will report to the Ministry any major risk or complaint within 24 hours of it occurring. The NASC is responsible for ensuring the quality of services purchased from their discretionary budget. Further details on this requirement are in the Appendix 'Requirements for NASC Discretionary Funding'.

5.13 Reviews

The NASC will make available to all people information detailing the procedure by which people may request a review of the outcome of a part, or the whole, of the assessment or service co-ordination process. Such procedures are to include the following elements:

- ability to screen out, or resolve through discussion, complaints arising from misunderstandings
- further assessment or a new support plan using assessment facilitators or staff members not involved in the previous assessment
- access to a second level of review within the NASC if the person remains dissatisfied.

The NASC is required to ensure:

- that the protocol for these Reviews, as included in the NASC Managers' Manual (2005), is known, consistently applied and monitored.

The above steps will be at the NASC's expense. If a complaint still exists, the Ministry may be requested to provide further review. The standard review procedure provided by the Ministry at that time will be followed.

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5.14 Budget Management

The requirements for budget management are contained in Appendix 1 which forms part of this service specification.

5.15 Payment Processes and HealthPAC

The requirements for payment processes relating to HealthPAC are contained in Appendix 2 which forms part of this service specification.

5.16 Discretionary Funding

The requirements for Discretionary Funding are contained in Appendix 3 which forms part of this service specification.

5.17 Individualised Funding

The requirements for Individualised Funding are contained in Appendix 4 which forms part of this service specification.

5.18 Key Inputs

The NASC will:

- provide staff with the competence and confidence to professionally undertake the separate roles of needs assessment facilitation and service co-ordination
- be an Equal Employment Opportunity organisation
- provide for the cultural aspects of the NASC Service Components
- fulfil the responsibilities of budget management
- have systems to provide access to the NASC service, fulfil the quality, information and monitoring requirements of this specification, and maintain records and reporting.

The NASC will ensure that staff are supported to develop and maintain competence and undertake formal training and qualifications as they are developed.

6 SERVICE LINKAGES

The NASC will develop and maintain effective relationships with other organisations providing services to people. These relationships will reflect the population profile served and their communities and will include community organisations, voluntary groups, support service providers and other public sector agencies. These will include, but not be limited to, Environmental Support Services within DSS; and Child, Youth and Family (CYF); Group Special Education (GSE); Housing New Zealand Corporation; Work and Income.

The Ministry will require the NASC to demonstrate effectiveness of relationships. For key agencies or providers the NASC should have in place Memoranda of Understanding, protocols and other liaison mechanisms that agree how the relationship will be conducted. These will be subject to audit.

The NASC will demonstrate effective linkages with the disability community (eg, disability groups, support networks, advocacy), and Māori and Pacific peoples' groups. Relationships will be managed with regard to the interrelationships that exist between people, their networks and social support systems.

In relation to Hunga Haua these need also to include, but not be limited to, marae, kohanga reo and kura kaupapa Māori; local Māori disability, health and social service networks, including local and regional services; primary health care providers, including marae based and primary health organisations; and Te Puni Kokiri, as appropriate. All linkages must enable, support and promote whānau ora (healthy families) and Mauriora perspectives, responsiveness to individual need and respect for the rights and opinions of the Hunga Haua.

7 SERVICE EXCLUSIONS

Nil.

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8 QUALITY REQUIREMENTS

The service is required to comply with the Ministry General Contract Terms and Conditions. In addition, the following quality standards and requirements also apply.

8.1 Quality Standards

National Health and Disability Sector Standards

Only specific parts of the Health and Disability Sector Standards (HDSS) are relevant to NASCs. All NASCs are required to meet the standards and criteria to be identified in the HDSS.

It is envisaged that NASC will work towards compliance with the HDSS over time. Until such time as a NASC is fully compliant it must meet the Provider Quality Specifications in this contract. Once it is compliant with the HDSS, or by __/__/__ the Provider Quality Specifications will be overridden by the HDSS.

a. Needs Assessment Standards (HFA 1999)
b. Service Co-ordination Standards (HFA 1999)
c. Standards for NASC Agencies (HFA 1999)

8.2 Quality Requirements

8.2.1 Access

Timeframes

First contact with the person will be made within two working days of receipt of the referral or enquiry on behalf of the person.

Time to complete needs assessment should be:

- within 24 hours in a crisis where a person's safety is at risk
- within 24–48 hours for urgent referrals, depending on the degree of urgency
- within five working days following acknowledgement of referral in 40% of cases
- within 14 working days following acknowledgement of referral in 40% of cases
- within 20 working days following acknowledgement of referral in the remaining 20% of cases.

Time to complete service co-ordination should be:

- within 10 working days of the completion of the needs assessment in 80% of cases
- within 20 working days of the completion of the needs assessment in the remaining 20% of cases.

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Note: It is anticipated that in the majority of situations partial completion of needs assessment and service co-ordination will progress to the point where immediate support needs are clearly identified and services put in place within 14 working days of first contact. Service co-ordination in this context refers to the development of a support plan and arranging access to services. It is recognised that the full service co-ordination role may extend over a much longer period as services are reviewed, and adjusted to meet the needs of the person. The intent of the time lines for completion of service co-ordination is to ensure that access to available services occurs in a timely manner once needs and goals have been identified.

Information will be transferred to another NASC within five working days of the transfer request being received.

8.2.2 Person, Family/Whānau/Aiga Involvement

The person, family/whānau/aiga members, support workers and advocates should be central to service delivery. This requires:

- the person be given a choice of who is involved in their needs assessment and service co-ordination processes
- the person, family/whānau/aiga members, support workers and advocates be provided information on how they can be involved in the needs assessment and service co-ordination processes
- the person, family/whānau/aiga members, support workers and advocates be notified of complaint procedures
- the family/whānau/aiga is involved in a culturally appropriate manner.

8.2.4 Acceptability

Acceptability of services will be monitored on an ongoing basis. This monitoring will use a range of methods to gather this information on the acceptability of services provided. All surveys will follow the guidelines for consumer surveys contained in the NASC Managers' Manual (2005). The methods used will identify the acceptability of, at least, the following areas of service as indicated by the person, support service providers, support staff, family/whānau and the person's advocates:

- information distribution
- staff professionalism
- staff cultural sensitivity
- staff communication skills
- respect for privacy
- rights of the consumer
- level of choice
- informed consent
- participation in community-based activities
- ease of use of NASC's services
- reduction of barriers that enable easier access to the NASC's services
- complaint and feedback systems.

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8.2.4 Safety

The NASC will have documented operational programmes/policies/protocols and guidelines that identify and minimise risk areas for the NASC. The use of these systems is to be included as part of the NASC Quality Improvement system. These areas must include, but are not limited to:

- abuse incidents, policy, protocols for response and reporting
- poor service delivery identification and how this will be reported to the Ministry
- service gap identification and how this is reported to the Ministry
- protocols if support service provider withdraws services to people and reporting this to the Ministry.

8.2.5 Reporting Change

The NASC is required to advise the Ministry of any significant change in the organisational structure or capability of the NASC, and of any other matters significantly affecting, or likely to affect, NASC function and quality.

9 PURCHASE UNITS

The service will be purchased for the eligible population of the region of coverage for a contract price.

PU Code	PU Description
DSS1004	Needs Assessment
DSS1005	Service Co-ordination
DSS1004D	Discretionary Funding

10 REPORTING REQUIREMENTS

Monthly reporting: to be supplied to the DSD Service Manager by the 12th of the month or the preceding working day.

Note: Rather than include other reports on a monthly basis, the Ministry may, from time to time, seek exception reporting of the NASC.

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NASC Budget Management Reporting Template		
Organisation Name:		
Reporting Period:		
MoH Service Manager:		
A: Assessments		
1	**Number of assessments of new clients (under following categories)** New clients As a result of a transfer Has been receiving service but no previous assessment Re-entry after a break **Total assessments**	
2	Number of reassessments	
3	Number of people waiting for first assessment	
4	Number of people waiting for a reassessment	
B: Service Co-ordinations		
5	Number of people waiting for a service co-ordination	
C: Reviews		
6	Number of reviews	
7	Number of people waiting for a service review	
8	Number of requests for review following allocations	
D: Discretionary Funding *Refer to 'NASC Requirements for Discretionary Funding'*		
9	Use of discretionary budget – % of line spent	
10	Number of clients receiving support options through discretionary funding	
11	Types of support provided (as per Ministry format) •	
12	Number of contracts with prices •	
13	How spend relates to service gap/unmet need *(written comment*) •	

E: Issues/Concerns/Risks		
No	**Description**	**Action taken/solution sought**
1		
2		
3		

Notes:

1 'New' = a person this NASC has never assessed before.

2 'Reassessment' = needs/circumstances of an existing client have changed > reassessment of current service needs is required.

3 'Review' = a review of current allocation of services.

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10.1 Quarterly Reports

In addition to above, a qualitative report is required on a quarterly basis.

The NASC will provide a written report which meets the requirements of Monitoring of Support Service Delivery (5.12); Māori Service Components (5.8); and includes, at least, updates and trends in unmet needs and service gaps, including for Māori, Pacific and other populations; allocation patterns; quality initiatives and risk management; complaints, issues, including any equity issues.

This information should be supplied within seven days after the end of each quarter, using the Ministry template format.

11 SPECIFIC REQUIREMENTS

11.1 Legislation

The NASC will be required, under the terms of the contract, to abide by all relevant New Zealand Legislation.

11.2 Policy

The NASC will be required to abide by all relevant Policy including, but not limited to:

- The New Zealand Framework for Disability Service Delivery – August 1994, Ministry of Health
- Standards for Needs Assessment for People with Disabilities – June 1994, Ministry of Health
- Guidelines for Service Co-ordination for People with Disabilities – February 1995, Ministry of Health
- He Korowai Oranga, 2002
- DSD Policy/Process to follow when Out of Home Placement may be necessary for Children and Young People with Disabilities', 2004.

11.3 Agreements

The NASC will observe:

- Memorandum of Understanding between the Ministry and CYF – 2000 (and revised version during term of this contract)
- Ministry of Education accredited therapy providers protocols agreed between the Ministry of Health/Ministry of Education, 1999.

The provider will also observe other protocols and/or Memorandum's of Understanding negotiated between the Ministry and other government departments or agencies.

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APPENDIX 1: BUDGET MANAGEMENT

The NASC is required to:

- manage and maintain data on the NASC's Portfolio to make sure that the Client Claim Processing System (CCPS) accurately reflects the disability group and that the funder is correctly assigned to the Portfolio
- monitor and manage the utilisation levels of services
- promote consistent and equitable service co-ordination outcomes for people. This means using the Service Allocation Tool (SPA Tool) and allocating average levels of service to the client population consistent with Benchmark Indicators
- project/forecast future costs and planning for this within your indicative budget
- provide clear processes for appeal review of packages including use of current Ministry review panel processes for complex and high cost support packages
- identify to the Ministry cost effective and appropriate solutions to supporting the needs of their population/sub-populations.
- ensure all requirements and guidelines are followed, including, but not restricted to:
  - *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting*, 2002
  - NASC Managers' Manual, 2005
  - Discretionary funding requirements
  - Supported independent living specification and guidelines
  - Intensive service co-ordination guidelines
  - SPA tool, or its equivalent as determined by the Ministry, is known to all NASC staff, adhered to, and appropriate application is evidenced and monitored to ensure equitable and nationally consistent access to support services
  - mandatory letters to service users provided by the Ministry
  - meeting regularly with the Ministry.

To assist the NASC with budget management the Ministry will provide NASC with the following tools:

- an annual indicative budget
- access to CCPS
- reports on service utilisation and service allocations including trend reports
- reports on the Client Portfolio and status and history of the service user
- population service indicators
- access to a moderation and review panel for people with complex needs and high cost packages
- a schedule of providers contracted by the Ministry, details of the services contracted, contracted rates or pricing models such as the Allocation Resource (ART) Tool, with update of these from time to time as contracts are varied and/or renewed
- and will meet regularly with the NASC manager.

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In managing the budget the NASC will need to take into account the following factors:

- people's needs may increase over time and they may seek more services at greater cost. Changing demographics (eg, the increase in the age of the population)
- cessation rates from services due to improvement in condition (effective outcome of rehabilitation or treatment), service exit, death, etc
- crisis events will occur for people and they may then require immediate extra support
- any factors that may lead to an increased number of referrals to the NASC (eg, pressure from other funders to fund support for people) or increased referrals from agencies where people may no longer be eligible (eg, CYF and/or SES).
- price increases agreed to by the Ministry. Projects managed by the Ministry that may directly or indirectly result in higher costs (eg, the move to more appropriate services for younger people who reside in aged residential care).

In order to manage these factors the NASC will need to adopt strategies and procedures, such as, but not limited to:

- prioritising needs and providing services so that people with the highest needs receive support first. Protocols and processes for prioritising need will be established in conjunction with the Ministry to ensure consistency of approach by NASCs
- allocating support packages for the disability population of the region consistent with the population service indicators
- managing boundary and other eligibility issues so that the Ministry is paying for only those supports for which they are responsible
- identifying situations where reassessment could result in lower cost through use of creative service packages where appropriate
- identifying situations where rehabilitation, access to treatment or other specialised services could result in lower service packages
- maintaining a crisis pool of resource for emergency service demands. The Ministry will discuss and review this crisis pool with the NASC quarterly.

The Ministry will assist with forecasting by providing relevant information on demographic trends and other information to input into trend analysis. The Ministry will develop with the NASC allocation guidelines according to clients' support needs level.

The NASC is required to ensure:

- all supports/services are funded by the appropriate funder. It is expected that the NASC will observe, where they exist, Memoranda of Understanding between the Ministry and other government funders and agencies (eg, ACC, SES, CYFS and Work and Income). The NASC will also have in place protocols defining areas of responsibility for providing access to support services with other providers, including the DHB.

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APPENDIX 2: PAYMENT AND HEALTHPAC PROCESSES

General

An important function of the NASC is to supply information to HealthPAC so that providers can be paid through the Client Claim Processing System (CCPS). The information transmitted must be complete, accurate and timely.

The NASC must use the correct forms, both electronic and manual, for sending information to HealthPAC. For paper forms the NASC must use the stamp provided for completing the NASC organisation's name. HealthPAC will send back to the NASC any forms that are not completed correctly.

Eligibility Load into CCPS and Provider Invoice Rejections

NASC have the responsibility of ensuring that legitimate claims are not rejected, and to ensure that legitimate claims that have been rejected are rectified in a timely way. Specifically the NASC must:

- have a data quality rate higher than 95% (ie, the NASC's data feed should not have rejections greater than 5% for any given period)
- send to HealthPAC assessment data within five business days from the service co-ordination completion date
- process 80% of invoice rejections referred by non residential service providers within 10 business days (ie, NASC's must submit to HealthPAC the correct assessment details to allow the non-residential invoice claim to process in the next invoicing period)
- process 100% of invoice rejections referred by non residential services providers, these corrected assessments must be received by HealthPAC within four weeks of the original invoice rejection notification issued by HealthPAC being received by the NASC.

It is important for NASC to manage legitimate claims that have been rejected. Failure to do this creates unnecessary work for Home Based Support Service (HBSS) providers, other providers, NASC, and the Ministry.

Invoice rejections are caused because the HBSS provider has:

- made a claim that they have not been authorised for, or
- made a legitimate claim but the NASC authorisation has not been processed in CCPS.

On any occasion that the NASC is unable to fix a legitimate invoice rejection the NASC must notify HealthPAC, with a copy to the Ministry Service Manager, of any data issues that prevents the NASC from meeting these targets.

The Ministry will provide NASC with access to invoice and eligibility data stored in CCPS to assist with the management of invoice rejections. The Ministry will also provide monthly reports on NASC and HBSS provider rejections.

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Client Portfolio

The list of eligible persons is central to the NASC budget management system. The Ministry will provide the NASC with the list of their eligible persons.

The NASC must check their list each month to ensure that the list reflects:

- new people who entered their service
- people who have exited their service
- the correct funder.

APPENDIX 3: REQUIREMENTS FOR NASC DISCRETIONARY FUNDING

1 Background

This appendix is to be read in conjunction with the Ministry of Health's (the Ministry) Needs Assessment Service Co-ordination (NASC) Service Specification. All the requirements of the base service specification apply with regard to the implementation of discretionary funding, in particular with respect to a person's eligibility for service.

2 Definition

The Ministry is responsible for funding a range of services for people with a disability. These are outlined in the Service Coverage document and include services such as needs assessment and service co-ordination, information services, household assistance, personal care, carer support, short and long-term residential care, rehabilitation and environmental support services.

In the majority of situations most people's needs will be able to be successfully met through the standard range of services funded directly through the Ministry.

However, the Ministry notes that there may be occasions when an individual's needs are not able to be met through the Ministry's directly contracted services and therefore may require access to other support options tailored to meet an individual's needs.

Therefore, the Ministry has supported the development of discretionary funding arrangements through NASC as a way of providing more flexible and innovative supports to meet the needs of a small number of people. A person can be in receipt of Ministry contracted services and/or discretionary funding support.

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3 Objectives

The original purpose of discretionary funding was to enable NASC to be more innovative and flexible in developing support packages that could meet a person's identified needs. Thus, achieving better outcomes for the person that might not have been possible through traditional Disability Services Directorate (DSD) services. To be able to achieve this the NASC is expected to engage the services of other organisations to provide these supports. Dependent on the situation, these supports would usually either be one-off, or, in a limited number of cases, may be on an ongoing basis for a set length of time.

The NASC will not directly provide flexible support services to people, but will engage other parties to do so. The NASC will facilitate the provision of this support.

The Ministry notes that in the past it has allowed the development of direct payments, self-managing contracts or individualised hosting for individual clients. However, the Ministry has introduced a moratorium on these supports. As this is still in place, NASC are unable to offer these options to any new people entering NASC services. The development of a national Individualised Funding Agency will mean all such packages will be managed by this new agency in the future.

4 Outcomes

Discretionary funding will complement the natural supports and existing resources that the client may have access to by:

- enabling marae-based and/or cultural activities to enhance participation
- resourcing creative solutions that achieve desired outcomes
- developing solutions to meet identified service gaps of Ministry contracted services
- tailoring service packages to meet unique individual support needs
- enhancement of the service users autonomy, control and self reliance
- integration of the person into community life, in accordance with each person's needs agreed through the needs assessment and service co-ordination process.

5 Exclusions

Flexible service options do not include:

- provision of service that is the responsibility of other funders and agencies such as the DHB, ACC, Child Youth and Family, Education and Work and Income
- reimbursement of payments for services that require a user charge
- provision of services/supports already purchased though other DSD contractual arrangements such as environmental support, residential care, home based support services or supported independent living, including services which are capacity funded.

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6 Service components

The Ministry will advise each NASC of its budget for discretionary funding and each NASC is expected to stay within these budget allocations.

6.1 Discretionary Funding

NASC are required to work with individual and groups of providers in their area to provide information on the unmet need with a view to facilitating new service developments to respond to that need. Particular effort should be made to develop services in keeping with stated Ministry targets and priority areas.

The NASC may have sub-contractors provide goods and services through its discretionary funding budget (in accordance with Ministry policy or frameworks). The NASC remains liable for ensuring that all sub contracts are in place and responsibilities are met including regular review of these contracts and the actual service provision.

NASC must ensure the service provision meets all Ministry requirements.

NASC must have contracting, accounting and payment policies and processes for the utilisation of discretionary funding.

6.2 Quality Requirements

The Ministry's expectations are that any sub-contract set up through a NASC will reflect the same level of quality as outlined in all Ministry contracts.

NASC should ensure that they do not enter into sub-contractual arrangements that expose themselves, and therefore the Ministry, to any unnecessary service quality risks.

6.3 Essential Requirements for NASC Entering into Sub-contracts with Service Providers, utilising Discretionary Funding

Arrangements between the NASC and provider for discretionary funded support (other than providers already directly contracted by the Ministry) will be documented in a written agreement between the two parties.

The NASCs will ensure that agreements with providers clearly specify:

- the services/support to be provided
- the roles and responsibilities of both parties
- price and volume
- the Ministry's access to premises and records
- any specific quality standards
- term of agreement (up to 12 months maximum)
- start date and end date for the provision of the service
- any review dates of the service
- information and reporting requirements

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- method of payment
- dispute and termination processes
- the Ministry's right of veto of agreements which do not meet requirements specified in this agreement.

6.4 Limitations on Sub-contracting Arrangements with Providers

NASC must not enter into agreements:

- that make payment at a rate which compromises the provision of the specified quality of support (ie, rate must be realistic)
- with rest homes or hospitals which do not have a current contract with the Ministry for the provision of residential support services
- with organisations that are business partners of the NASCs (without the express agreement of the Ministry)
- where the proposed service is estimated to cost greater than **$10,000** per annum without the specific prior agreement of the Ministry. In this instance the NASC needs to work with the Ministry with a view to trying to establish a direct contract between the provider and the Ministry
- with individual providers for provision of discretionary support options ie, as an employee of the NASC. The NASC must ensure that providers who are individuals are legitimately classified and treated as self-employed (Employment Relations Act 2000).

The Ministry retains the right to veto agreements entered into by the NASC, particularly in the event the requirements specified in this Schedule have not been adhered to.

7 Reporting

The NASC will report monthly to its DSD Service Manager detailing:

- use of discretionary budget – % of line spent
- types of support provided (as per Ministry format)
- how spend relates to service gap/unmet need
- number of people receiving support options through discretionary funding.

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8 Invoicing

The NASC is required to submit an invoice to the Ministry on a monthly basis for the actual amount spent on discretionary funding. The NASC is to attach a schedule detailing:

- the names of sub-contracted provider organisations
- amount spent per provider
- number of people on Direct Payments (should be those under grandparented arrangements only)
- amount spent per person by NHI number
- service purchased with discretionary funding
- provider name who conducted the service
- service description.

9 Specific requirements

Any service costing over $1000 at any one time or that is proposed on an ongoing basis (more than 12 months) must be agreed in writing by the Ministry service manager.

NASC will observe the *Support Needs Assessment and Service Co-ordination Policy and Procedure Information Reporting Guidelines* (Ministry of Health 2002).

10 Guidelines

The NASC will observe the following guidelines:

- to ensure NASC understand discretionary options information requirements
- to ensure that discretionary options are used well and aligned with the intent of the Ministry
- to provide support to NASC in their use of discretionary options
- to ensure that NASC are aware of the responsibilities of the Ministry and how they impact on the decisions
- to provide information that enables NASC to use discretionary funding appropriately.

10.1 NASC Responsibilities

There is a balance between managing responsibilities and creating an environment that enables service co-ordinators to be flexible and innovative in their use of resources. Where a NASC is not sure that a solution is appropriate then they should contact the Ministry for advice.

There are three key responsibilities that the Ministry needs to consider as it carries out its business that are relevant to NASC when considering using discretionary funding.

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10.1.1 The Funding Agreement between the Ministry and Crown

DSD receives funds to purchase disability support services to meet the needs of the eligible population. Other government departments, of course, receive funds to purchase and meet a range of other needs (eg, Education, MSD). A NASC is not expected to purchase solutions that are the responsibility of another funder, although solutions may complement the services of another funder (eg, after school care).

For most services there needs to be a level of prioritisation, with highest needs being met first. Discretionary funding should not be used to avoid or shortcut processes and criteria for accessing existing disability-contracted services. However if all other options have been exhausted, it may be used to purchase intermediate solutions eg, while a client waits for a residential support service.

The Ministry is required to assure the quality of services provided. Where the NASC is contracting directly for provision of a service, then the contract should specify quality requirements.

10.1.2 The DSD Framework

The auditable boundaries separating needs assessment and service co-ordination purchasing and service provision should be maintained. This means that NASC are not expected to provide services, and therefore must ensure that they do not engage in activities that would usually be carried out by providers (ie, the recruitment of suitable carers for individuals). Where the parent company of a NASC is also a service provider, the NASC will need the approval of the Ministry before they can contract with the parent or one of its subsidiaries.

NASC and the Ministry need to be aware of all legislative obligations in relation to use of Discretionary Funding, for example that particular arrangements are not anti competitive or restrict trade practice.

10.1.3 Process

The NASC is required to:

- determine that all available contracted support options have been explored
- determine that the discretionary funded option(s) is the most appropriate option for the individual
- identify the solution, ensure that it is acceptable to the person and will meet identified goals and outcomes sought
- ensure that the solution will not put the person or carer in any greater risk than other available support options
- ensure that the NASC Manager has signed-off the discretionary funding proposal and sent this onto the Ministry for approval if necessary (ie, where the cost is over $1000 or is ongoing)
- ensure all internal and Ministry requirements relating to the process, delegated authorities and approvals have been followed.

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APPENDIX 4: INDIVIDUALISED FUNDING

Individualised Funding (IF) is a means of enabling some people with disability to manage their own needs assessed budgets and employ their own support staff.

A two-year national programme is underway to introduce IF. During 2005–2006 eligibility and suitability for the scheme will be determined through facilitated needs assessment by the NASC in accordance with the eligibility criteria and other regulations operated by the Individualised Funding Agency (IFA) for the scheme. Individual people considered eligible, competent and confident to manage their own budgets will be referred on to the IFA by the NASC. The IFA will then make administrative and other support arrangements necessary to enable budget holders to manage their budgets successfully.

NASC and the IFA will be required to sign a Memorandum of Understanding that clearly describes the scope of their joint and individual responsibilities to each other, the scheme and to the budget holders.

It needs to be noted that initially only those people currently on a form of IF will be assessed for the new programme and this will occur on a region by region basis as the new agency is set up. It will take some time to work through all the current people and the IF agency will liaise with each NASC around timeframes for their area. No new referrals will be accepted until current assessments have been completed.

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2 MINISTERIALS

PURPOSE

The purpose of this paper is to clarify the:

- Ministry of Health's (the 'Ministry') approach to providing services for Ministers (ministerial support services)
- Disability Services Directorate's (DSD) system of managing disability ministerial work
- Needs Assessment and Service Co-ordination organisation's (NASC) role in supporting the disability ministerial process.

WHAT ARE MINISTERIAL SUPPORT SERVICES?

The Ministry provides ministerial support services to the Minister of Health and Associate Minister of Health with delegation for disability issues. These services are required as part of the Ministry's performance agreement with the Minister of Health.

The following is a summary, of the main ministerial support service. (See this Appendix 2a for a fuller description of responsibilities.)

- Draft responses to ministerial correspondence are known as **ministerials**. They take the form of a letter from an agency, group or individual to a Minister. They are sent to the Ministry for draft of reply for the Minister's signature.
- Parliamentary questions, known as **PQs**, are the means by which Ministers fulfil responsibility to Parliament through questions in the house.
- Requests for official information under the Official Information Act 1982 are known as **OIAs**. Official information is available to the public or protected in the public interest and for personal privacy.
- Briefing papers and speech notes are a response to Minister requests for specific information.
- Responses to select committee questions (requests for specific information from Ministers or government agencies) are prepared.
- Appointments are made to occupational bodies and committees such as District Health Boards.

WHAT IS THE NATURE AND SIGNIFICANCE OF THE MINISTERIAL SUPPORT WORK?

The ministerial process supports the Government's goals for open, transparent and accountable government. Agencies, groups or individuals may seek responses from Ministers to a wide range of issues. These may include sharing new ideas, current experiences and information on the health and disability system, requesting services or funding, complaining about government policy or the way services are provided.

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Ministers place a lot of importance on ministerial work. It is a means of keeping informed about current sector issues and being alerted to emerging issues or potentially controversial matters. They expect a high standard of performance from the Ministry (see Appendix 2b).

There is significant ministerial workload.[3] The Ministry therefore has a dedicated Ministerial Services Unit (MSU) located in the Corporate Information Directorate at its Molesworth Street offices in Wellington. Ministerial work is driven by strict timeframes, some of which are very urgent such as an hour to respond to oral PQs.

HOW DOES THE MINISTERIAL SYSTEM WORK IN THE MINISTRY OF HEALTH?

The role of MSU is to co-ordinate all requests for ministerial work that come into the Ministry and ensure all services are completed to a satisfactory standard, and on time. It has a database to log and monitor progress and outcomes of all the ministerial work.

MSU completes most briefings requested by Ministers for the Disability Services Directorate. The MSU writer/analyst assigned to disability ministerial work is responsible for ensuring timely and satisfactory completion of the final work. Further, there is one person responsible for co-ordinating all requests for official information.

WHAT IS DIFFERENT ABOUT DISABILITY MINISTERIAL WORK?

Disability ministerial work differs from 'health' ministerial work. There are different characteristics and needs of disability client groups and the disability sector as a whole. Client information may be required from NASC organisations to get a clearer understanding of the client's particular situation, needs and perspective. Further, issues are often multidimensional and can span across different service areas such as mental health, personal health, disability aids and equipment, housing, transport, welfare entitlements, human rights. Information may be required from different parts of the Ministry or sought from other agencies. This results in disability ministerial work requiring more time and effort on information gathering, research, letter drafting and liaison.

WHO IS RESPONSIBLE IN THE DISABILITY SERVICES DIRECTORATE FOR DISABILITY MINISTERIAL WORK?

The table below identifies key administrative roles and responsibilities for ministerial work in the Directorate.

Role	Responsibility

[3] For example in 2001/02, the Ministry dealt with 7104 items of ministerial correspondence, 3077 PQs, 715 requests for official information and 568 requests for briefing papers and speech notes, and 100 appointments to statutory bodies.

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EA (Business Support)	• Co-ordinates with MSU on all ministerial work requests referred to DSD • Ensures distribution of ministerial work requests to the right people in their sections in timely manner • Maintains spreadsheet to track work progress and completion
Policy Team	• Advises on allocation of work to designated area of responsibility within the Directorate • Identifies someone to 'steer' or co-ordinate information gathering and provide information and advice to ministerial or briefing writers • Identifies another person to 'peer review' the work
Service Managers	• Liaise with and obtain information from NASCs and other disability providers, as required • Provide timely and accurate information and advice to ministerial or briefing writers
Operational Managers	• Advise on information for letters and briefings, as required • Peer-review letters and briefings, as required
Planning and Development Managers	• Advise on specific knowledge areas eg children and young people, on information for letters and briefings, as required. • Peer-review letters and briefings, as required
DDG	• Advises on DSD response to serious issues and incidents • Sign-off or delegate sign-off for all briefings and PQs (especially complex ones)

WHAT ARE THE RESPONSIBILITIES OF NASC ORGANISATIONS IN SUPPORTING THE MINISTERIAL PROCESS?

NASC organisations can receive Ministry requests for information on their services and clients to support ministerials, PQs, briefings complaints, human rights issues and so on. Most ministerial-related requests should come in the first instance from their DSD Service Manager. Occasionally, however, the MSU writer/analyst assigned to the work may have to contact NASCs directly for information, for example when a DSD Service Manager is unavailable to support urgent request. NASCs should have their own internal processes for dealing with information requests from the Ministry.

NASC organisations must comply with relevant legislation that protects privacy of the person and service information on them, notably the Privacy Act 1993 and the Health Information Privacy Code 1994.

In assuring privacy and confidentiality for clients and avoiding breaches of the Privacy Act and the Code, NASC organisations will need to determine whether consent is required to share client information. This determination is based on Rule 3 of the Code in relation to purpose, use and disclosure of information, including withholding of sensitive information.

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NASC organisations may be required, however, to disclose information under certain legislation in certain situations without the client's consent and where they are at a risk to themselves or others such as Health Information Act 1956, Mental Health Act 2002, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2004.

NASC organisations should only provide the Ministry with personal client information on the clear and agreed understanding that the Ministry will use information only for specific ministerial or briefing purposes.

NASC organisations should expect that the Ministry treats personal client information in strictest confidence and that information is stored safely and protected while being used. Further, the information must either be destroyed (by deleting email or sent for document destruction) or returned in full to the originating NASC if no longer required.

WHAT CAN NASC ORGANISATIONS DO IF INFORMATION PROVISION IS GOING TO BE DIFFICULT TO ACHIEVE, LATE OR OVERDUE?

If NASC organisations anticipate any difficulty in providing information such as the capacity to respond, the NASC manager should make this clear at the time of the request and agree on a workable timeframe with the requester.

WHO CAN NASC ORGANISATIONS CONTACT IN THE MINISTRY FOR INFORMATION AND ADVICE ON MINISTERIAL PROCESSES AND ISSUES, INCLUDING TRAINING NEEDS?

In the first instance, the NASC manager should contact their DSD Service Manager if they have any queries or concerns about the ministerial process or seek training. Alternatively, the DSD Policy Team can respond to queries, if the Service Manager is unavailable. Finally, MSU Team Leaders can also advise generally on the Ministry's ministerial or wider government processes.

WHAT IF THE NASC ORGANISATION IS THE SUBJECT OF A QUERY OR COMPLAINT THROUGH A MINISTERIAL OR BRIEFING?

If the NASC organisation itself is the subject of a ministerial or briefing, the DSD Service Manager will co-ordinate any information gathering and investigation on the matter with the NASC concerned.

People have the right to complain about the standard of NASC services provided or conduct of staff from the perspective of a client, family member, or another organisation. If the NASC organisation is the subject of a complaint, every effort will be made to obtain a balanced view from parties involved in the matter.

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In serious cases an escalation process and possibly a service review or audit or another investigation may be required.

APPENDIX 2A: SUMMARY OF MINISTERIAL SUPPORT SERVICE RESPONSIBILITIES

Type and description	Requirements	MSU responsibilities	NASC and DSD responsibilities
Ministerial Letter written to a Minister/Associate Minister is sent to the Ministry for draft of reply for the Minister's signature.	Letters have 5, 10 or 20 working days to be completed and back to the Minister's office.	• Research letters • Draft letters • Editing • Prepare for Minister's signature	NASC may be required to provide service and client information. DSD peer-reviews ministerial letters.
Official Information Act Requests Under the OIA official information is available to the public or protected in the public interest and for personal privacy.	OIA co-ordinator role is to ensure that OIA requests are logged, assigned and completed by the appropriate directorate within the set timeframes.	One person is responsible for the co-ordination of OIAs for the Minister of Health, the Director-General and Ministry of Health staff.	NASC may be required to provide service and client information. DSD writes responses and collates information in relation to the information it holds and its understanding of the issues concerned.
Briefing papers Respond to Minister requests for specific information (eg, speech notes).	All briefings are formatted in the Health Reports database and must have a number and be completed within set timeframe. Responses to oral questions are answered by the Minister at 2 pm on the day the House is sitting. There is a limit of 12 oral questions drawn for each day the House sits.	MSU briefings team co-ordinates all briefing requests from Minister's offices.	NASC may be required to provide service and client information. DSD supplements information and peer-reviews disability briefings or disability content in other briefings. DDG approves all DSD-allocated briefings. DSD is generally responsible for completing oral questions, including supplementary information and question(s), for drafting within 1¼ hours, sign off and dispatch directly to Minister's office by 12.15 pm on the same day the oral question is received.
Select committee questions or requests for information	Requests can be direct to Ministers or the Ministry via Director General of Health.	MSU is developing protocols for the Ministry's responses to select committees.	NASC may be required to provide service and client information. DSD supplements information and peer reviews replies.

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APPENDIX 2B: ESSENTIALS OF GOOD MINISTERIAL SERVICES

This appendix is intended to illustrate the requirements of good ministerial services. NASCs are not expected to draft letters or briefings.

Effective ministerial services have the following requirements.

- Letters are well understood from all relevant perspectives, including those of the correspondent, the responsible Minister(s) and the Ministry:
  - letters must be read carefully
  - issues are researched and analysed carefully
  - focus is on the questions and issues concerned
  - problem(s) facing the Minister(s) is (are) identified and explained
  - evidence is provided to support the facts or the Government's position or goals
  - arguments are logical and compelling
  - options and risks for Minister(s) are clearly identified
  - proactive steps for addressing issues and concerns are identified, wherever possible.
- Letters drafted follow the *Communication Standards for the Ministry of Health* (2003) for writing, style, editing and procedures for communication by the Ministry:
  - writing is clear, brief, to the point, well presented and correctly formatted
  - content is appropriate and factually correct
  - jargon or technical language is avoided
  - the reader is not patronised.

The Minister of Health and Associate Minister of Health have their own style requirements which Ministerials Services Unit will follow when drafting anything for their signature.

DSD December 2004

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3 Competencies for Needs Assessment Facilitators

COMPETENCIES FOR NEEDS ASSESSMENT FACILITATORS

Source Standards and Competencies for Needs Assessment (Health Funding Authority 1999b).

Outcome 1: Needs assessment is flexible, and responsive to clients and the community.

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Competencies

- Demonstrates the value of involvement of family/whānau, hapū and iwi in needs assessment.
- Demonstrates the value of involvement of family/carers and significant others in assessment.
- Demonstrated knowledge of contractual timeframes.
- Demonstrated implementation of contractual timeframes.
- Demonstrated implementation of assessments according to prioritisation criteria.
- Demonstrated time management and workload planning skills.
- Demonstrated active listening, and related responses.
- Responds and directs to referrals according to client need.
- Describes key disability and community agencies' roles/functions and entry procedures.
- Describes key Māori disability and community agencies roles/functions and entry procedures.
- Demonstrates respect for clients right to refuse access to other assessment reports.
- Demonstrates ability to establish a relationship with the client/advocate/family whānau based on trust.

Outcome 2: Needs assessment respects health as a taonga for Māori and reflects the four dimensions of Māori health: tinana, wairau, whānau and hinengaro.

Competencies

- Demonstrates knowledge and application of the four dimensions of Māori Health.
- Demonstrates knowledge of Tikanga.
- Demonstrates openness and willingness to include Tikanga in needs assessment.
- Facilitates needs assessment that includes the four dimensions of Māori Health and Tikanga for Māori clients.

Outcome 3: Clients are informed of the purpose and process of facilitated needs assessment.

Competencies

- Demonstrates the knowledge of the purpose and process of needs assessment.
- Recognises communication barriers and responds to individual client need. Demonstrates ability to convey accurate information to the client/advocate. Seeks client/advocate understanding of information shared.
- Demonstrates knowledge, and situational context for application of the Privacy Act, Code of Rights and Responsibilities and review process.

Outcome 4: Facilitated needs assessment is responsive to the diversity of people having their needs assessed.

Competencies

- Recognise and able to articulate own culture.
- Values and demonstrates respect for each person inclusive of disability, gender, ethnicity, sexual orientation, age and spirituality.
- Recognises own limitations and facilitate access to an alternative acceptable assessor.
- Demonstrates openness and willingness to respond to the client's choice of physical and social environment for the assessment.

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Outcome 5: Facilitated needs assessment ensures the client's knowledge and experience of disability is recognised alongside the identification of their needs in the assessment.

Competencies

- Demonstrates the ability to work alongside the client/advocate, and best represent their needs, goals and abilities.
- Demonstrates respect for each individuals' values, beliefs and experience to support self-expression.
- Demonstrates facilitation skills that enable the client to identify and express their needs.
- Demonstrates the ability to recognise and communicate with the client, unexpressed client needs.
- Demonstrates an ability to identify and seek other information compatible with client need.

Outcome 6: Needs assessment is facilitated by people who are competent and knowledgeable about disabilities.

Competencies

- Recognises own limitations and competency deficits and accepts responsibility for personal development.
- Demonstrates understanding of disability culture and philosophy.
- Demonstrates understanding of the broad and diverse nature of disability and demonstrates the ability to individualise assessments.
- Demonstrated ability to identify client needs that require specialised assessment and implement referral.
- Demonstrates knowledge of specialised assessment services and entry procedures.

Outcome 7: An accurate summary of the client's goals, needs and abilities is produced.

Competencies

- Demonstrates the ability to accurately reflect the clients needs, goals, aspirations and abilities in a written report.
- Client records demonstrate client confirmation of needs assessment summary.

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COMPETENCIES FOR SERVICE CO-ORDINATORS

Source: Standards and Competencies for Service Co-ordination (Health Funding Authority 1999c).

Outcome 1: Service co-ordination is flexible, easy to access and responsive to clients and the community.

Competencies

- Demonstrates the value of involvement of family/whānau, hapū and iwi in service co-ordination.
- Demonstrates the value of involvement of family/carers and significant others in service co-ordination.
- Demonstrated knowledge of contractual timeframes.
- Demonstrated implementation of contractual timeframes.
- Demonstrated time management and workload planning skills.
- Demonstrated active listening, and related responses.
- Responds and directs to referrals according to client need.
- Describes key disability and community agencies' roles/functions and entry procedures.
- Describes key Māori disability and community agencies' roles/functions and entry procedures.
- Demonstrates respect for clients right to refuse access to other assessment reports.

Outcome 2: Service co-ordination respects health as a taonga for Māori and reflects the four dimensions of Māori health: Tinana, wairua, whānau and hinengaro.

Competencies

- Demonstrates knowledge and application of the four dimensions of Māori Health.
- Demonstrates knowledge of Tikanga.
- Demonstrates openness and willingness to include Tikanga in service co-ordination.
- Facilitates needs assessment that includes the four dimensions of Māori Health and Tikanga for Māori clients.

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Outcome 3: Clients are informed of the purpose and process of service co-ordination.

Competencies

- Demonstrates the knowledge of the purpose and process of service co-ordination.
- Recognise communication barriers and responds to individual client needs.
- Demonstrates ability to convey accurate information to the client/advocate
- Seeks client/advocate understanding of information shared.
- Demonstrates knowledge, and situational context for application of the Privacy Act, Code of Rights and Responsibilities and review process.

Outcome 4: A range of options that reflect the client's choice, resources and self-determination are provided.

Competencies

- Demonstrates respect for the client's dignity.
- Demonstrates knowledge of existing service options available.
- Demonstrates ability to think creatively to address service gaps in order to meet individual needs.
- Ability to formulate a range of services options to meet individualised needs.
- Describes eligibility and access criteria and allocation guidelines of publicly funded services.
- Demonstrates the ability to facilitate client decision-making to choose a service option.
- Demonstrates negotiation skills to achieve an outcome which is acceptable to the client and their advocate.

Outcome 5: Service co-ordination is provided by people who are competent and knowledgeable about disabilities, and are able to respond to the diversity of needs and cultures.

Competencies

- Recognises own limitations and competency deficits and accepts responsibility for personal development.
- Demonstrates understanding of disability culture and philosophy.
- Values and demonstrate respect for each person inclusive of disability, gender, ethnicity, sexual orientation, age and spirituality.
- Demonstrates understanding of the broad and diverse nature of disability and demonstrates the ability to individualise service co-ordination.

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- Demonstrates ability to develop and maintain networks with disability support services and community resources.
- Demonstrates ability to develop and maintain networks with disability support services and Māori community resources.

Outcome 6: Service co-ordination is flexible and innovative in the use of resources; ensuring support options provided are consistent with people's prioritised goals and needs.

Competencies

- Demonstrates knowledge of existing service options available for Māori and non-Māori clients.
- Demonstrates ability to identify support needs that require more flexible service options than are currently provided.
- Demonstrates the ability to accurately reflect the client's prioritised needs, goals and abilities in the service option outlined in the support plan.

Outcome 7: Service co-ordination will enable the client's choice of support.

Competencies

- Demonstrates the ability to convey accurate information to the client/advocate.
- Seeks client/advocate understanding of information shared.
- Evidence of transfer of client's support plan to the provider within contracted timeframes.
- Demonstrated ability to negotiate with service provider(s) for timely service provision.

Outcome 8: Client's ongoing needs are met and outcomes are achieved.

Competencies

- Demonstrates ability to convey accurate information to the client/advocate related to review processes.
- Seeks client/advocate understanding of information shared.
- Client records document unmet need.

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4 Intellectual Disability Eligibility Assessment: Guidelines for Requests and Reports

These draft Guidelines, June 2003, have been developed in consultation with:

Organisation	Contact Person	Position
Community Living Trust, Behaviour Assessment Team	Mel Smith Richard Edghill	Psychologist Psychologist
IHC, Behaviour Support Team	Gwen Williams Donna Mitchell	Team Leader National Manager
Disability Support Link (NASC)	Jan White Rachel Daysh	Manager Care Co-ordinator
Access Ability (NASC)	Pip Nicols	Manager
Support Net (NASC)	Mairi Lauchland	Manager
Ministry of Health, Midland Region		Locality Manager
Tanya Breen (Private Practice)	Tanya Breen	Clinical Psychologist
Sharon Brandford, Timata Hou	Sharon Brandford	Clinical Psychologist

These Eligibility Assessment Guidelines were prepared by Rachel Daysh, Registered Psychologist, MNZPsS, NZCER Test Registered.

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INTRODUCTION

These guidelines have been developed as a collaborative effort between both Needs Assessment and Service Co-ordination Agencies (NASC) and Psychologists working in the area of Intellectual Disability. The purpose of this document is to establish accurate and consistent practice in the area of assessment of intellectual disability for the purposes of establishing eligibility to receive services specifically targeted by Ministry of Health intellectual disability service contracts. We have sought national clinical representation and used both national and international standards as outlined in the consultation section below.

These guidelines have been developed in accordance with:

- Psychologists Board and College of Clinical Psychologists, Code of Ethics (2002)
- Test Catalogue, New Zealand Council for Educational Research (2003)
- Psychology Catalogue, Psychological Corporation (2002)
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)(2000)
- ICD-10 Classification of Mental and Behavioural Disorders (1993)

- Mental Retardation: Definition, Classification, and systems of Supports 10th Edition (2002)
- Service Specifications for Behaviour Support Teams (Midland Region)
- Needs Assessment and Service Co-ordination Agency, Service Specification (Midland).

WHAT IS AN ELIGIBILITY ASSESSMENT?

An Eligibility Assessment is the formal evaluation undertaken by a psychologist or other suitably qualified professional to establish if a person has an intellectual disability that is low cognitive ability and significantly limited adaptive functioning. The definition and classification of intellectual disability, as well as the recommended assessment tools and protocols for conducting an eligibility assessment, are outlined in the DSM-IV-TR. Additionally the AAMR (2002) publication, relating to the definition, classification and systems of supports, emphasises the importance of clinical judgement and experience exercised by professionals throughout the process of gathering and interpreting information to reach the formal diagnostic decision. This process is undertaken in order to establish entitlement to services specifically contracted by the Ministry of Health for people with intellectual disabilities and NASC disability services in general.

Roles

It is the psychologist's task to determine if the person has an intellectual disability or not, this is not the role of NASC. It is the NASC role to identify the necessary supports and put these in place once eligibility has been determined. A psychologist might make recommendations within the eligibility assessment report but this is not the primary purpose of this assessment. Recommendations by a psychologist might include further specialist assessment activity, the addressing of safety issues, actions that might be taken to address specific support needs.

The process for eligibility assessment consists of psychometric testing, clinical interviewing, and the review of any available documentation that relates to the person's functioning throughout the developmental period.

According to DSM IV TR and ICD 10 the diagnosis of an intellectual disability is made according to the following diagnostic criteria.

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Cognitive Functioning	Significantly sub-average intellectual functioning. This being an IQ of **approximately** 70 or below on an individually administered IQ test. The level of disability can be further classified as Profound, Severe, Moderate or Mild.
Adaptive Behaviour	**Concurrent** deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self care, home living, social and interpersonal skills, use of community resources, self direction, functional academic skills, work leisure, health and safety.
Onset	The onset is before 18 years of age, sometimes referred to as 'developmental years'. This does not mean assessed before the age of 18, but present before18.
Clinical Interview	This is likely to include an interview with the person, immediate family/whānau members and/or carers and may also include other professionals involved such as psychologists, case managers, psychiatrists, social workers, ministers and teachers. Where possible this may also include an overview of supporting documentation and observation of the client. It is important for any assessor to be aware that the results obtained from standardised assessment instruments are affected by a variety of variables including rapport, socioeconomic status, ethnicity, language, sensory impairments, communication impairments and social and cultural influences. Effective gathering of pertinent information at this point assists with the overall interpretation of these tests and the diagnosis reached at the completion of the assessment.
Clients Unable to be tested	DSM IV TR makes specific provision for psychologists to make a diagnosis of intellectual disability, severity unspecified, when there is a 'strong presumption' that an individual has an intellectual disability but they are unable to be tested by standard tests.

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Notes for NASC	Notes for Psychologists
• **IQ Cut Off:** Diagnostic criteria also allow for consideration to be given to standard error of measurement for the standardised tests used. This allows clinicians the ability to statistically evaluate performances outside this score range that is over 69. These ranges are provided within the test manual. For this reason it is possible for person to be diagnosed with an intellectual disability when their IQ score is above 70 IQ points. NASC should not adopt and apply their own individual IQ cut off scores for entry to services. • Some confusion exists about the IQ score used as a cut off point. The IQ score is not significant to NASC and should not be used as a cut off measure. This number is only important to the psychologist in context with the other supporting information. The important issue for NASC is the concluding diagnostic decision. There should be no expectation on the psychologist to provide this information as to do so contravenes their code of ethics. • Mild intellectual disability is more prevalent than other classifications of disability. Approximately 85% of people with an intellectual disability will be classified as having a mild intellectual disability. Classificatory labels are defined by bands of IQ scores, and have no direct relationship to a person's support needs. • Ministry of Health contracted services are purchased on behalf of people with an intellectual disability. Diagnostic guidelines give very specific instructions about how intellectual disability is to be diagnosed. Therefore it is the presence of the intellectual disability that establishes eligibility to access these services, not NASC guidelines.	• Psychologists should always remain within the guidelines offered in DSM IV TR, any deviation to standard protocol must be supported in by significant clinical reason and discussed in the report to NASC co-ordinators or managers. • It is sometimes helpful to outline the eligibility criteria (DSM IV TR) and offer some explanation in the text of the report. • Regarding onset, it is important for NASC to know when a client meets criteria for age of onset but has their disability resulting from brain injury. This will not affect their eligibility for services but some NASC regions have some specialised facilities and resources available to them for head injured clients.

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WHAT IS THE PURPOSE OF ELIGIBILITY ASSESSMENTS?

The NASC brokers a number of different services available to people with disabilities. Some of these include Carer Support, Respite Care, Buddy Support, Vocational and Day Services, Home Help, Residential Care, Behaviour Support, Social Work and so on. All of these services have criteria for eligibility. Many of these are easily established such as age or evidence of disability such as GP confirmation. However, some services have been purchased by the Ministry of Health specifically for people with intellectual disabilities.

Establishing the presence of an intellectual disability is not a simple process that can be achieved merely by looking at an individual. Therefore definitions as well as psychometric, statistical and clinical evaluative tools have been developed to assist in diagnosis, and enable clinicians to make more objective diagnosis.

It is important to ensure that people have an intellectual disability before they access the services purchased of this group for the following reasons:

- Services have been developed specifically to meet the needs of individuals with intellectual disabilities. These services have not been designed for clients with other support needs. Some clients may have needs in addition to their intellectual disability that may also be accommodated.
- There are limited resources and they need to be protected for the client group for whom they have been purchased.
- Service provision by its very nature can limit potential for people to exercise personal choice and live in the least restrictive environment. Only those individuals who genuinely require additional specialist supports are likely to benefit from them. Any decision relating to eligibility and access to service should reflect the best interests of the person concerned.

Note: What to do If an eligibility assessment has been completed and it is determined that the person does not have an intellectual disability but may have another form of disability?

Other issues that may arise during an eligibility assessment may include the presence or suspicion of head injury, mental health issues, physical disability or an autistic spectrum disorder. These findings should be detailed in the report to NASC. This will allow the service co-ordinator to refer this person to the appropriate support agency or for additional assessment. Not having an intellectual disability does not eliminate the opportunity to receive other NASC services it only precludes those services specifically provided for those with an intellectual disability.

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Notes for NASC	Notes for Psychologists
• It is not necessary to ask for an eligibility assessment for every person accessing NASC Intellectual Disability services. The presence of intellectual disability is sometimes apparent without assessment. There are also some clients with sufficient documentation from GPs and other specialists such as neurologists and paediatricians. • The presence of an intellectual disability does not validate the provision of intellectual disability resources alone. The question to ask is how the client would benefit by the provision of intellectual disability services and what type of service is likely to best meet their needs. • If you are unable to confirm previous diagnosis, if insufficient assessment data are available or if sufficient doubts exist as to whether or not a person is eligible, then request an Eligibility Assessment. • Look for evidence of prior testing. If testing was completed when the individual was a child and the individual is now an adult, or previous testing was incomplete then it may be appropriate to request a further assessment. • Always provide prior assessments to the Eligibility Assessor as this may assist in the prevention of additional testing. • An Eligibility Assessment should be requested when a NASC service co-ordinator is in doubt if a person has an intellectual disability. **Where there is clear evidence, do not request another assessment.**	• If you discover an assessment has only recently been completed, and meets the criteria outlined in this document do not repeat the testing. Please request that this information be provided to the NASC or write a summary report accordingly. • If upon assessment you discover the client's disability is too severe to assess, please refer to the guidelines offered in DSM IV and notify the NASC accordingly. • If a full assessment is unable to be completed please summarise your findings for the NASC and discuss possible alternatives to establish diagnosis.

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WHO SHOULD CONDUCT ELIGIBILITY ASSESSMENTS?

According to the Psychologists Ethical Code (2002) only psychologists practising in their field of expertise should conduct these assessments. This means psychologists with experience working specifically in the field of intellectual disability. According to the NZCER test user guidelines, tests should only be administered and interpreted by those with training and experience to use and interpret them with professional care.

In New Zealand the necessary credentials for conducting a formal eligibility assessments are:

- being a Clinical Psychologist or
- being a Registered Psychologist or
- completing appropriate post-graduate university papers in the administration and interpretation of psychometric tools and becoming registered as a test user with the New Zealand Council for Educational research. Standard psychometric tools to assess cognitive functioning require Level C test user registration.

In addition to having the above academic qualifications and training, it is highly desirable that the assessor has a reasonably extensive work experience in the field of intellectual disability, or be NZCER authorised test registered psychologist working in their field of expertise, in this case intellectual disability.

Notes for NASC	Notes for Psychologists
• When an initial request for Eligibility Assessment is made to a psychologist ensure you are making the request of an appropriately qualified and experienced person. You may like to ask if they are currently, or have previously, practised specifically in the area of intellectual disability, are a registered psychologist or have NZCER test user registration. It is unlikely that any psychologist would mind offering their credentials. (If anyone is unsure you could offer these guidelines as support).	• Please refer to your own code of ethics and NZCER and Psychological Corporation guidelines to ensure you have appropriate training and expertise. • Psychologists should use professional judgement and not present as experts in the field of intellectual disability unless they have significant and recent expertise in the field.

WHAT SHOULD A REQUEST FOR ASSESSMENT INCLUDE? (REQUEST FOR ASSESSMENT GUIDELINES)

Request for an eligibility assessment needs to be very specific and should be accompanied by any appropriate supporting documentation. The request should state identifying information and supply contact details for the person and an appropriate alternative contact or support person. The request should specifically ask an Eligibility Assessment to be undertaken to determine eligibility to receive intellectual disability services through NASC.

Notes for NASC	Notes for Psychologists
• Be specific in your request. State that you are requesting an assessment of cognitive (intellectual) and adaptive functioning to determine if the person has an intellectual disability. State that this assessment will establish the persons eligibility to receive specialised intellectual disability services resources. • Ensure you always include contact details. • Documentation that would be of assistance to the psychologist may include recent needs assessment, any previous assessments, social history, school records, other professionals assessments.	• If you do not feel you have a clear request for services or you do not have sufficient information to commence an assessment then contact the referrer.

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WHAT SHOULD AN ELIGIBILITY REPORT CONTAIN? (REPORT GUIDELINES)

There is no one specific format that is or should be required for Eligibility Assessments, however there are basic requirements that should be met by each report. A report should outline:

- date of the report, date of the assessment
- identifying information
- who requested the assessment and what was requested
- people and documentation consulted
- background information, family history, schooling, employment, previous service or specialist involvement, medical conditions and medication, other diagnosis, significant life events
- current situation
- psychometric test information and interpreted results
- any relevant findings that have bearing on the referral question
- summary and conclusions including the clear statement as to whether or not the person has an intellectual disability
- recommendations
- psychologist's signature and qualifications.

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Notes for NASC	Notes for psychologists
• If you are unsure if all of the required information is in the report speak directly with the writer. It might be necessary to be provided with a copy of these guidelines. • Eligibility outcomes should always be provided to you in report format and not verbally, in accordance with the guidelines above. • It is standard practice for psychologists to forward a copy of their report to the person subject to the assessment for comment and information. The final report will be sent directly to the NASC. It is the responsibility of the co-ordinator to ensure the person has a copy of the report. If the person is found not to have an intellectual disability it is the responsibility of the NASC to inform the person and discuss appropriate options.	• Eligibility reports have been requested for a specific purpose and are contracted on the basis of specific costs and time intervals. If you are asked for more than the requirements of a basic eligibility assessment you need to discuss this with the referrer. You may like to refer to or provide these guidelines. • If, while assessing, you have additional findings and see the need for other areas of work required make these recommendations additional to your eligibility findings. Do not undertake additional work without consultation with the NASC. • Ensure both the interpreted findings of cognitive assessments and adaptive behaviour scales such as VABS and ABS are outlined in the report. • Provision of raw scores contravenes the code of ethics and can lead to confusion when scores appear to contradict a diagnosis. • Be specific in your conclusions or recommendations about the outcome such as 'Mark is a young man with a mild intellectual disability'. Do not assume that NASC staff will reach this conclusion based on psychometric outcomes. • Provide a rational if standard assessment or testing procedures were not followed. • Be aware when using the classificatory label 'mild' when reporting findings. This term can often be interpreted as the person only having a slight disability. It can be helpful to offer good explanation of terms or offer percentile ranks such as comparative to the whole population.

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5 Out of Home Placement for Children and Young People

Disability Services Directorate (DSD) of the Ministry of Health is responsible for the provision of disability support services to children and young people with disabilities in accordance with the Ministry of Health definition of disability.

Children are subject to specific operational policy and protocol.

- Children's developmental needs are specific and arise from achieving developmental tasks within families en route to adulthood.
- Under the overarching *New Zealand Disability Strategy*, the Ministry of Health has committed to national consistency and equity of access across the population groups.
- Children at present are a unique population group in disability support services. This population has a huge interface with education and health resulting in a direct shift in focus and service use that is not experienced by other population groups.

In some circumstances parents have difficulty looking after their children or young people with disabilities. The necessity for an out of home placement is most likely to occur for children and young people with disabilities who have high and complex needs, requiring a level of care that is beyond the coping abilities of the family and where all options for supporting the family so that the child can remain at home have been explored and exhausted by the NASC.

The Disability Services Directorate of the Ministry of Health has developed policy and requirements for children and young people with disabilities who have complex needs and may require placement outside the family home.

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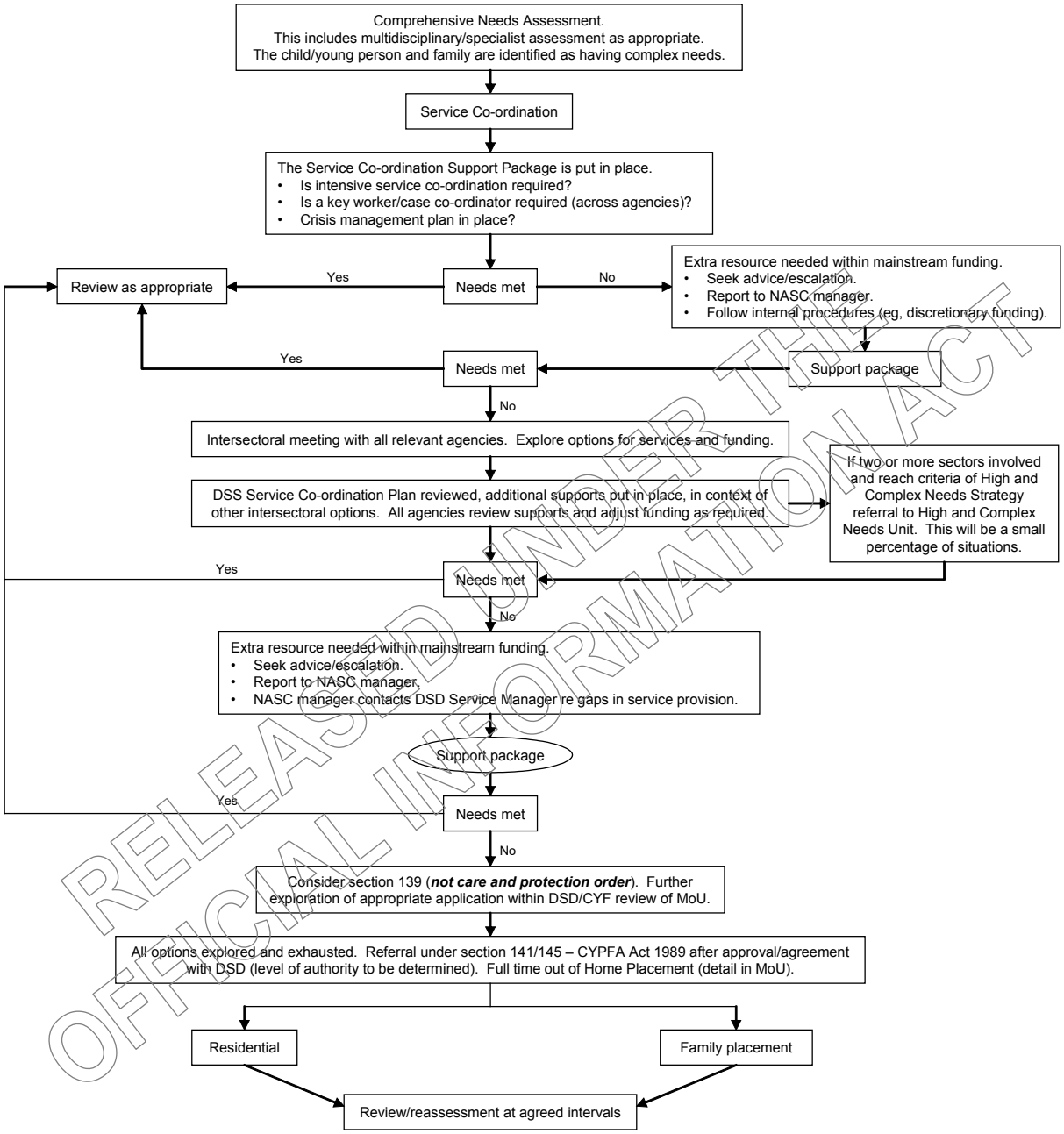
MINISTRY OF HEALTH MEMORANDUM DDG TO NASCS, JANUARY 2004 (EXTRACT)

Subject: Clarification of DSD Policy where Out of Home Placement may be necessary for Children and Young People with Disabilities under 16 years of age.

The purpose of this document is to provide information regarding DSD contracted NASC process and DSD policy to be followed prior to a section 141/145 agreement under the CYPFA 1989 Act. This document was developed in response to a request to provide clarification of DSD policy relating to residential care for children and young people under 16 years of age.

This document outlines the DSD required practice in the process of responding to children and young people with disabilities who may require placement outside the family home. Further review of this process will take place within the review of policy surrounding the Memorandum of Understanding which the Disability Services Directorate and the Department of Child, Youth and Family Services are currently undertaking.

Policy/Process for DSD Contracted NASC to Follow when Out of Home Placement may be necessary for Children and Young People with Disabilities



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Principles for Out of Home Placement

Residential out of home placement will be considered as an option following agreed principles.

1. There is an expectation that NASC processes are followed.
2. No options are excluded prior to or separate from the process, therefore other interfacing processes for complex situations are followed.
3. There are expectations that family/whānau will be fully involved with the entire process.

NASC and Care and Protection Issues

The Department of Child, Youth and Family Services (CYFS) is responsible for the provision of care and protection and youth justice services to 'all children and young people'. CYPS has legislative powers that enables it to act on behalf of the child or young person's welfare and interests.

Sections 15 to 19 of the Children, Young Persons and Their Families Act 1989 (3) are applied in situations where a child or young person with a disability is in need of care and protection. This is when an out of home placement may become necessary due to the family's neglect, ill treatment or abuse of the child and not because of the child's disability support needs.

In these circumstances a notification must be made to CYFS under section 15 of the Act. Such a notification can be made by phoning the On Duty Intake Co-ordinator at the CYFS Call Centre (0508 326 459). NASC may sometimes make this referral if it is the first to identify the risk to the child.

Following a notification, it is the responsibility of CYFS to investigate the immediate risk to the child or young person within a specified timeframe. It will take immediate action to ensure their safety, which may mean uplifting the child from the family home. In some instances it may be necessary for the police to become involved. A referral is then made for a Family Group Conference under section 20 of the Act.

The NASC organisation needs to be involved in any Family Group Conference for children with disabilities. CYFS is required to fund an out of home placement where there are care and protection concerns such as severe neglect and abuse. CYFS may direct that the child live with other extended family or a full-time foster placement may be provided by one of the department's own foster care families. In these instances the NASC is required to facilitate a needs assessment and allocate a level of support that recognises the additional support needs of the child with a disability. This support is in addition to what CYFS is required to provide to support the child's full-time placement. In most instances an allocation of Carer Support days is granted by the NASC manager to give the full-time carer time out.

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Resources

Department of Child, Youth and Family Services. URL: www.cyf.govt.nz

Copies of the Children, Young Persons and their Families Act 1989 can be purchased from government bookstores.

Foster Care

Services providing foster care placements for children and young people for CYFS must operate in accordance with certain legislative requirements under the Children, Young Persons and Their Families Act 1989. They are required to undergo an accreditation process to be approved as a registered Child and Family Service.

These services are monitored regularly to ensure that their practice and policy remain in compliance with the standards set.

Different arrangements exist for any foster care provided through DSD; these details need to be confirmed with DSD Service Managers.

DRAFT MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES AND THE HEALTH FUNDING AUTHORITY (1999)

This MoU was developed to assist in managing and funding services to children and young people with intellectual and physical disabilities to facilitate comprehensive service provision for this population group in the context of their families.

The MoU is a comprehensive document that outlines the roles and responsibilities of both agencies, in particular funding responsibilities. It also provides case studies, practice guidelines for both parties and information about service models.

It is important for all NASC managers and service co-ordinators to familiarise themselves with both DSD out of home policy and the above MoU, as documented in this appendix, before considering an out of home placement for a child or young person.

The MoU document has been distributed to all NASCs. Further copies are available by contacting the Disability Services Directorate at the Ministry of Health.

A review of the Memorandum of Understanding is planned during 2004/05.

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6 Regional Intellectual Disability Care Agency

Regional Intellectual Disability Care Agency (RIDCA) is a specialist service for people with an intellectual disability whose behaviour poses serious risk of physical harm to themselves or others. These behaviours may have resulted in the person not being able to access mainstream service or in a breach of the law.

There are two streams to RIDCA services, available to:

1. those clients meeting the statutory requirements of having an intellectual disability and having committed a serious offence
2. those with high and complex needs meeting the eligibility criteria of posing serious risk of physical harm to themselves or others.

To assist services to identify the differences between the two streams, those clients meeting statutory requirements will be referred to as **IDCCR** (Intellectual Disability Compulsory Care and Rehabilitation) **clients** and the high and complex needs group will be referred to as **RIDCA clients**.

It is important to note that not everybody who commits an offence may be placed under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and it may be that similar pathways as previously used, such as the Protection of Personal and Property Rights Act 1988 and supervision orders, are deemed more appropriate in meeting individual need.

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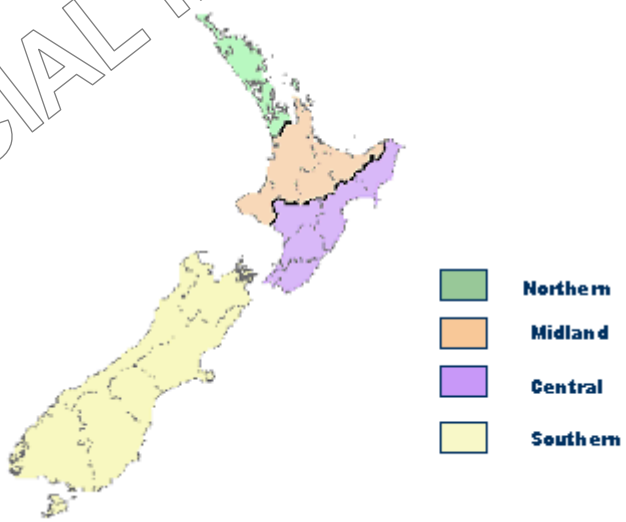
RIDCA Regional Boundaries



RIDCA CONTACT DETAILS AS AT DECEMBER 2004

Northern

Access Ability, PO Box 23725, Hunters Corner, Papatoetoe, Auckland.

Midland

Disability Support Link, PO Box 9201, Hamilton.

Central

Capital Support, PO Box 50137, Porirua.

Southern

Canterbury-Nelson: Lifelinks, PO Box 2379, Christchurch.
Otago–Southland: Access Ability, PO Box 966, Dunedin.

BACKGROUND TO THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT 2003

The Mental Health Act 1969 was replaced by the Mental Health (Compulsory Assessment and Treatment) Act 1992. The new Act introduced a new definition of mental disorder which excluded people who had an intellectual disability.

These changes, and changes that had been made to the Criminal Justice Act 1985, then left a gap which meant that the courts could not place individuals with an intellectual disability under the Mental Health Act 1992 as an alternative to sending them to prison or discharge them into the community.

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Purpose of the IDCCR Act

The IDCCR Act was designed to:

- provide courts with appropriate compulsory care and rehabilitation options for people who have an intellectual disability and who are charged with, or convicted of, an imprisonable offence
- recognise and safe guard the special rights of individuals subject to this Act
- provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system can remain subject to this Act.

REFERRAL

Referrals to RIDCA can be made from NASC organisations, Corrections Services, Courts and other mental health and disability support services. Referrals should be made on the RIDCA referral form with information/documentation demonstrating that the individual meets the RIDCA eligibility criteria.

Eligibility Criteria

RIDCA services are available to:

- any person referred for assessment under the IDCCR Act or under section 47A of the Mental Health (Compulsory Assessment and Treatment) Act or

- any person subject to compulsory care orders made pursuant to the IDCCR Act or
- any person who meets the following criteria.

Eligibility criteria for accessing services for all people with intellectual disability and high and complex behavioural support needs are:

Contract Criterion		**We take this to mean ...**
Intellectual Disability		Any person referred for assessment under the IDCCR Act or under section 47A of the Mental Health (Compulsory Assessment and Treatment) Act. Any person subject to compulsory care orders made pursuant to the IDCCR Act. Has a clear and assessed intellectual disability according to standard psychometric measures and with significant adaptive behaviour deficits in at least two areas, evident in developmental years.
Whose behaviour poses serious risk of physical harm to self/ others		Distinction is by way of likely outcome (serious harm), and the likelihood of the event occurring (serious risk) – that is, there is a likelihood of risk of serious harm to the person or others arising from the behaviours. The source of the harm is from behaviour related to their intellectual disability, rather than from health conditions or extremely high support needs. Serious harm means death, permanent injury, psychological trauma, harm requiring acute medical care. High risk of harm to themselves includes suicide attempts, exposure to hazards, self harm requiring medical intervention. High risk of harm may arise when the person behaves in ways that increase their or other's vulnerability to harm such as unsafe sexual practices, sexual exploitation, or an itinerant lifestyle which increase vulnerability to assault.
And either	Access to mainstream or community options is limited or prevented	Documentary proof of refusal of disability services to provide care. Documentary proof that all appropriate steps have been taken to support the person in mainstream services. Or that the person has refused to participate in or has withdrawn from programmes or services.
Or	Manifests a psychiatric disorder, or substance use disorder	Has co-existing mental disorder (not necessarily clearly diagnosed at time of referral) and where the management is unable to be achieved within the client's current service, ie, requires a degree of clinical mental health oversight within the disability service. Where the person's management is unable to be achieved within the client's current service ie, requires a degree of clinical mental health oversight within the disability service. Documentary proof that all appropriate steps have been taken to support the person in mainstream services. Where drug or alcohol abuse increases the risk behaviour.
Or	Behaviour results in a breach of the law	Recent history of serious and or repeat involvement with the police or criminal justice system.

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The decision of whether to accept or decline a client who has not offended but does have high and complex behavioural needs lies with RIDCA.

Exclusions

RIDCA will not provide a service for clients with an intellectual disability who:

- require an assessment solely as a result of a mental health need
- have needs that can be more appropriately assessed and met by generic NASC services (according to the principle of least restrictive intervention).

NEEDS ASSESSMENT

To determine if the person meets the eligibility criteria for RIDCA (RIDCA client) it needs to be ascertained if the person has a diagnosed intellectual disability and then from there determine/confirm the level of risk through a comprehensive needs assessment completed by the RIDCA Care Co-ordinator or Intensive Service Co-ordinator. This involves consultation with the person, family, present and past service providers, and clinicians involved in supporting the person. Once the needs assessment has been completed a request for services is developed in consultation with the person, their family and the service provider of choice.

When an application for a person to be a care recipient has been made under the IDCCR Act the process of needs assessment is a legal requirement of the Act. There are timeframes and other processes within the Act that need to be adhered to. Within the IDCCR Act there are designated roles. These include the Compulsory Care Co-ordinator, Specialist Assessor/Medical Consultant and Care Manager.

Care Co-ordinator

The Care Co-ordinator is appointed by the Director-General of Health and employed by the RIDCA.

The role of the Care Co-ordinator is to be the administrator of the Act. Tasks include:

- needs assessment
- designation of Care Managers
- designation of Specialist Assessor(s)
- determination as to when application to the court for compulsory care order is appropriate
- approval of care and rehabilitation plan
- six months after initial approval of care and rehabilitation plan, reporting to Family Court on appropriateness of the order and plan
- recommendations to the court where orders are changed.

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Specialist Assessor/Medical Consultant

The Specialist Assessor/Medical Consultant is an appropriately qualified health or disability professional who is for the time being designated by the Director-General of Health for the purposes of the IDCCR Act.

It is the role of the Specialist Assessor to:

- determine whether the proposed care recipient has an intellectual disability and is in need of compulsory care
- assess the level of care that is required to manage the risk that the care recipient's behaviour poses to the health and safety of the care recipient or of others
- six months after initial care and rehabilitation plan approval, report to the Family Court on the appropriateness of the plan and the continued appropriateness of the order.

The role of the Medical Consultant incorporates the following requirements.

- Medication being given for the purpose of managing the condition for which compulsory care is required can only be given with the support of a second opinion given by a medical consultant designated by the Director-General under section 180 of the IDCCR Act.
- Doctors authorised under this section must be specialists who have experience/ expertise in intellectual disability.
- The process of the opinion should include review of care plans, discussion with the prescribing medical specialist, the care team and examination of the person where required.

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Care Manager

The Care Manager is designated by the Compulsory Care Co-ordinator for a person under the IDCCR Act and is employed by the Regional Intellectual Disability Supported Accommodation Service (RIDSAS), Regional Intellectual Disability Secure Service (RIDSS) or Community Liaison Team.

The role of the Care Manager includes:

- providing input into needs assessment
- participating in case conferences
- preparing a care and rehabilitation plan
- setting out a care programme
- explaining to the care recipient their rights under the IDCCR Act
- being legally entrusted with the care of the care recipient
- when required by the Family Court, preparing reports for the purpose of reviewing care recipient's compulsory care order and care and rehabilitation plan.

SERVICE CO-ORDINATION

Once needs are identified, RIDCA assists in the development and co-ordination of services including links to services such as supported accommodation, supported living, vocational support, planned respite and Community Liaison Teams. For RIDCA clients this may mean a change in service provider to a RIDSAS or additional supports and services being provided to the person in their established home.

If the person meets the eligibility criteria for RIDCA or is made a care recipient under the IDCCR Act, they are able to access services from the RIDSAS. It is the function of the RIDSAS to provide a community-based residential service with intensive supports ensuring security and physical safety within the person's home and the community. Care recipients under the IDCCR Act will have their care requirements determined by the court through the signing off of Care and Rehabilitation Plans and Care Programmes. Changes to these programmes will need to be taken back to court for approval.

Referrals to the RIDSAS and RIDSS are managed by RIDCA. The level and type of service the individual receives reflect individual need and have to be agreed with RIDCA.

It is the responsibility of the RIDSAS to ensure that the person has an individual plan developed in conjunction with the person, family/whānau and RIDCA. For IDCCR clients this is a legal requirement. It is also expected that clients of RIDCA remaining in generic services will have plans, and support can be provided to develop these by the Community Liaison Team.

An individual plan includes:

- the person's short- and long-term goals and timeframes for achievement
- the supports, activities and inputs required to achieve the goals
- family/whānau/friends/advocate involvement
- skills attainment
- recognition of Māori and other cultural aspects
- assignment of responsibilities for implementing goals
- acknowledgement of risk factors in the achievement of goals
- transition goal setting.

It is the responsibility of the RIDSAS to ensure that specific treatment, learning-based programmes, and behavioural support is provided both from within the service by appropriately skilled people and by accessing, with the assistance of the RIDCA, any additional specialist services that may be required.

Risk management is addressed through the formulation of a plan that has agreed strategies for managing behaviours, crises and incidents and for responses to be made, including communication with family and others.

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REVIEW

RIDCA maintains an ongoing role by monitoring and reviewing the supports and services being provided to the person. The individual plans are reviewed at least six-monthly, with multidisciplinary team input or when there are significant changes in the person's needs. For those under the IDCCR Act this includes meeting the requirements of the Act.

EXIT

All people leaving RIDCA services will do so in a manner that is planned. For RIDCA clients the readiness for exit will be determined through a process of review and supported transition with NASC organisation involvement. The RIDCA will continue to be available for consultation after the exit of the client.

For IDCCR clients exit will be through the process of review and court orders meeting the requirements of the IDCCR Act.

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7 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) is a companion Act to the Criminal Procedure (Mentally Impaired Persons) Act 2003, and will allow the courts to make a compulsory care order for people with an intellectual disability who are charged with or convicted of an imprisonable offence.

The purpose of the IDCCR Act is to:

- provide courts with appropriate compulsory care and rehabilitation options for people who have an intellectual disability and are charged with or convicted of an imprisonable offence
- recognise and safeguard the special rights of people subject to this Act
- provide for the use of different levels of care.

The three ways in which people can become subject to the Act are by:

1. an order made in the course of criminal proceedings
2. transfer from prison
3. transfer from the Mental Health (Compulsory Assessment and Treatment) Act 1992 for special patients or former special patients.

The creation of interfaces between the key agencies involved in operationalising the new legislation will be led by the Ministry of Health. These agencies include Police; Housing; Child, Youth and Family; Courts; Corrections; and DHB Mental Health Services.

The Ministry of Health will also be supporting residential services that deliver on the care options outlined in the Act.

PROCESS

In consultation with the person, their family/whānau and the health specialists involved in the care of the intellectually disabled offender, the needs assessment is completed and a care and rehabilitation plan devised.

A compulsory care order is then made to detain the person as a care recipient. This can be made for up to three years' duration and may be extended by the Family Court if it considers that a care recipient continues to pose serious danger to themselves or others.

Regular reviews and reports to the Family Court will reflect the continued appropriateness of the care and rehabilitation plan.

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LEVELS OF CARE

There are two levels of care depending on the risk to the person and the community. The person may be ordered to receive secure care, either in a hospital or secure community-based facility, or supervised care which is community based.

The Act contains a number of statutory powers to enforce care orders.

STATUTORY SAFEGUARDS FOR PEOPLE IN CARE

Safeguards include:

- a court review of terms and conditions of a compulsory care order six months after its commencement
- ongoing six-monthly reviews of the care order
- independent monitoring of the care order by a district inspector
- the ability for a High Court judge to inquire into any matters relating to a person under this Act as the judge sees fit.

In addition to the rights of a consumer under the *Code of Health and Disability Services Consumers' Rights*, the person has a number of specific rights guaranteed by the Act.

RELEASE FROM COMPULSORY CARE

A person can be released from compulsory care if:

- they are sent back to court, in the case of an individual formerly found unfit to plead, and subsequently are sentenced to a prison sentence
- the compulsory care order expires
- a Family Court cancels a person's compulsory care order on application by a co-ordinator
- a decision for release is made following an inquiry carried out by the High Court judge.

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8 High and Complex Needs Unit

The purpose of the High and Complex Needs (HCN) Unit is to identify through intersectoral case management those children and young people with the highest and most complex unmet needs across at least two of three sectors (health and disability; education; and social services) who would benefit from HCN funding. Children and young people receive funding and associated intensive support through the approval of a one-year plan and then are transitioned back to mainstream or adult services.

Eight intersectoral teams are developing and implementing innovative joint service responses with HCN funding and support throughout the country. At this stage the fund is fully committed for 2004/05 and beyond.

The threshold for access to the exceptions funding is very high. As noted above, children and young people accessing it must have service needs in at least two of three sectors (health and disability; education; and social services). Their needs will be severe, of long-standing duration (over 12 months) and unable to be met by the core services in each sector.

The exceptions funding is subject to the following criteria.

The individual has a range of high and complex needs where needs result in either risk of harm to self or others (interpreted with a broad understanding of harm); **or** there is medical frailty; **and**

- the individual has been presenting in at least two sectors with an intensity of needs sustained over a period of at least 12 months; **and**
- the individual requires unusual intensity of care; **and**
- in the opinion of two specialist practitioners from different sectors (not directly involved in case management), the individual:
  - has needs that cannot be catered for adequately through the provision of existing services or through planned services in timeframes that take into account the needs of the child or young person; **and**
  - has ongoing, persistent and complex needs that would require a period of at least one year to stabilise and address before it could be expected that the individual could return to existing services; **and**
- individualised care and support are required, with active service co-ordination, services purchasing, and service management to develop and manage the number and complexity of services required to stabilise and improve outcomes; **and**
- the individual is under 17 years old, or is under 21 **and** agencies have explored all opportunities for accommodation within adult services **and** all available adult services have been established as unsuitable; **and**
- the circumstances place the family or alternative caregivers under extreme stress or they are severely compromised in their ability to provide adequate care.

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The process works on intersectoral casework already occurring around the child or young person. The intersectoral casework may be using either the Strengthening Families Case Management model or other intersectoral forums operating within a given geographic area. Local HCN managers will need to support the decision to apply, to ensure that all local solutions have been explored, establish that the individual is among those with the highest and most complex unmet needs in the locality, and to ensure that local managers are aware of all applications from their locality. This is called **local prioritisation**.

The HCN processes have been developed to ensure that children and young people are accepted for funding on principles of consistency and equity, and have equivalent levels of unmet need, regardless of what part of the country they come from.

The HCN Unit seeks to work in partnership with local intersectoral teams as they develop their plans, based on acceptable clinical understandings and inspirational thinking about effective practice, and Plan Advisors are available to offer active support. The advisors will continue their support throughout the development of the plan, its implementation and review to achieve the best outcomes for these children and young people.

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REFERRALS INTO HIGH AND COMPLEX NEED UNIT

Referral practice for NASCs follows the out of home placement policy and protocol outlined in Appendix 5.

Some children with a disability are funded by HCN. In some cases the need to address behavioural or safety issues that threaten the success of long-term support for children or young people with a disability may present. If these needs **cannot** be met through the services available in the area where the child lives, and if local service managers agree they should be prioritised, the HCN Unit will accept these referrals. Planning for young people can then incorporate short-term intervention set in the context of a longer-term support plan. Where the child has ongoing support needs that existing services cannot support to the level required, the NASC manager needs to take this up within the sector concerned. The HCN Unit is happy to support the process but is unable to provide long-term funding for this group of young people.

CYFS July 2004

9 DSD Mandatory Communication Tools, November 2004

These letters of information for disabled people and communication tools have been provided by the Ministry of Health to support the provision of information being delivered in a nationally consistent manner.

9.1 For use when a person has been newly assessed and is eligible for funding. It is expected you would speak to the person first and follow up with this letter.

Dear

Re: Your assessment for disability support services

You recently participated in an assessment by (NASC name), on behalf of the Ministry of Health, for support services to assist with your disability.

You are eligible for Ministry of Health funded disability support services. From (date) you will receive the following disability support package:

(SUPPORT PACKAGE DETAILS HERE)

The Ministry of Health has criteria that (NASC name) uses for assessing the support needs of people with disabilities.

Allocation must be prioritised so the highest level of need across the population is met and that a national level of consistency is achieved to ensure all people access a fair level of funded services.

As advised, everybody receiving Ministry of Health funded disability support services also has a periodic review of their support package to ensure it is appropriate and working well.

You can contact (NASC name) at any time for reassessment if your circumstances and support needs change significantly.

If you have any questions please contact me and we can discuss your situation.

If you are not happy with this decision you can speak to (name of NASC manager), Manager (NASC name), and ask for a review of the decision.

Yours sincerely

(Designated NASC person)

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9.2 To be used when a person is likely to experience delay in the start of a service that they have been assessed as eligible for. It is expected you would speak to the person first and follow up with this letter.

Dear

Re: Your assessment and referral for (Supported Independent Living package/Household Management support)

You recently participated in an assessment by (NASC name), on behalf of the Ministry of Health. You were assessed as needing the following services:

(SUPPORT PACKAGE DETAILS HERE)

Although your application meets the current Ministry of Health access and eligibility criteria, there is a delay in the implementation of your package of services.

This is because when deciding who has priority for disability support services, NASC organisations are directed by the Ministry of Health to give priority to those people whose health or safety may be at risk if they do not receive those disability support services.

If you have any questions or if your circumstances change, please contact (NAME of contact person and phone contact details) who can arrange for another assessment to be carried out.

You will be contacted in (TIMEFRAME) to discuss the implementation of your support package.

If you are not happy with this decision you can speak to (name of NASC manager), Manager (NASC name) and ask for a review of the decision.

Yours sincerely

Service Co-ordinator

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9.3 For use when a person has been newly assessed and declined DSD-funded disability support services (other than equipment) and is eligible for funding through other agencies. It is expected you would speak to the person first and follow up with this letter.

Dear

Re: Your assessment for disability support services

You were recently referred to (NASC name) for assessment for support services to assist with your disability.

The assessment has established that you do not meet the access and eligibility criteria for Ministry of Health funded disability support services.

However, you may be eligible to receive funded services through (FUNDER NAME).

As we have agreed, you will contact (specify department and contact details) at the (FUNDER NAME).

If you have any further questions, please contact me and we can discuss your situation.

If you are not happy with this decision you can speak to (name of NASC manager), Manager (NASC name), and ask for a review of the decision. (NASC name) can arrange for a different person to review your situation.

Yours sincerely

(Designated NASC person)

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9.4 For use when a person has been declined DSD-funded disability support services (other than equipment) and is not eligible to funding through other agencies. It is expected you would speak to the person first and follow up with this letter.

Dear

Re: Your assessment for disability support services

You were recently assessed by (NASC name), on behalf of the Ministry of Health, for disability support services.

Your needs have been placed in order of priority amongst all those people seeking disability support funding at present. As your need for disability support services has been assessed as having a lower priority you do not meet the criteria for accessing support services at present.

The Ministry of Health has criteria that (NASC name) uses for assessing the support needs of disabled people. Allocation of services must be prioritised so the highest level of need across the country is met and that a national level of consistency is achieved to ensure all people access a fair level of funded services no matter where they live.

If you have any questions or if your circumstances or needs change, please contact me and we can discuss your situation.

If you are not happy with this decision you can speak to (name of NASC manager), Manager (NASC name), and ask for a review of the decision.

Yours sincerely

(Designated NASC person)

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9.5 For use when a person's package has been changed. It is expected that you would speak to the person and follow up with this letter.

Dear

Re: Your reassessment/review of your disability support services

You recently participated in a reassessment of your support needs by (NASC name), on behalf of the Ministry of Health, in relation to the support services you receive to assist with your disability.

This is a routine process of review/reassessment which all people funded through the Ministry of Health go through periodically to see if their support needs have changed.

As your needs have been reassessed as having a lower/higher priority your package of services has changed. From (date) you will receive the following disability support package:

(SUPPORT PACKAGE DETAILS HERE)

The Ministry of Health has criteria that (NASC name) uses for assessing the support needs of disabled people. Allocation of services must be prioritised so the highest level of need across the country is met and that a national level of consistency is achieved to ensure all people access a fair level of funded services no matter where they live.

If you have any questions or if your circumstances or disability support needs change, please contact me and we can discuss your situation.

If you are not happy with this decision you can speak to (name of NASC manager), Manager (NASC name), and ask for a review of the decision. (NASC name) can arrange for a different person to review your situation.

Yours sincerely

(Designated NASC person)

9.6 For use when a person has been reassessed and no longer meets access or eligibility criteria for DSD-funded support. It has been agreed that all people in this situation will be referred on to another funder. If there is no funder the disabled person will be retained within the Ministry of Heath until a process has been put in place. It is expected that you would speak to the person and follow up with this letter.

Dear

Re: Your reassessment/review of your disability support services

You were recently reassessed by (NASC name), on behalf of the Ministry of Health, for the support services you receive to assist with your disability. This is a routine process of reassessment which all people funded through the Ministry of Health go through periodically to see if their needs have changed.

The assessment has established that you no longer meet the access or eligibility criteria for disability support services funded through the Ministry of Health, Disability Services Directorate. However, you do meet the access and eligibility criteria for (NAME OF FUNDER).

As agreed, we have referred your file on to (NAME OF FUNDER). We will continue to fund your existing package of services until (NAME OF FUNDER) has completed their assessment process and alternative support services have been agreed.

(NAME OF FUNDER) will be in touch with you shortly to discuss your situation. If you do not hear from them within one month of this letter, please contact me.

If you have any questions or if your circumstances or needs change, please contact me and we can discuss your situation.

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If you are not happy with this decision you can speak to (name of NASC manager), Manager (NASC name), and ask for a review of the decision. (NASC name) can arrange for a different person to review your situation.

Yours sincerely

(Designated NASC person)

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10 DSD NASC Fact Sheet

Note: This Fact Sheet and the FAQs in Appendix 11 were provided to DSD-funded NASCs in November 2004 for use across all stakeholders.

Disability Services Directorate (DSD), Ministry of Health, will fund approximately $670 million of disability services for the financial year 2004/05.

There has been a baseline increase in funding for 2004/05 for DSD funded disability support services. This increase will largely be offset by one-off funding from 2003/04 not being available in 2004/05. This means available funding in 2004/05 will be approximately the same as 2003/04. Funding has not been cut.

As a government department the Ministry of Health receives an appropriation of money from government called Vote: Health. The Ministry of Health is subject to laws which mean it has to manage its spending within the budget set by the Vote: Health appropriation. Like businesses or private individuals government departments cannot spend money they do not have and DSD has to manage its resources to stay within budget.

Disability support services funded by DSD include:

- residential accommodation for disabled people not able to continue to live in their own homes
- environmental support services including wheelchairs, ramps and equipment to assist people to continue to live in their own homes
- vehicle and home modifications
- needs assessment and service co-ordination
- home support and carer support
- disability information
- respite care and rehabilitation.

Expenditure on disability support services funded by the Disability Services Directorate of the Ministry of Health has grown over the last few years.

This growth can be attributed to a number of factors including the increased costs of technology which derive from providing people with more modern or technologically advanced equipment to enable fuller participation in society. This growth can also be attributed to widening of accessibility criteria and increased demand due to population increases and heightened expectations from people with disability as a result of attitudinal and societal changes promoted in the New Zealand Disability Strategy.

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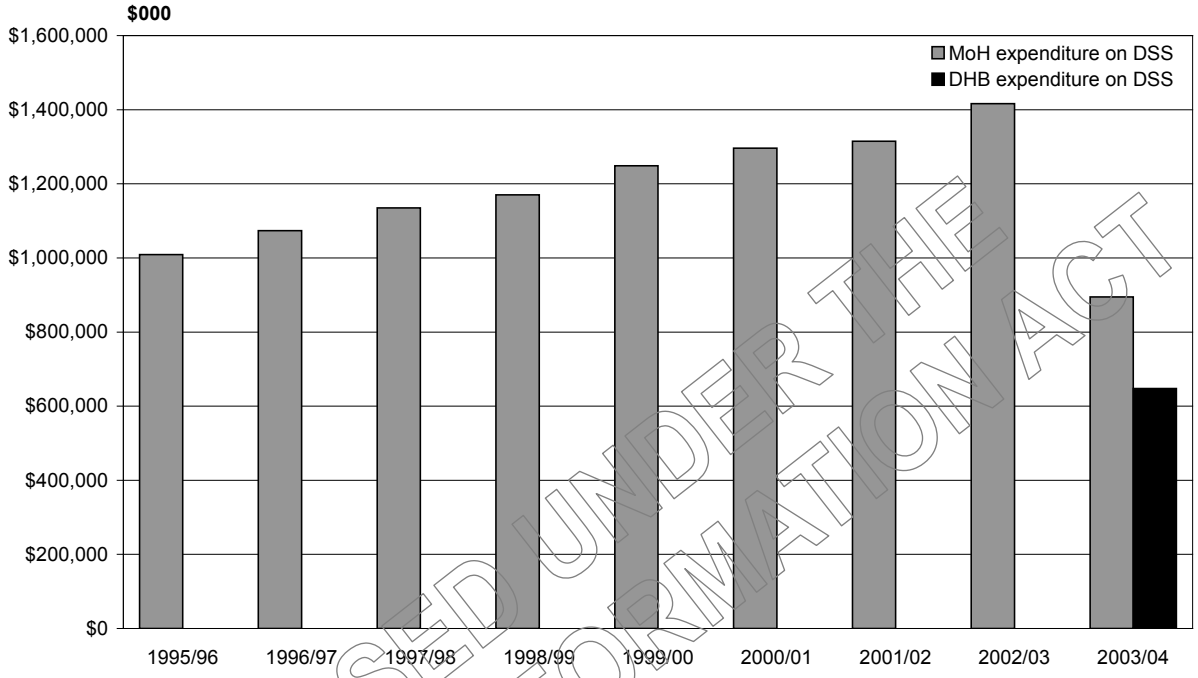
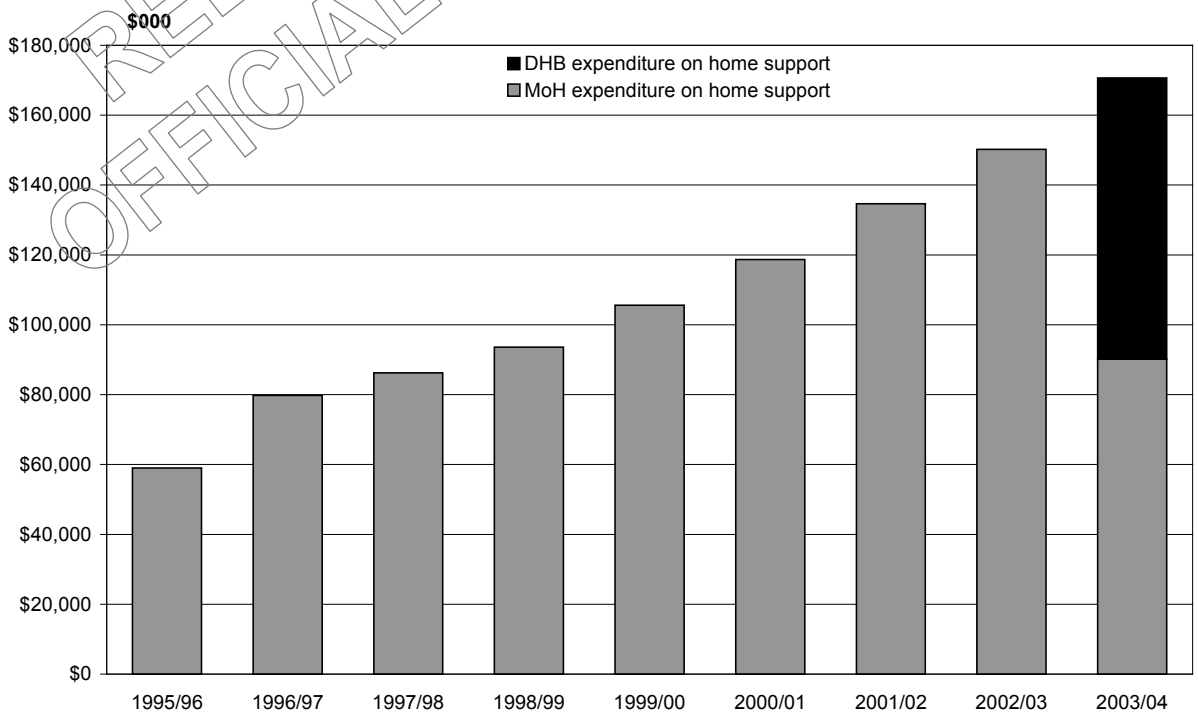
Note for this chart: Because the Ministry of Health devolved funding for older people in October 2003 to the DHBs the chart below includes overall expenditure in 2003/04 for both Ministry of Health expenditure and the devolved DHB expenditure for the period October 2003 to June 2004.

DSD-funded Disability Support Services Expenditure, 1995/96–2003/04



Home Support Expenditure, 1995/96–2003/04



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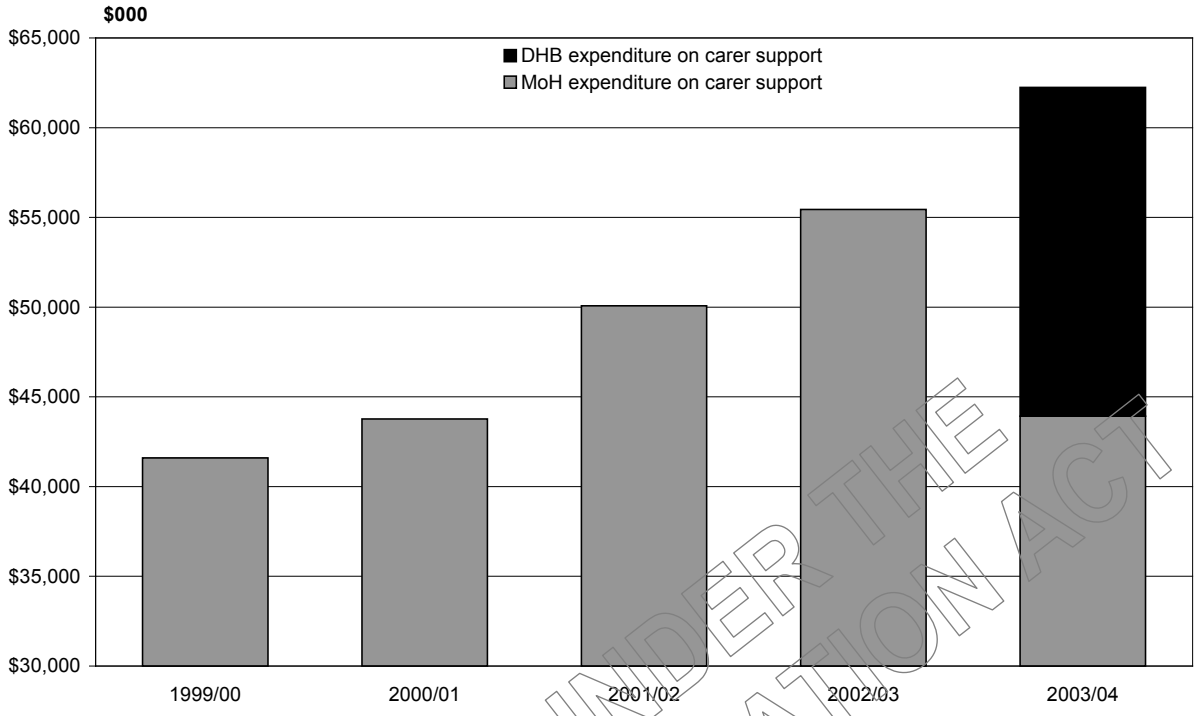
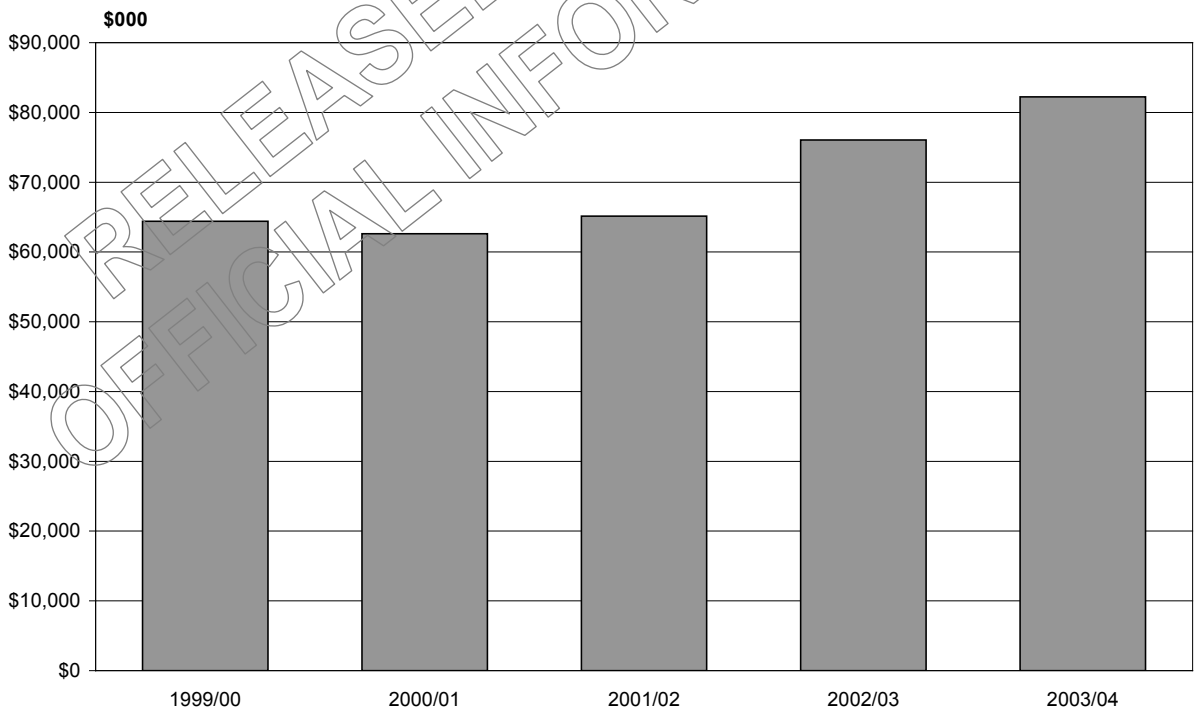
Carer Support Expenditure, 1999/00–2003/04



Environmental support services expenditure trend, 1999/00–2003/04



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Between 1996 and 2001 the number of people with disability living in households in New Zealand increased by 6%. This was entirely due to an increase in the adult disabled population (from *'Living with Disability in New Zealand'* Ministry of Health, in publication). This increase reflects our increasing ability to better treat illnesses and conditions with increased survival rates. It may also explain some of the increased demand for disability support services in recent years.

The Ministry of Health, NASC organisations, equipment management providers and service providers are all committed to ensuring that services are provided to keep disabled people living as independently as possible in the community and the sector continues to work towards objectives outlined in the New Zealand Disability Strategy.

In order to try to bring DSD's spending back in line with its budget we have prioritised a number of initiatives including putting resources into developing NASC organisations and improving our business systems and data collection. This gives DSD the opportunity to deal with discrepancies in access to and equity of disability support services across the country. It is also a great opportunity to ensure that the way we are allocating resources currently is the best way possible. To do this we need to have a dialogue to ensure the sector is involved in the solutions.

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11 Service Users' Frequently Asked Questions

Note: These FAQs and Fact Sheet in Appendix 10 were provided to DSD-funded NASCs in November 2004 for use across all stakeholders.

Q. What disability support services are funded by the Ministry of Health?

A. Disability support services funded by the Disability Services Directorate in the Ministry of Health include:

- residential accommodation for disabled people not able to continue to live in their own homes
- environmental support services including wheelchairs, ramps and equipment to assist people to continue to live in their own homes
- vehicle and home modifications
- home support
- carer support/relief
- rehabilitation.

Disability Services Directorate (DSD) will fund approximately $670 million of disability services for the financial year 2004/05.

Q. I've heard that the budget has been cut for some of these services, is this true?

A. No, this is not true. There has been no budget cut, but demand has outpaced funding.

There has been a large increase in demand on disability support services over the last few years and often support packages have been inconsistent nationally.

Between 1996 and 2001 the number of people with disability living in households in New Zealand increased by 6%. This was entirely due to an increase in the adult disabled population (from *'Living with Disability in New Zealand*', Ministry of Health in-house publication). This increase reflects our increasing ability to better treat illnesses and conditions with increased survival rates. It may also explain some of the increased demand for disability support services in recent years.

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Q. Why has my disability support package changed?

A. Your support package has been reviewed and as a result it has been brought into line with other people around the country who have similar support needs to you.

Review of support packages is part of the ongoing work conducted by Needs Assessment and Service Co-ordination organisations (NASCs) on behalf of the Disability Services Directorate in the Ministry of Health that funds many disability support services. The review of support packages aims to ensure that people across the country get access to services in a fair and equitable way and that people with greatest need receive priority access to a fair level of service.

Q. Why has my application for support been put on a waiting list?

A. Your need for government-funded disability support services has been placed in order of priority alongside a range of other people seeking disability support at this time. If you have been put on a waiting list it is because your need for disability support services has been given a lower priority than other people with disability. The Ministry of Health has criteria that NASC organisations use for assessing the support needs of disabled people. Allocation of services must be prioritised so that the highest level of need across the country is met and that a national level of consistency is achieved to ensure all people access a fair level of funded services no matter where they live.

When deciding who has priority for disability support services, NASC organisations are directed by the Ministry of Health to give priority to those people whose health or safety may be at risk if they do not receive those disability support services.

However, if your circumstances change, contact your NASC as they will reassess you and may re-prioritise your application.

Q. I am on a wait list; when can I expect to receive disability support services?

A. Your situation will be under constant review and you should contact your NASC organisation should your circumstances change. Your future access to support services will depend on your prioritised needs relative to other people seeking services.

People with greatest need will receive priority access to support services across the country. NASC organisations consider a range of risk factors such as health and safety, the risk of loss of employment or delayed discharge from hospital or the likelihood that remaining in your own home is put at risk.

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Q. What can I do if I am not happy with the decision of the NASC organisation?

A. If you are not happy with the outcome of your needs assessment or service co-ordination – for example, you do not receive the supports you think you should have – you can speak to the NASC manager and ask for a review of the service.

If you have a complaint about the way the NASC has worked, for example about the quality of their work rather than the outcome for you, you can make a complaint to the NASC. Each NASC has a complaints policy which they can explain to you.

This is different from asking for a review of the NASC decisions relating to your own needs assessment or service co-ordination.

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12 DSD Service Utilisation Reports

This appendix comprises details of reports which will be supplied to the NASC manager by DSD to support them in their information and budget management responsibilities.

12A HOME SUPPORT REPORT

Field Name	Description
NASC_NAME	NASC recorded for client's latest invoice line
NASC_REGION	Region of the NASC (N,M,C,S)
NASC_DERIVED_IND	Indicates whether the NASC was found from a service co-ordination, or derived from client's address
CLIENT_ID	Client's PerOrg ID
CLIENT_FIRSTNAME	Client's first name
CLIENT_SURNAME	Client's surname
CLIENT_NAME	Client's full name
CLIENT_NHI	Client's NHI
CLIENT_DOB	Client's birth date
CLIENT_DOD	Client's date of death
CLIENT_REGION	Client's region from other reference
CLIENT_ADDRESS	Client's current residential address
CLIENT_DHB_CODE	Client's DHB code at time of last invoice
CLIENT_TLA_CODE	Client's TLA code at time of last invoice
CLIENT_FTC_IND	Whether the client is carer or client, based on roles and services
CLIENT_PRIMARY_DISABILITY	Client's primary disability, if they are not receiving a CR service
SERVICE_ID	Last service that was invoiced
ELIG_NUMBER_OF_UNITS	Number of units the client is eligible for in a period. The unit and period are based on the service type
ELIG_FROM_DATE	When the eligibility begins
ELIG_TO_DATE	When the eligibility ends
ELIG_DURATION	Number of days of the eligibility
ELIG_EXPIRED_IND	Y if the eligibility is still current, otherwise N
INVOICED_AMOUNT	Total amount invoiced (exclusive of GST) between 1 September 2003 and 31 August 2004
INVOICED_UNITS	Total units invoiced between 1 September 2003 and 31 August 2004
WEEKS_CLAIMED	Number of weeks in the year that they invoiced for
WEEKLY_AMOUNT	Average weekly invoice amount (Column 23 / Column 25)
WEEKLY_UNITS	Average weekly invoice units (Column 24 / Column 25)
CLAIMS	Invoice lines submitted and accepted
AMOUNT_PER_CLAIM	Average amount per invoice (Column 23 / Column 28)
UNITS_PER_CLAIM	Average units per invoice (Column 24 / Column 28)
LATEST_INV_SERVICE_START	Start date of latest invoice
LATEST_INV_SERVICE_END	End date of latest invoice
LATEST_INV_NUMBER_OF_UNITS	Number of units on latest invoice
LATEST_INV_AMOUNT_EXCL	Amount on latest invoice
YEAR_PROJECED_COST	Expected total invoice amount for one year, based on latest invoice
ORIGINAL_CLIENT_ID	The person who invoiced being the full-time carer of a single client, otherwise the client ID
LINE_EVENT_ID	Invoice line ID
GL_CODE	GL Code: company-directorate-responsibility-account_code-provider_type-ministry

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12B CARER SUPPORT REPORT

Field Name	Description
NASC_NAME	NASC recorded for client's latest invoice line
NASC_REGION	Region of the NASC (N,M,C,S)
NASC_DERIVED_IND	Indicates whether the NASC was found from a service co-ordination, or derived from client's address
CLIENT_ID	Client's PerOrg ID
CLIENT_FIRSTNAME	Client's first name
CLIENT_SURNAME	Client's surname
CLIENT_NAME	Client's full name
CLIENT_NHI	Client's NHI
CLIENT_DOB	Client's birth date
CLIENT_DOD	Client's date of death
CLIENT_REGION	Client's region from other reference
CLIENT_ADDRESS	Client's current residential address
CLIENT_DHB_CODE	Client's DHB code at time of last invoice
CLIENT_TLA_CODE	Client's TLA code at time of last invoice
CLIENT_FTC_IND	Whether the client is carer or client, based on roles and services
CLIENT_PRIMARY_DISABILITY	Client's primary disability, if they are not receiving a CR service
SERVICE_ID	Last service that was invoiced
ELIG_FOR	Number of days the client is eligible for in the period.
ELIG_FROM_DATE	When the eligibility begins
ELIG_TO_DATE	When the eligibility ends
ELIG_PERIOD	Number of days of the eligibility
ELIG_LESS_THAN_330	Y if the eligibility period is less than 330 days, otherwise N
DAYS_UNCLAIMED_CURRENT_ELIG	Total days available in the period – days invoiced so far (Column 16 – Column 22)
DAYS_CLAIMED_CURRENT_ELIG	Total days invoiced so far
AMOUNT_CLAIMED_CURRENT_ELIG	Total amount invoiced so far
DAYS_CLAIMED_1_YEAR_AGO	Total days invoiced in the year up to the eligibility start date
AMOUNT_CLAIMED_1_YEAR_AGO	Total amount invoiced in the year up to the eligibility start date
DAYS_CLAIMED_2_YEARS_AGO	Total days invoiced in the year up to one year before the eligibility start date
AMOUNT_CLAIMED_2_YEARS_AGO	Total amount invoiced in the year up to one year before the eligibility start date
DAYS_CLAIMED_3_YEARS_AGO	Total days invoiced in the year up to two years before the eligibility start date
AMOUNT_CLAIMED_3_YEARS_AGO	Total amount invoiced in the year up to two years before the eligibility start date
ORIGINAL_CLIENT_ID	The person who invoiced being the Full Time Carer of a single client, otherwise the client ID
LINE_EVENT_ID	Invoice line ID
GL_CODE	GL Code: company-directorate-responsibility-account_code-provider_type-ministry

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12C RESIDENTIAL REPORT

Field Name	Description
NASC_NAME	NASC recorded for client's latest invoice line
NASC_REGION	Region of the NASC (N,M,C,S)
NASC_DERIVED_IND	Indicates whether the NASC was found from a service co-ordination, or derived from client's address
CLIENT_ID	Client's PerOrg ID
NHI	Client's NHI
CLIENT_FIRSTNAME	Client's first name
CLIENT_SURNAME	Client's surname
CLIENT_NAME	Client's full name
DOB	Client's birth date
DATE_OF_DEATH	Client's date of death
PRIMARY_DISABILITY	Client's primary disability at time of last invoice
CLIENT_ADDRESS	Client's current residential address
CLIENT_DHB_CODE	Client's DHB code at time of last invoice
CLIENT_TLA_CODE	Client's TLA code at time of last invoice
SERVICE_ID	Last service that was invoiced
DATE_OF_REFERRAL	Date of referral from service co-ordination of latest eligibility
SERVICE_START	Start date of latest invoice
SERVICE_END	End date of latest invoice
NUMBER_OF_UNITS	Number of units invoiced
APPROVED_AMOUNT_EXC	Amount invoiced
DAILY_RATE	Average amount per day (Column 20 / Column 21)
CLIENT_CONTRIBUTION	Client contribution per day
LINE_EVENT_ID	Invoice line ID
GL_CODE	GL Code: company-directorate-responsibility-account_code-provider_type-ministry

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12D OTHER

Field Name	Description
NASC_NAME	NASC recorded for client's latest invoice line
NASC_REGION	Region of the NASC (N,M,C,S)
NASC_DERIVED_IND	Indicates whether the NASC was found from a service co-ordination, or derived from client's address
CLIENT_ID	Client's PerOrg ID
CLIENT_FIRSTNAME	Client's first name
CLIENT_SURNAME	Client's surname
CLIENT_NAME	Client's full name
CLIENT_NHI	Client's NHI
CLIENT_DOB	Client's birth date
CLIENT_DOD	Client's date of death
CLIENT_REGION	Client's region from other reference
CLIENT_ADDRESS	Client's current residential address
CLIENT_DHB_CODE	Client's DHB code at time of last invoice
CLIENT_TLA_CODE	Client's TLA code at time of last invoice
CLIENT_FTC_IND	Whether the client is carer or client, based on roles and services
CLIENT_PRIMARY_DISABILITY	Client's primary disability, if they are not receiving a CR service
SERVICE_ID	Last service that was invoiced
ELIG_NUMBER_OF_UNITS	Number of units the client is eligible for in a period. The unit and period are based on the service type
ELIG_FROM_DATE	When the eligibility begins
ELIG_TO_DATE	When the eligibility ends
ELIG_DURATION	Number of days of the eligibility
ELIG_EXPIRED_IND	Y if the eligibility is still current, otherwise N
INVOICED_AMOUNT	Total amount invoiced (exclusive of GST) between 1 September 2003 and 31 August 2004
INVOICED_UNITS	Total units invoiced between 1 September 2003 and 31 August 2004
WEEKS_CLAIMED	Number of weeks in the year that they invoiced for
WEEKLY_AMOUNT	Average weekly invoice amount (Column 23/Column 25)
WEEKLY_UNITS	Average weekly invoice units (Column 24/Column 25)
CLAIMS	Invoice lines submitted and accepted
AMOUNT_PER_CLAIM	Average amount per invoice (Column 23/Column 28)
UNITS_PER_CLAIM	Average units per invoice (Column 24/Column 28)
LATEST_INV_SERVICE_START	Start date of latest invoice
LATEST_INV_SERVICE_END	End date of latest invoice
LATEST_INV_NUMBER_OF_UNITS	Number of units on latest invoice
LATEST_INV_AMOUNT_EXCL	Amount on latest invoice
BREAK	
ELIG_LESS_THAN_330	Y if the eligibility period is less than 330 days, otherwise N
DAYS_UNCLAIMED_CURRENT_ELIG	Total days available in the period – days invoiced so far (Column 18–Column 38)
DAYS_CLAIMED_CURRENT_ELIG	Total days invoiced so far on this eligibility
AMOUNT_CLAIMED_CURRENT_ELIG	Total amount invoiced so far on this eligibility
DAYS_CLAIMED_MINUS_1_ELIG	Total days invoiced in the year up to the eligibility start date
AMOUNT_CLAIMED_MINUS_1_ELIG	Total amount invoiced in the year up to the eligibility start date
DAYS_CLAIMED_MINUS_2_ELIG	Total days invoiced in the year up to one year before the eligibility start date
AMOUNT_CLAIMED_MINUS_2_ELIG	Total amount invoiced in the year up to one year before the eligibility start date

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Field Name	Description
DAYS_CLAIMED_MINUS_3_ELIG	Total days invoiced in the year up to two years before the eligibility start date
AMOUNT_CLAIMED_MINUS_3_ELIG	Total amount invoiced in the year up to two years before the eligibility start date
LINE_EVENT_ID	Invoice line ID
GL_CODE	GL Code: company-directorate-responsibility-account_code-provider_type-ministry

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13 Accessing Long-term Residential Care and the Residential Support Subsidy

The process of accessing long-term residential care for people with disabilities generally under 65 years of age, and the interface of Ministry of Health and Ministry of Social Development's (MSD) Work and Income in accessing the Residential Support Subsidy (RSS) are described in a way that takes the disabled person and the NASC manager and staff through the process step by step.

1 A person with a disability

- is referred or self refers to the DSD-funded Needs Assessment and Service Co-ordination organisation (NASC)
- meets the requirements of the *2003 Direction of the Minister of Health Relating to Eligibility for Publicly-Funded Health and Disability Services in New Zealand*, ie, is eligible to receive publicly funded health and disability services (an eligible person is generally a New Zealand citizen or resident, or meets one of the requirements of the Direction; refer to www.moh.govt.nz/eligibility for more information), and the Ministry of Health's definition of disability
- is assessed by a DSD-funded NASC as a person with a lifelong impairment (physical, intellectual and sensory disability), is generally under 65, and does not require support services appropriate for older people, and has support needs.
  - If initial screening determines a person 50–64 is 'close in interest' and has needs similar to those of an older person, the person will be referred on to the NASC funded by the District Health Board (DHB).
  - A person may be referred on for specialised assessment such as to a Pain Clinic while remaining the client of the DSD-funded NASC.

The service co-ordinator at the DSD-funded NASC provides information on options and either:

- develops and allocates a home and community-based support services package, or
- authorises and assists with long-term residential care, if required, (Specialised assessment may or may not be requested to support the need for long-term residential care and rehabilitation) or
- develops and allocates a Supported Independent Living (SIL) package to enable the person to continue living in the community. If the person is on a long-term benefit such as an Invalids Benefit (IB), the person can keep control of their IB and any extra help such as a Disability Allowance.

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2 Long-term residential care

- If the person is aged 50–64 years and up to this point has not been assessed as 'close in interest' and having needs similar to those of an older person but there is a possibility or probability that they may fit into this category, they should be referred to the DHB's Assessment Treatment and Rehabilitation (AT&R) for assessment. The AT&R should come back with a recommendation. If the recommendation is that it is appropriate that this person goes into a rest home or continuing care hospital, they will henceforth come under the DHB NASC and should be referred to this. Refer Residential Care Subsidy (RCS) process flow chart at the end of this appendix. People aged 50–64 who are unmarried and have no dependent children currently are income and asset tested in order to receive the RCS but from 1 July 2005 they will be income tested only.

- If the person is under 65 and has a lifelong impairment and is assessed as requiring long-term residential care, the DSD-funded NASC manager initiates the process for the granting of a Residential Support Subsidy.
  - Some people with lifelong impairments **over the age of 65**, and previously in receipt of MOH funded community support who are now assessed as needing long-term residential care but not specifically residential services appropriate for older people, may receive a RSS until such time as they are reassessed and deemed in need of long-term residential care for older people such as in a rest home, continuing care facility or dementia unit. This reassessment means the person would transfer from a RSS to a RCS and be income and asset-tested.
  - The current legislation, as amended by the new Social Security (Long-Term Residential Care) Amendment Act 2004, requires all people aged over 65 years to be income and asset tested if assessed under the Act as needing long-term residential care in a rest home, continuing care facility or dementia unit. As indicated above, currently unmarried people aged 50–64 with no dependants who are assessed as needing this type of care, such as a rest home, are also income and asset tested, but under the new legislation, from 1 July 2005, this group will not be asset tested (they will continue to be income tested).
  - All people on RSS (or RCS) are required to contribute any main benefit they receive, less a Personal Allowance (PA) which is returned to them, to the service provider towards the cost of their care. This is usually done by redirection of their benefit. However, the client may choose to make his or her own arrangements to pay the service provider.
  - The level of the PA varies according to disability. At present for people with intellectual disability it is $46.17 per week, and for people with physical disability $78.24 per week. There are different rates for those with psychiatric/drug and alcohol issues, and for people on RCS. PA is adjusted annually on 1 April in line with cost of living changes.
  - People with lifelong impairments who receive RSS are **not** income and asset tested if they enter a rest home or hospital for older people through a needs assessment not conducted under the Social Security Act, and due to lack of other appropriate options. However, any main benefit they receive such as IB is subject to an income test, in order to determine whether they qualify for the benefit in the same way as all other people receiving or applying for a benefit through Work and Income.

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The DSD-funded NASC and the client, in consultation with family or whānau members, or a guardian or advocate where appropriate, decide where the client will go for long-term residential care.

Notes

- All those in long-term residential care who are paying private fees and/or receive funding through the Ministry or DHB (ie, on RCS or RSS) are by law unable to receive Disability Allowance (under section 69c(2B) of the Social Security Act 1964 or Accommodation Supplement (under section 61EA(4)(e) of the Social Security Act).
- If a person is on IB and receives a RSS, when they turn 65, they should automatically transfer from an IB to New Zealand National Superannuation. This may affect Ministry of Health and Work and Income payment arrangements.

3 The service provider agrees to take the person with lifelong impairment.

3.1 DSD Service Manager, North or South Operations Team approves the placement in writing if the residential service is a rest home or private hospital for older people.

- A range of service specifications, based largely on disability group and situation (see Volume 1, Chapter 5), will form the basis of the contract and payment rates appropriate for individual clients.
- For people subject to resettlement plans (deinstitutionalisation) or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act), or the civil population of people who are supported through the Regional Intellectual Disability Care Agency (RIDCA) process, different service specifications/rates may apply. If NASC managers have queries related to people under the IDCCR Act or the civil population, they should contact the RIDCA for their area.

4 Ministry of Social Development's Work and Income process of entry to all residential care

- See flow diagram at the end of this section provided by the Ministry of Social Development for RCS only.
- For RSS only, the client signs the authorisation for Work and Income to re-direct their benefit payment (less a Personal Allowance) to be paid directly to the service provider until the date they leave the service, or the person continues to receive their benefit in their own account, and is responsible for payment of the benefit contribution directly to the service provider. The client continues to receive a Personal Allowance.

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4.1 Particular issues

> The information provided above and particularly below is a general guide to policies and processes of the Ministry of Health and Ministry of Social Development as they currently apply. They may be affected by the individual circumstances of the client and possibly their partner/spouse and family. The legislation will also need to be considered and if anything is inconsistent with the legislation, the legislation will prevail. It would be wise to check a particular client's situation with Work and Income's centralised Residential Subsidy Unit (RSU).

Residential Support Subsidy free phone 0800 999 779 (drug and alcohol, psychiatric, intellectual disability, physical/sensory)

Residential Care Subsidy free phone 0800 999 727 (older people)

4.2 What should be done in the following situations?

- A single person is aged under 65, deemed to have a lifelong impairment, and on first receiving RSS is not on a long-term benefit (eg, IB) although the person may have been entitled to this had they earlier applied for this – and is not working. If the person has no means of support, the client and/or their advocate should approach Work and Income and test the client's entitlement for income assistance (eg, IB or Sickness Benefit).
- A married person is aged under 65, has a lifelong impairment such as cerebral palsy, and on first receiving RSS, is not on benefit. The client and their partner/spouse and/or an advocate should approach Work and Income and test the client's entitlement for income assistance, being aware that their eligibility will depend on their partner/ spouse's income.
- If a person on RSS is not on a benefit and is in paid work, the policy decision of Government at the time of the transfer of responsibilities from the then Department of Social Welfare to Regional Health Authorities, now Ministry of Health, was that the person may choose to make a contribution to their care cost to the service provider but cannot be obliged to contribute. The Ministry will continue to pay the RSS if they do not contribute.

December 2004

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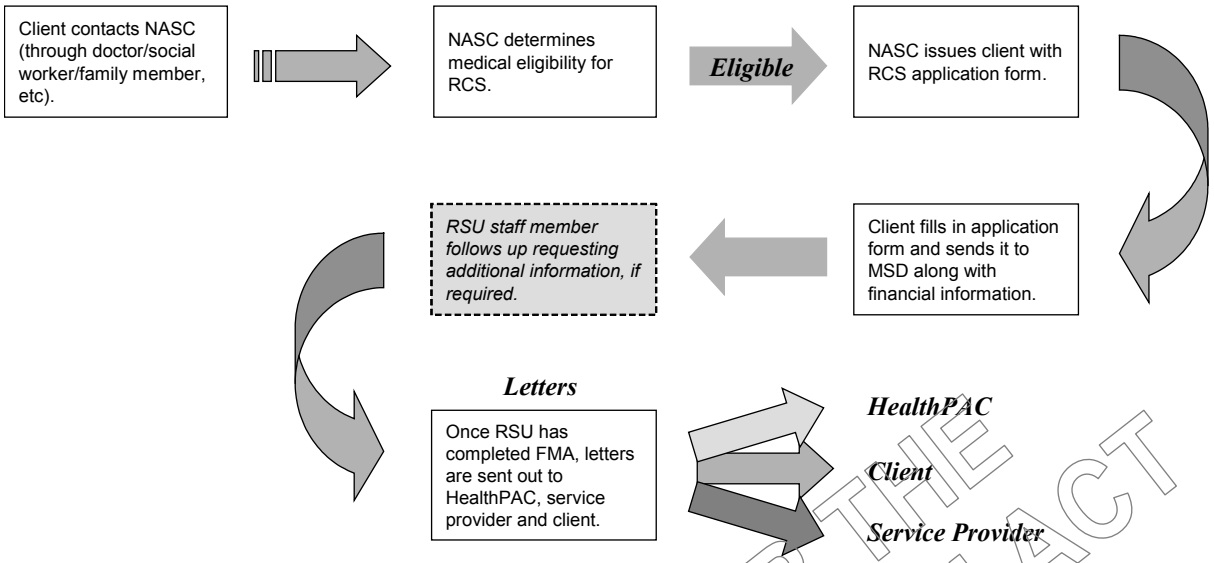
Residential Care Subsidy: Financial Means Assessment (FMA) Process



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14 Residential Care – Progressive Removal of Asset Testing

Health of Older People Sector Policy, Ministry of Health, December 2004

Questions and answers

The Government has introduced the Social Security (Long-term Residential Care) Amendment Bill. The Bill makes a number of significant changes to income and asset testing for older people requiring long-term residential care. These changes will come into effect from **1 July 2005** and will progressively remove asset testing.

The following questions and answers provide more information about the proposed changes.

1. What is the current situation?

When a person aged 65 and over is assessed as needing long-term residential care, they can apply for a residential care subsidy to cover the cost of their care. Eligibility for this subsidy is subject to an asset test. The following level of assets is currently exempt from asset testing:

- $15,000 for a single or widowed person in care
- $30,000 for a couple with both partners in care
- $45,000 for a couple where one partner is in care, and their house and car.

Assets tested include the house, holiday home, car, shares, bonds and savings.

2. What does the new decision mean?

The government has decided to progressively remove asset testing by gradually increasing the exemption thresholds for assets.

From 1 July 2005, the thresholds will increase:

- from $15,000 to $150,000 for a single or widowed person in care
- from $30,000 to $150,000 for couples with both partners in care
- from $45,000 to $55,000 for couples with one partner in care (plus their house and car).

The exemption thresholds for all groups will then increase by $10,000 a year, so that asset testing is progressively removed.

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3. What assets will be eligible for exemption?

All assets will be eligible for exemption, including the house, holiday home, car, shares, bonds and savings. This supports the government's objectives for encouraging retirement savings.

4. Why is the government progressively removing asset testing?

The Government is keeping its 1999 election promise to introduce legislation to remove asset testing for older people in long-term residential care.

This promise was made because asset testing is unfair. People aged 65 and over are required to use up their assets to contribute to the cost of their care, whereas younger people are not.

5. How much will the progressive removal of asset testing cost?

The changes to asset testing are expected to cost $112 million in the first year (2005/2006), rising to $166 million in 2009/10. The increase in cost over time reflects the $10,000 annual increase in the exemption threshold and the growing number of older people in the population.

6. How much would it cost to remove asset testing completely?

It would cost $252 million to remove asset testing completely in the first year (2005/06), rising to $322 million in 2010/11 and $507 million in 2020/21.

7. Where will funding for the changes come from?

The Government has made separate provision for the additional funding to pay for these changes. This funding will come from outside the Health Funding Package. The Health Funding Package is a rolling three-year funding path for the publicly funded health sector to provide certainty for planning.

8. Who is responsible for funding residential care services for older people?

From 1 October 2003, funding for residential care services for older people was transferred from the Ministry of Health to District Health Boards. This is as part of DHB's new responsibility for disability support services for older people.

9. Why was the exemption threshold set at $150,000?

The new $150,000 threshold substantially increases the assets that people can keep before their assets are used to contribute to the cost of their care – single and widowed people will be $135,000 better off than at present and married couples who are both in care will be $120,000 better off. These amounts will increase annually by $10,000.

For many people, their house will be immediately exempt. People who have sold their houses will be able to keep a significantly increased level of savings.

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10. Who will the new policy apply to?

Around 31,000 older people are currently in long-term residential care, 7 per cent of older New Zealanders.

The new policy will apply to:

- people already in care who are not currently eligible for a residential care subsidy
- all new people who are assessed as needing long-term residential care from 1 July 2005.

All these people will benefit from the substantial increase in the thresholds.

People who currently receive a residential care subsidy will continue to receive the subsidy. From 1 July 2005, an additional 5600 people are estimated to receive the subsidy, taking to 70 percent the people in care who receive the subsidy.

11. Will the new policy be retrospective?

No, the new policy will apply only from 1 July 2005. No refunds will be given.

12. How do people apply for a residential care subsidy?

People must first have a needs assessment through their local DHB that shows they need long-term residential care indefinitely.

Work and Income then carries out a financial means assessment on behalf of the Ministry of Health. If their assets are under the exemption thresholds, people qualify for a subsidy. They are then income tested. The level of subsidy paid depends on their income.

13. What happens if a person's assets are worth more than $150,000?

If a person's assets exceed $150,000, they will have to contribute towards the cost of their care until their total assets reduce to $150,000.

14. If a person's assets are worth more than $150,000, how much will they have to contribute weekly to the cost of their care?

Currently, people have to contribute a maximum of $636 a week towards the cost of their care if they have assets above the exemption thresholds. In future, this amount will be adjusted in line with inflation.

In many cases, people's weekly contribution does not cover the full cost of care. For example, national average prices are $712 a week for dementia care and $1010 a week for hospital-level residential care.

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15. If a person's house is worth more than $150,000, will they have to sell it to pay for their care?

In exceptional circumstances a residential care loan scheme is available whereby the Crown can fund care costs as an advance. This will accumulate as an interest-free loan secured by a caveat over a person's house. When the house is sold or the estate is wound up, the loan will be repaid to the Crown.

16. What if a person's assets are worth less than $150,000?

If a person's total assets, including their house, are worth less than $150,000, they will not have to use their assets to contribute towards the cost of their care.

17. How will a person's house be valued?

Houses will be valued according to rateable valuations, issued by local authorities when they advise people of their annual rates. In most areas, these valuations are done at three-yearly intervals.

18. Is the Government going to remove income testing?

No, the Government does not intend removing income testing. If older people are receiving income from investments, rent, superannuation etc, it is fair to expect that they will contribute to the costs of care they would expect to pay if living in their own home.

19. Are there any changes to income testing?

Yes. From 1 July 2005, income from assets that are below the threshold will be income tested. However the first $780 per person per year of income from these assets will be exempt.

Another change to income testing is that the employment earnings of the spouse of a person in care will be excluded from the income test.

20. Will any other group benefit from the new policy?

Yes. From 1 July 2005, asset testing will be fully removed for people aged 50–65 years whose health support needs such as dementia are assessed as requiring long-term residential care indefinitely. Currently, single people aged 50–65 without dependents are subject to the same asset testing as people aged 65 and over.

21. Will the public be consulted on this legislation?

Yes. The legislation will be referred to the Health Select Committee after the Bill's first reading early in 2004. The Select Committee will then publicly call for submissions (usually through daily newspapers). Anyone can make a submission to the Select Committee.

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22. Where can I get further information?

A copy of the legislation can be purchased from Bennetts bookshops and will also be available on the Parliamentary Council Office website www.knowledge-basket.co.nz/gpprint/docs/welcome.html

For information about needs assessment, contact your local DHB or call WEKA on free phone 0800 17 1981 or visit their website www.weka.net.nz

For information about applying for a residential care subsidy or residential care loan, contact your local Work and Income office.

The Ministry of Health has published a booklet 'Long Term Residential Care in a Rest Home or Hospital: What you need to know', 2004, Wellington, Ministry of Health or available on www.moh.govt. The Ministry of Social Development also have a booklet 'Residential Care Subsidy: Financial assistance for those in rest homes or hospitals', available on www.workandincome.govt.nz

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15 Supported Independent Living Guidelines for NASCs and Providers

Disability Services Directorate, Ministry of Health (implemented March 2001, updated November 2004)

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1 INTRODUCTION

The Disability Services Directorate (DSD) funds a continuum of services for disabled people ranging from minimal support in people's own homes to very high levels of support and care in residential settings. Supported Independent Living is one of the services in this continuum and is funded in response to the growing number of people with disabilities who wish to live independently in their own homes.

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Population

The significant groups for whom this service is attractive are:

- those living with their parents and at an age where it is appropriate for to transition to an independent living situation such as a shared flat or their own house
- those who acquire a disability later in life and require an increased level of support to continue living independently
- those people who are currently in residential settings who wish to live independently.

This service was developed to assist those people who may require a significant amount of support to get established in an independent living situation. For some people this level of support may reduce over time, however, other people may always require a significant level of support to maintain them in independent living. Their needs are of a nature that will require ongoing planning and review.

Objective

The objective of supported living services is to assist a person with a disability to live safely in the community with an appropriate level of support. Key outcomes are to maximise the person's choice about where and how they live, develop the skills to access their community and to prevent, or delay the need for admission into a residential care service.

It should be noted that the main component of Supported Independent Living is support for skill development and maintenance. It is not intended to be a 24-hour support service and was not designed as a 'hospital in the home' service. If a person wishes to pursue a 'hospital in the home' service then DSD would only partly fund the support required, that is one which is based on DSD's ability to meet assessed need.

Service Packages

The SIL service funded by the Ministry of Health DSD is based on a person's support needs to meet their lifestyle choices in living independently. Support needs are determined through the NASC process and form the basis for the service Support Package that is agreed between the person, SIL provider and the NASC agency.

It is unlikely that support for all the person's goals will be funded by the DSD as part of the Support Package. There are likely to be options that are either funded by other agencies or provided through informal networks. These should be used wherever possible as they enhance the independent nature of the person's choices. Choices that relate to lifestyle, rather than support need, are not funded as part of the Supported Living Package but never the less will form part of the Individual Plan of the person. For example, if a person chose to join a sports club, fees, sporting equipment and transport to events would not be funded as part of the Supported Living Package, but their personal support to enable them to participate could be. In this example it could be possible for this personal support to be provided over time by informal networks that develop within the sports club.

The DSD will continue to work toward ensuring equity of service access across New Zealand.

Note: these guidelines should be read with reference to the Supported Independent Living service specification and service provider agreement terms and conditions.

Note: Subsequent references in this document to 'the person' or 'people' should be understood as referring to an eligible person/people for SIL services.

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2 SUPPORTED INDEPENDENT LIVING FREQUENTLY ASKED QUESTIONS

2.1 What are the components of the service?

- **Individual Plan**: is based on the support needs identified through the NASC process and outlines the person's development and lifestyle goals. The IP is the basis for the development of a Support Plan.
- **Personal Care/Household Management:** as described in home based support service agreements. These services may be included as part of the support package administered by the provider where appropriate. Personal Care and Household Management support generally does not include a development component. It is expected that in most cases Home Based Support services will not form part of the Supported Independent Living service and that these services

will be provided by Ministry of Health contracted providers Home Based Support services.

- **Community Support Worker:** Provides oversight of the day-to-day needs of the person and works with the person to develop the skills identified in the Individual Plan, that is budgeting, motivating, supervision, assisting the person to build community linkages and networks and assisting with co-ordination of the support package. Supervision is intended to mean support of a person's development rather than 'keeping an eye' on them in case some unplanned event occurs.
- **Service Plan Set-up and Review**: Proposing and co-ordinating a care package including the initial brokering of service linkages, review and revision of the package at agreed intervals, or when a persons needs change. It is expected this will occur at defined intervals over the life of the support package where there is a requirement for intense supervision and management of service changes.
- The provider may be contracted to provide all these components. In some circumstances the provider may choose to sub-contract personal care and household management to a Ministry of Health contracted home support agency. If the SIL provider does directly provide personal care and household management they must meet the same standards of service provision as if they were a Ministry of Health contracted provider of Home Based Support services. However, in terms of the SIL service, the SIL contracted provider will have overall responsibility for the provision of these services where they form part of the Support Package and are agreed by the NASC agency.
- There is also work being done with agencies who provide services for people with Intellectual Disabilities and complex needs who require a higher level of supervision than most people on the programme. An administrative component may need to be contracted for separately. This will be done on a case-by-case basis with individual providers as appropriate.

2.2 Who is the service for?

- Supported Independent Living services are available for those people with a disability who have been referred to the Provider for service by a contracted Needs Assessment Service and Co-ordination Service (NASC) organisation.
- A person with a disability is someone who has been assessed as having a physical, intellectual or sensory (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.
- People who wish to live in their own home, or in a flat either by themselves, or with others and who may require a level of support or supervision that is beyond normal personal assistance/household management services. Some boarding arrangements may be included.
- People who wish to move from their parental home into supported independent living.
- People who wish to stay in their own home but require additional support because of increased needs.

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- People who are in a residential care facility that wish to move into supported independent living.

Note: The level of support will be determined through the NASC process.

2.3 What SIL is not intended for

- SIL is not intended to be a fully staffed 24-hour seven-day per week support service.
- SIL is not residential care.
- SIL is not a 'hospital in the home' nursing service.
- SIL cannot be provided in a residential care facility.
- SIL does not fully fund all support to meet a person's goals. Other supports may be provided by other agencies and/or through informal networks.
- SIL cannot be provided in a person's parental home unless as part of the transition from parental home into independent community living.
- SIL is not intended to provide ongoing high levels of service to ensure safety. This refers specifically to managing public and personal safety with high levels of behaviour support or medical components of care. These types of services are available to individuals through separate contracts DSD holds with other providers and may be used on a time-framed basis.
- SIL is not intended to provide 'day-care' services or support for the children of disabled people who are on the SIL programme. This is the responsibility of the disabled person as a parent.

2.4 What is the role of the NASC in the SIL process?

- Completes an initial needs assessment.
- Explores and discusses all of the support options available for the person based on DSD's ability to meet the assessed need.
- Ensures that SIL is the preferred option of the person.
- Ensures the person is well informed of the SIL options available to them and that they understand what is funded by the DSD of the MOH (ie, that funded support is needs based, not based on lifestyle choices).
- Makes an appropriate referral to the SIL provider selected by the person.
- Negotiates and approves the proposed support package up to the funding limit indicated by the SPAR tool, or up to a total of $40,000 per annum. If the total DSD funding required to fund the support package exceeds $40,000 per annum the NASC manager will defer to the DSD Service Manager for the locality.
- Ensures the support package meets the goals identified through the NASC process and documented in the Individual Plan.
- Ensures the financial resources are available to meet the proposed support package within the overall budget management responsibilities of the NASC.

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- Responds to the need to review or revise a service package if support needs change.
- Provides regular re-assessment and review of service users' needs as required by NASC Service Specifications and Guidelines.
- Provides notification of service changes (or exit) to the Ministry of Health in a timely manor to ensure service payment is made as agreed by the NASC organisation.

Note:
Section 3 Operational Protocol for Supported Independent Living services of these guidelines outline the need for each NASC to develop a protocol that would include processes around the resolution of disputes between the provider and the NASC. It is important to remember that the potential service contract is between the NASC and the provider, not the person and the NASC. Consequently service users should not be directly involved in the negotiation of the package, although clearly the person will be totally involved in the identification of needs and development of the package.

For further information on the NASC process refer to 'Support Needs Assessment and Service Co-ordination – Policy, Procedure and Information reporting Guidelines' developed by the Ministry of Health (2002).

2.5 What is the role of the provider?

- Completes a proposed support package, which will meet the goals outlined in the Needs Assessment and documented in the Individual Plan.
- Ensure the support package submitted to the NASC includes only those things that are needs based and funded by the DSD. This may not include all of the goals identified in the Individual Plan as some of the goals may either be funded through other Government agencies. For example support at Day/Vocational programmes, support while in hospital, or are personal goals of a nature not funded by the DSD such as overseas travel, engaging in the same social activity every night of the week.
- Submits the proposed support package to the NASC for approval.
- Implements the approved support package. Note: The provider must notify the NASC if there are any changes to hours of service provided to that specified in the approved support package.
- Manages the day-to-day support needs of the person as outlined in the Supported Independent Living service specification.
- Provides information to the Ministry of Health to ensure prompt payment for services delivered.
- Monitors and reviews the support package. The service specification indicates this should occur at least every six months.
- Involves the NASC organisation in the review if there has been a significant change in support needs.

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- Ensures support staff have a sufficient level of training to meet the persons support needs, are aware of the service philosophy, organisation process and have adequate role supervision/orientation.
- Ensures the person has access to an external advocate who is not the provider.
- Submits a support package review at time intervals agreed with the NASC.

2.6 What is the role of the Ministry of Health?

- Negotiate contracts with providers to whom the NASC may refer.
- Approve/decline exceptional support packages. This would include packages outside SPA bands or support packages, not including the cost of equipment, exceeding $40,000 per annum.
- Monitor NASC expenditure and performance.
- Monitor providers' performance.
- Report service expenditure to NASC agencies.
- Develop a purchase strategy, RFPs and so on.
- Develop and revise service specifications.
- Contract for audits.
- Provider development.
- Respond to complaints to the Ministry.

2.7 What components should be in a proposed support package?

- Relevant history.
- Statement of goals.
- Current and future needs.
- The person (and family/whānau where appropriate) preferences.
- Appropriate and realistic options.
- Resources required to meet needs.
- Individual risk management plans when appropriate.
- Specialist clinical reports when appropriate.
- Timeframes for implementation and review.
- Service exits – if a person wishes to exit a service this will prompt a provider review of the support plan and package, the provider will immediately inform the NASC agency and will propose a transition process in the support package review, timeframes will be agreed between the provider, the person and the NASC agency. Each participate is responsible for the timeframes and actions agreed in the transition Support Plan. The overall process will be managed by the NASC agency.

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2.8 Things to remember when developing a support package

- The support package should support, not replace, natural support systems.
- The support package does not include hotel costs such as rent, food, and utilities. These are expected to be paid for out of personal income such as employment or benefit. Therefore the person will not be income and asset tested.
- The Community Support worker hourly rate includes all overhead costs of the service provision including; management, supervision, training and travel costs. Community Support Worker hours should account for all of the direct contact hours with a person where there is an element of personal development and supervision in line with the goals identified in the Individual Plan.
- Support plan set-up and periodic reviews are likely to occur at set times within a support package. These will be agreed with the NASC organisation. Support plan set up and review is not expected to be an ongoing weekly component of the service.
- There should be a clear connection between goals/needs/and the services proposed to meet those needs.
- It is often a fine line between personal choice and support need. For each person this will be different. The DSD funds need based support. The question that will be asked is 'what is reasonable in this case' in light of the service described in the service specification and the needs outlined through the NASC process.
- A support packages may include a level of provider discretion within the service package delivery if agreed by the NASC agency. A person's changing needs can then be managed within the SIL service with fewer referrals back to the NASC agency and a reduced need for funding level changes. If implemented there needs to be an acknowledgement by both NASC and SIL provider that over the term of the support package there will be periods where cost is higher than weekly funding and visa versa. The provider takes responsibility for ensuring the agreed goals are met within the funding agreed over the agreed term. Providers and NASC agencies have to be proactive ion reviewing service packages.
- Supported Living is not twenty-four hour, seven day per week, residential care.
- The more relevant information included the better.
- A person's support proposals is not to be considered a 'contestable' process (ie, NASCs should not send a referral to more than one provider).

2.9 Reviewing/revising the support package

- The support package should timeframe a date for review – this will depend how dynamic the person's situation is.
- The provider is responsible for the six-monthly reviews as described in the Supported Independent Living service specification.
- The support package should be reviewed if there is a significant change in the person's needs, goals or circumstances. It is the provider's responsibility to identify this.

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- The NASC organisation is to be informed of the support package review. Information including goals met by the person and new objectives set should be forwarded to the NASC organisation.
- The NASC organisation will acknowledge receipt of the reviews and ensure that the objectives set are in line with the Needs Assessment and Individual Support Plan.
- The NASC organisation should be involved in the review if there is a significant change in the persons support needs or at other times as agreed with the NASC agency and as required by NASC Service Specifications and Guidelines.

2.10 Can a provider invoice separately for time spent on developing the proposal?

While, the Support Plan set-up time is to be included in the package that is approved by the NASC, the initial Support Plan set-up cannot be charged as a separate service component.

It does require a level of trust and positive relationships between NASC and provider. This may present a challenge in some complex situations. However in working through these issues, it requires a different level of working together than the traditional assessment/residential placement process.

Clearly there would be an initial meeting with the person and family/whānau to discuss their situation, and to discuss what the provider can offer. As in residential care, the Ministry of Health would expect that this is a preliminary information gathering/provider marketing meeting. We would not expect that the Ministry of Health would pay for this time, as this is part of the process of identifying an appropriate provider.

2.11 What happens if the provider and the NASC cannot agree on a package?

Supported independent living services require a strong relationship of trust between providers and NASCs. This will develop over time. The relationship will need to be managed in a more active way than more traditional residential care services have required.

If the provider and NASC cannot agree on a package it will be referred to the DSD Service Manager for the locality for consideration.

2.12 If a provider has a contract for Supported Independent Living: Intellectual Disability, can they provide services to a person whose primary disability is physical, and vice versa?

No. Unless approved by the Disability Services Directorate prior to acceptance of the NASC referral.

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SIL services were contracted with two separate service descriptions, one for intellectual and one for physical disability.

The service specifications were separated so that there would not be an automatic assumption that a provider can provide SIL services to both client groups.

The Disability Services Directorate has moved away from the approach of having separate Supported Independent Living service specifications for people. Previously there was a service specification for services to people with support needs related to Intellectual disability and one for support needs related to physical disability. The primary focus of the service specification is to ensure the service meets the needs of the person as identified through the NASC process.

People with intellectual and physical disabilities can have very different needs. This will be acknowledged through the NASC process and in the Support Plan for the person. Some clients will have both an intellectual and physical disability. In this situation, as in all situations, it is more important to find the provider who best meets the needs of the individual.

Where a provider provides services to people with an Intellectual disability only this will be specified in the provider specific terms and conditions of the service agreement. Likewise if a provider provides services to people with a physical disability only this will be specified in the provider specific terms and conditions of the service agreement.

2.13 Should specialist services and assessments by specialists be part of the proposed support package, and who will pay for them?

If approved by the NASC specialist services they would be paid through the flexible funding stream, not under the SIL code. Referrals for assessments by specialists should be made by the NASC and it would normally be expected that this would have taken place before the referral for SIL has been made. Consequently assessments by specialists should not be part of the proposed support package.

2.14 Can the provider also provide accommodation for SIL clients?

In some situations providers have entered into tenancy arrangements with Housing New Zealand for a house in the community. If an SIL client lives in this house they can be charged rent or a board payment. These payments are not included in the SIL support package. The rent or board payment is made to the landlord, the provider. There is no client contribution for SIL services. SIL services do not cover the cost of rent, utilities, food and other hotel costs.

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3 OPERATIONAL PROTOCOL FOR SUPPORTED INDEPENDENT LIVING SERVICES

Each NASC is encouraged to develop an operational protocol which sets out the ground rules for how the NASC and contracted SIL providers will work together to implement the service.

Most of the contracted providers cover more than one NASC area, so there is a strong argument for the development of a joint protocol between all NASCs. This will support a consistency in how services are delivered. As a suggestion, the protocol could set out:

- referral processes
- assessment processes
- expectations for negotiating a proposed support package
- principles for prioritisation
- decision review procedures.

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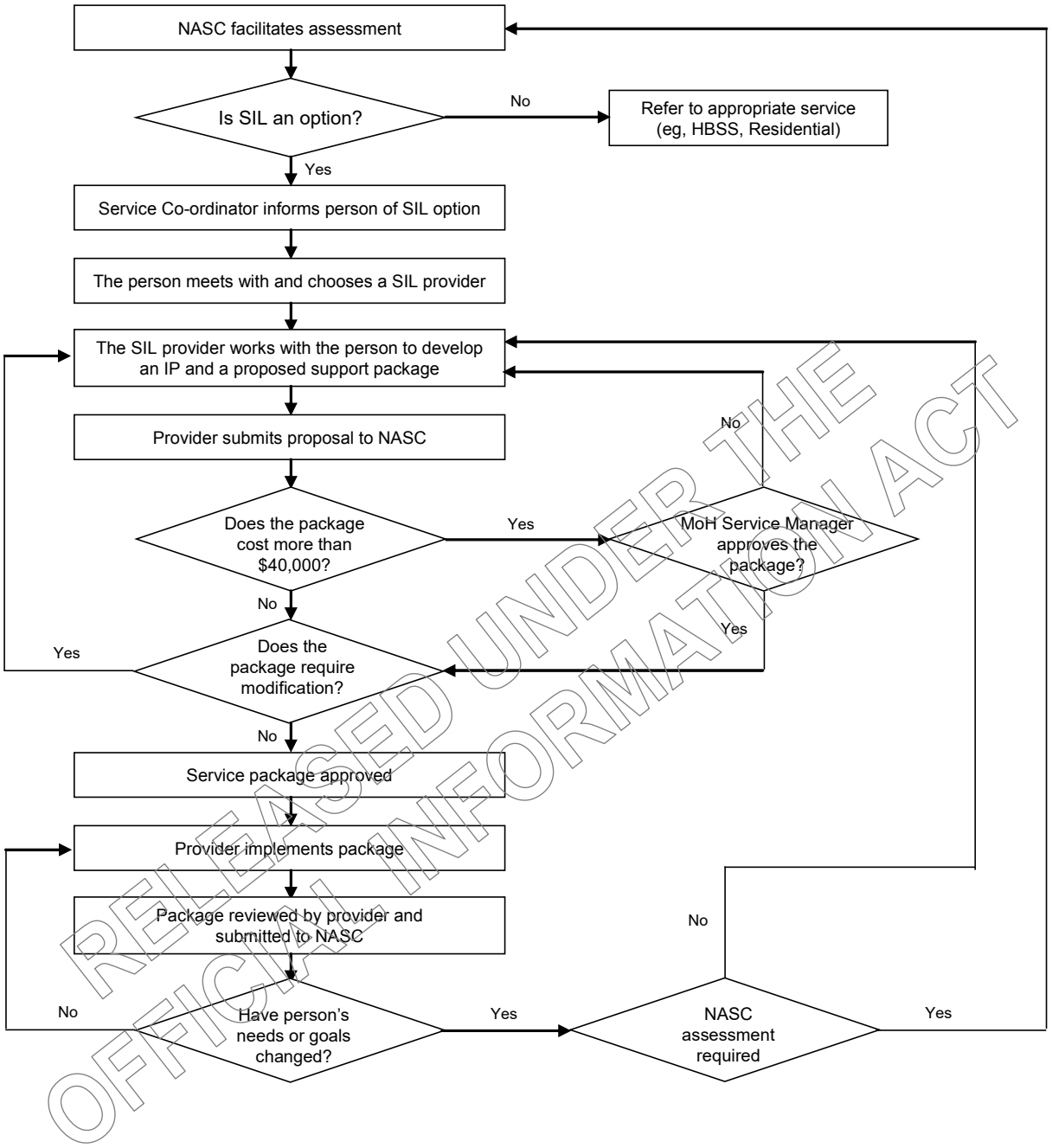
Flow Chart of SIL Process



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16 Quality NASCs for Māori – Three Examples of NASC Experiences

1 NORTHLAND DISABILITY RESOURCE CENTRE NASC

Northland Disability Resource Centre NASC has appointed a Māori Services Advisor who has brought skills of Te Reo, Tikanga, local knowledge of the networks within Tai Tokerau and appropriate iwi and hapū affiliations to the organisation.

Key roles identified include to:

- work with the NASC manager to identify and address how the NASC team can best respond to the cultural requirements of the local people and the contractual requirements of the NASC
- provide training and support to the NASC team and to monitor cultural safety and work practice
- increase access for Māori and to provide support for those doing so if that is their wish.

Differences this position has made to the NASC team include:

- an awareness and understanding of cultural differences and complexities of working within whānau, hapū and iwi
- knowledge regarding Māori processes and protocols and the confidence to participate appropriately
- confidence that their mahi is culturally safe.

This is a developing and ongoing role. The NASC Māori Advisor works with the Northland Disability Resource Centre Māori Liaison to ensure that ongoing training and development for NASC staff is addressed. All staff take part in a 'Te Tiriti o Waitangi' training at least every two years, participate in the 'Dynamics of Whanaungatanga' training and learn waiata weekly.

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2 DISABILITY SUPPORT LINK WAIKATO

The need for a more culturally competent service from Disability Support Link Waikato (DSL) was obvious due to the reticence of Māori to access services, and this was confirmed following discussion with the community, kaumātua and others. The combined view was that if the NASC developed a culturally appropriate assessment tool, had assessors from various iwi and the option of Māori service co-ordinators, some of the barriers to access may be lessened.

As a result DSL now has a staunch, supportive, active advisory group, Ngā Tau Manu. This group includes kaumātua, clients, iwi providers and other interested Māori. Through this group, and with community consultation, DSL developed the first step of a more acceptable tool that aligned to Whare Tapa Wha and the principles of the Treaty. It has developed assessor training, contracted and trained assessors from various iwi and recruited Māori service co-ordinators. This work continues to evolve, change and grow.

The outcomes have been a gradual increase in the number of Māori accessing services, joint partnerships with iwi providers to fill gaps in services, development of kaumātua day programmes, and different approaches to community support tailored to individuals but through contracted providers.

3 LIFE UNLIMITED TAIRAWHITI

Some indicators reflected the limitation of the existing service of LIFE Unlimited Tairawhiti.

- Families identified the need for culturally appropriate assessors and service co-ordinators.
- The numbers of Māori people who were accessing the service were low in comparison to the population base. It was clear that without a culturally competent service a significant portion of the population would not access NASC services.
- Client and community feedback were asking for a service that was delivered to suit the cultural needs of the people.

LIFE Unlimited responded to the need to provide a culturally appropriate service by:

- ensuring that staff employed were culturally appropriate and acceptable to the community in general
- working with local mana whenua to ensure their support and guidance
- holding hui when appropriate to talk about the needs of the particular roopu and how the NASC could respond to these
- consulting with, and working alongside, kaumātua and leaders from the community to gain the confidence and support of the local people
- ensuring that Māori were well represented on our Consumer Advisory Board.

The following outcomes have been achieved since these strategies were implemented:

- an increase in Māori participation within the NASC
- a partnering relationship with kaumātua and leaders within the community
- a service that better meets needs both culturally and regionally
- an ability to identify gaps and service development opportunities that are culturally appropriate
- an acceptance in general from Māori in the region that the NASC service is able and willing to work with them to meet their needs.

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17 Excerpt from 'Guidelines for Cultural Assessment – Māori' Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

MĀORI CULTURAL ASSESSMENT COMPETENCIES

Māori assessor positions can be established to manage quality control or carry out the assessment process. If there are insufficient people available to do this task within a locality then workforce development needs to be implemented to recruit and retain competent Māori assessors.

It is important that the cultural assessor/s are Māori and have experience and knowledge of working in the intellectual disability area. In many cases it will require a range of skills that may not be found in one person. For example in order to get both a mix of cultural, disability and clinical skills it may be preferable to engage the skills of both kaumātua and a person with disability and clinical skills in order to ensure that the assessment is carried out in a successful manner.

The assessor/s must have a good understanding of the concepts of whakapapa, mythology, kawa, tikanga and te reo because this is the context within which cultural assessments take place. The assessor may not know specifics in relation to a particular person but when talking to the person, aspects of these concepts need to be considered in order to determine whether there are any cultural aspects to the person's needs. It should be noted that certain cultural constructs might be associated with certain behaviours.

The assessment process also validates Māori healing methodologies, such as karakia, rongoa, spiritual assistance, tohunga, whanungatanga, te wātea, awhi, manaakitanga, whakapapa, whakawhānaungatanga, moemoeā, matauranga Māori taha wairua and mauiuitanga.

MĀORI CULTURAL ASSESSMENT ENVIRONMENT

The following conditions set the environment conducive to conduct a Māori cultural assessment process. Because of their broad nature these conditions are also applicable to the overall assessment process. These conditions will assist disability support services and Māori cultural assessors in developing policy, procedures and processes for Māori cultural assessments as part of their service delivery.

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- **To strengthen the wairua (spiritual wellbeing) of the individual and their whānau or hapū (under whare tapa whā – the four cornerstones of Māori health)**

  'All things in nature cohere. It is wairua that is the cohesive element.' Assessment of the wairua must be included in the assessment process as this forms the basis and core of all that Māori was, is and will be. The wairua consists of many aspects and components; the identification of those components gives insight and offers explanations for behaviour not only mentally and psychologically, but also physically. The wairua of an individual, whānau, hapū, iwi and waka and all that these entail take precedence over all other considerations.

- **To promote the wellbeing of the individual and their whānau/hapū**

  A whānau will ideally provide reassurance, aroha, confidence, warmth, empowerment and mana to the person and will sustain the person. It is appropriate for the whānau to be involved during the assessment and care provision process.

  'If there is anything you wish to know about me, ask me and ask my whānau.'

  Whānau is the nurturing environment in which a person feels they have support and aroha and will help them at all times. A whānau may be the immediate family, extended family, and in the social development of New Zealand, new forms of whānau for some people may be a residential support service, a support group or a group of friends whom the person has chosen to support them. Besides being a 'caretaker' of the wairua, the whānau also ensure the 'physical being' is nurtured and maintained. The participation of others is about defining and establishing a new type of relationship through this process and legislation.

- **The wairua of the service**

  Just as a meeting house has wairua that is distinct, so has a residential service. This wairua will depend on several factors or influences including staff and personnel, the buildings, the function of each building, its artwork, furniture and others provide a service to the people being assessed. In any service however, the wairua is developed or maintained by those who manage and work in that service.

  The integrity of the Māori cultural assessment will contribute to the wairua of the service by recognising the person's cultural needs in their care and rehabilitation. The knowledge of kaumātua and kuia will provide guidance for the service in ensuring that the wairua is maintained.

  The service must be careful not to alienate those Māori people who choose not to have a Māori cultural assessment nor to participate in Māori cultural activities. These people's choice must be respected and they must not be subject to harassment or coercion to try and change their mind. In the end it is the choice of the person to determine their involvement with tikanga Māori and their whakapapa.

- **To develop the whakapapa/mythology/history/kawa/tikanga/te reo of the individual**

  The assessor must have a good understanding of the concepts of whakapapa or genealogy, mythology, kawa, tikanga and te reo or Māori language because this is

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the context under which Māori cultural assessments take place. The assessor may not know specifics in relation to a particular person but when talking to the person, aspects of these concepts need to be assessed to determine whether there are any cultural aspects to the person's needs. It should be noted that certain cultural constructs might cause certain behaviours.

The assessment process also validates Māori healing methodologies, such as karakia, rongoa, spiritual assistance, tohunga, whanungatanga, awhi and manaaki.

- **To acknowledge the mana whenua**

  It is important that the local iwi or mana whenua are acknowledged, their advice sought and the different kawa of each area be recognised. The assessment and service co-ordination service must consult with local iwi in order to get their support for the Māori cultural assessment process. Kaumātua and kuia from local iwi may be included in the development of the process and have continual involvement in an advisory role. Their knowledge of tikanga, kawa and networks with other iwi will be invaluable to the disability support service in providing an effective cultural programme.

- **To establish and maintain kawa whakaruruhau within the service**

  Kawa whakaruruhau or cultural safety is a necessary component of a disability support service to assure Māori that the needs assessment, service co-ordination and service delivery they receive is safe for a Māori person in a predominantly non-Māori environment. While it is desired that the cultural assessment take place within a culturally safe service or location the impact on the quality of information will be affected if the 'place' is properly acknowledged. Once the assessment has been made, cultural safety is also inherently important in the summary of the individual's needs in order to provide a holistic picture. Key people such as compulsory care co-ordinators and care managers must have access to appropriate Māori resources and be competent in the area of Māori disability to ensure culturally safe assessments.

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CONFIDENTIALITY/RELEASE OF INFORMATION

The question of confidentiality is an issue for Māori. The compulsory care co-ordinator will have to determine the level and appropriateness of sharing or releasing sensitive information to the whānau.

As a general guideline it may not be advisable to release information to whānau if it is not going to lead to a good outcome for the individual or is against the wishes of the individual.

PRINCIPLES AND GOALS FOR CULTURAL ASSESSMENT

- To provide an holistic picture of a person's needs.
- It is an inherent right of an individual to receive a culturally appropriate assessment, care and service.

- That the individual is heard and considered throughout their assessment, care and rehabilitation.
- To enhance the cultural perspective on the needs of the person and their whānau through appropriate assessment, care and rehabilitation.
- To establish and maintain a culturally effective and safe assessment and care under the IDCCR Act 2003.
- To ensure the quality and effectiveness of assessment and service delivery for people with an intellectual disability.
- To ensure that people assessed are cared for in the least restrictive environment and their rights upheld.
- To ensure that assessors undertaking the cultural assessment are competent in the area of intellectual disability.
- To ensure the involvement of Māori in the development and delivery of intellectual disability services.
- To respect the wishes of a person who may not wish to have contact with their whānau.

Resource

Ministry of Health. 2003. *Guidelines for Cultural Assessment – Māori Intellectual Disability Compulsory Care and Rehabilitation Act (IDCCR)*. Wellington: Ministry of Health.

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18 Memorandums of Understanding

The NASC must establish and sustain effective relationships with other organisations providing services to people with a disability. These relationships must reflect the profile of the population served and their communities and will include community organisations, voluntary groups, support service providers, and other public sector agencies.

A central function of the NASC business is assisting people to access support services not only from providers contracted by the funder, but also from other providers and services available within their community, including those contracted with other funding bodies. Particular attention should be given to establishing effective working relationships that will ensure people are aware of and understand the processes for referral and services available through NASCs.

The funder will require the NASC to provide evidence of the effectiveness of relationships. For key agencies or providers the NASC should have in place Memorandums of Understanding (MoUs), protocols and other liaison mechanisms that agree how the relationship will be conducted. These will be an area for audit.

The NASC will also need to provide evidence of effective linkages with the disability community such as disability groups, support networks, advocacy groups, Māori groups and groups of Pacific peoples. Relationships must be managed in a way that has regard for the interrelationships that disabled people have with their networks and social support systems.

An example of an MoU is provided for information.

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Example only

MEMORANDUM OF UNDERSTANDING

AND

PROTOCOL OF COMPLEMENTARY WORKING RELATIONSHIP

.....

AND

.....

Are concerned and mutually in agreement with the importance of presenting and providing people with disabilities their families and whānau the New Zealand public with recognised national information and referral systems and service networks, focussing on the needs and requirements of people with disabilities their families and whānau, to assist them in their choices for achieving self advocacy, support services and independence within their chosen living environment.

..... provider for disabled people under the age of 65 years (excluding Mental Health and Personal Health) acknowledge the expertise ..... have; particularly in regards to local regional knowledge of support services for people with disabilities and agree that from time to time this expertise is needed to enable ..... to fulfil their role in the community.

..... and ..... agree that ..... will meet the following objectives:

- The development and publication of a carers pack, containing relevant information on support, referral, benefits and services for families and whānau of disabled people in the ..... community. The ..... consumer advisory group will be consulted with in order to achieve this objective. To be achieved .....
- The facilitation of the intersectoral meetings including the administration by way of secretarial services for the production of meeting minutes and the dissemination of those minutes and the preparation of agenda and associated meeting functions.

It is therefore agreed that ..... will for a sum of ..... during the year of ..... until ..... reimburse ..... for the completion of the above objectives, ensuring that they best meet the needs of people with disabilities, their families and whānau.

This memorandum acknowledges that ..... and ..... must meet formally within six months to discuss their relationship and to ensure that both parties are satisfied that the agreement is meeting their needs.

After this, both parties agree to meet at least annually to review this agreement and negotiate changes.

This Memorandum of Understanding and Protocol of Complementary Working Relationship relate purely to the operation and provision of disability support and information services, referral and advocacy services.

It is understood by both parties that the existence of this agreement does not inhibit either party on the development of other initiatives and services.

The parties agree to the exchange of information which is mutually beneficial and which would assist each other in performance of respective roles.

Both parties agree to work towards the improvement of services for people with disabilities, their families and whānau taking into account the objectives of the Health & Disability Strategy.

..... must present an invoice to ..... for payment.

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SIGNED:	**SIGNED:**
.....	.....
.....	.....
.....	.....
.....	.....
On behalf of.....	On behalf of .....

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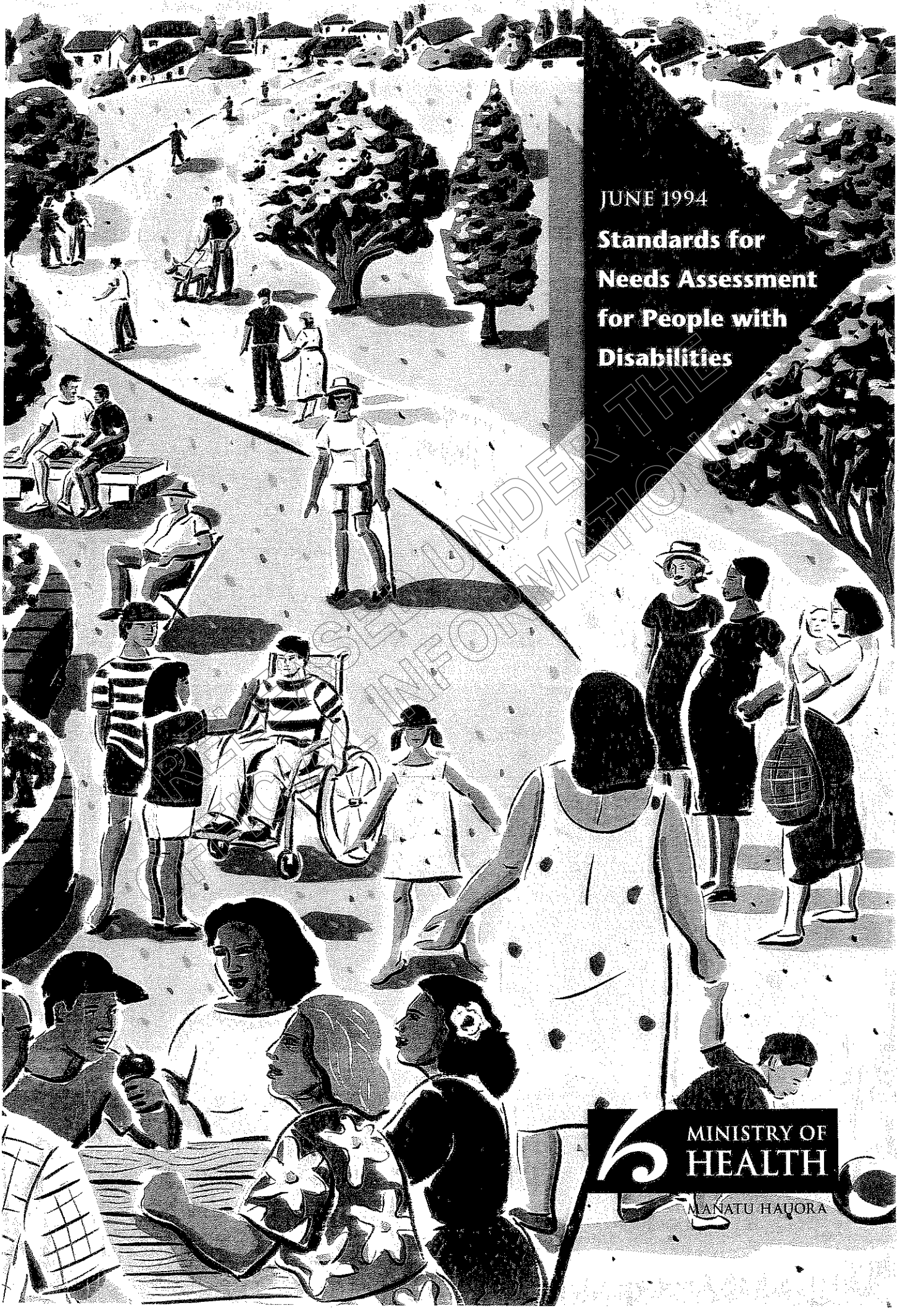

JUNE 1994

Standards for Needs Assessment for People with Disabilities

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MINISTRY OF HEALTH

MANATU HAUORA

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© Ministry of Health, June 1994

ISBN: 0-478-06752-6

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Foreword

In 1992 the Ministers of Health and Social Welfare produced the public consultation document *Support for Independence: A Discussion Paper for the Delivery of Disability Support Services*.

The people and organisations who responded to the document sent a clear message that assessment was the key to identifying disability support service needs. People with disabilities told us that while a range of assessment mechanisms were necessary for different situations, assessments varied across the country and consistent standards were needed.

In response, the Government made a commitment to having minimum national standards that providers of assessment services should meet. The *Standards for Needs Assessment for People with Disabilities* contained in this manual fulfil that commitment.

In developing the Standards, the Ministry of Health has consulted widely with people with disabilities, caregivers, groups representing people with disabilities, service providers and regional health authorities (RHAs).

The Standards represent a fundamental change in the approach to assessment. In the past, the purpose of assessment was often to determine people's eligibility for existing services - people had to fit the services rather than the other way round.

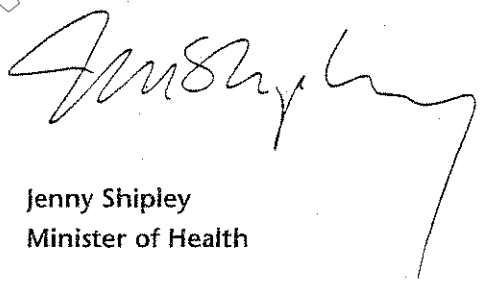
The new process of assessment will:

- focus on the needs of the person, their caregivers and family\whanau
- be a partnership between the person and their assessor
- recognise the knowledge and experience of the person, their caregivers and family\whanau
- recognise the importance of culture including disability, ethnicity, gender and sexual orientation

The new Standards will be introduced on 1 July 1994. From that date RHAs will be required to purchase assessment services from providers who meet the Standards or can demonstrate that they are working to achieve them.

The manual contains the Standards that assessment services will be required to meet within the next three years. This period of time will allow services to make the organisational changes required and to develop the necessary skills in a planned way.

The implementation of the Standards presents both challenges and opportunities for the providers of assessment services, and gives people with disabilities the process necessary to obtain effective, innovative and appropriate disability support services.



Jenny Shipley
Minister of Health

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Acknowledgments

Many people have contributed to the development of the *Standards for Needs Assessment for People with Disabilities*. Drafts of the Standards were widely circulated to consumers, caregivers and providers of disability support services. Valuable assistance was also provided by Maori whanau networks and Pacific Islands fono groups.

In particular, the Ministry of Health extends its appreciation to the members of the National Assessment Working Group who coordinated the development of the Standards.

James Brodie, Special Education Service

Jill Calveley, North Health

Adele Carpinter, Consultant

Di Davies, Ministry of Health

Jane Doherty, Southern Regional Health Authority

Ted Gallen, Central Regional Health Authority

Sue Gates, IHC

Jan Green, Ministry of Health and Caregiver

Kenneth Hand, Editor, Ministry of Health

Carmel Irwin, Ministry of Health

Wi Keelan, Ministry of Health (Senior Maori Advisor)

Jamesina Kett, Waikato Community Living Trust (Maori Representative)

Julie Lowe, Midland Health

Georgina Muir, Central Regional Health Authority

Fiona North, Ministry of Health

Jean O'Callaghan, Southern Regional Health Authority

John Stott, Southern Regional Health Authority

Steph Roberts, New Zealand Income Support Service

Carol Searle, Ministry of Health

Jiff Stewart, Social Policy Agency, Department of Social Welfare

Keriata Stuart, Ministry of Health

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We also wish to acknowledge the direction and support of Bert Biggs, Rehabilitation Studies Massey University; Don MacKenzie, Consultant; John Sinclair, The Treasury; Lester Mundell, Social Policy Agency, Department of Social Welfare; Paul Curry, Ministry of Health and the Disability Support Services Steering Group.

We are grateful to the consumers, caregivers, and organisations who provided valuable data during the consultative phases of the project.

The staff of the twelve services where the Standards were field tested deserve special thanks for giving so much of their time and experience. Thanks also go to the more than sixty individuals and groups who commented on the draft Standards.

To all those people who supported the development of the Standards, including those individuals or organisations which do not appear in these acknowledgments, our grateful thanks to you also.

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Introduction

A new approach to assessments for people with disabilities has been developed by the Government and the disability community. The new approach takes account of the comprehensive needs of people with disabilities, so that appropriate services can be co-ordinated to help meet those needs. This is a change from the current system where people are often assessed for their eligibility for existing support services. The *Standards for Needs Assessment for People with Disabilities* embody the new approach to assessment.

What is a needs assessment?

A needs assessment is a process of determining the current abilities, resources, goals and needs of a person with a disability and which of those needs are the most important. The purpose of the assessment is to decide what a person needs to achieve independence and participate fully in society, in accordance with their abilities, resources and goals. A person's comprehensive needs may include their recreational, social and personal development needs; their training and education needs; and their vocational and employment needs.

Needs assessments will be carried out by assessment services. A needs assessment service may be provided by a person, a group of people within a larger organisation, or a separate organisation, contracted by a regional health authority.

What are the Standards for Needs Assessment?

The Standards for Needs Assessment are minimum national standards for assessment services for people with disabilities. The Standards describe what is required for a high quality, effective needs assessment service. The Standards have been designed to ensure that assessment services provide nationally consistent, high quality assessments while allowing for flexibility and innovation in the delivery of those services.

The Standards reflect the kind of assessments that people with disabilities have asked for. They provide assessment in a way which recognises and is compatible with the person's cultural beliefs, values and aspirations. They can be used by all existing disability support services (including residential, vocational, social or educational) and, most importantly, by people with disabilities.

Who will use the Standards?

The Standards will primarily be used by assessment services, particularly assessment facilitators and specialist assessors; by regional health authorities; by people with disabilities, their caregivers, family/whanau and friends; and by groups which represent people with disabilities.

Regional health authorities will purchase assessment services which meet the Standards and the needs of the people of their regions. They will use the Standards to evaluate and monitor the assessment services they purchase.

People with disabilities will be able to use the Standards to judge the quality of the assessment services they receive. Caregivers, family and whanau, and groups representing, or advocating for, people with disabilities will also be able to use the Standards to evaluate assessment services.

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The needs assessment process

A needs assessment is about 'partnership' between a person with a disability and the assessment service; a partnership which recognises and respects the person's knowledge and experience of disability. The assessment service will encourage full participation by the person, their caregivers, family/whanau and friends, if the person wishes those people to be involved.

The person and the assessment service will agree on an assessment facilitator who is acceptable to the person, to manage the assessment process. The assessment facilitator will be responsible for informing the person about the assessment process and ensuring that they understand what is happening throughout. The assessment facilitator will inform the person about their rights and responsibilities, and ensure that the assessment process meets the person's cultural needs.

The assessment process ensures that the person's privacy and the confidentiality of the information they give will be safeguarded. The person has the right to have access to all information arising from their assessment.

The Needs Assessment Manual

The Needs Assessment Manual is made up of two parts: the Standards and the Specific Guidelines. A glossary of terms is also included in the Manual.

The Standards are based on seven key principles which embody the objectives of the assessment process. Each standard has a commentary which contains more detail about how assessment services are expected to perform. Each standard also has its own performance indicators. The performance indicators are questions that can be asked by RHAs or people with disabilities, their caregivers and family/whanau to evaluate whether an assessment service is meeting the Standards.

The Standards are supplemented by six specific guidelines which give more detail on key aspects of the needs assessment process. The Specific Guidelines must be followed to meet the *Standards for Needs Assessment for People with Disabilities*.

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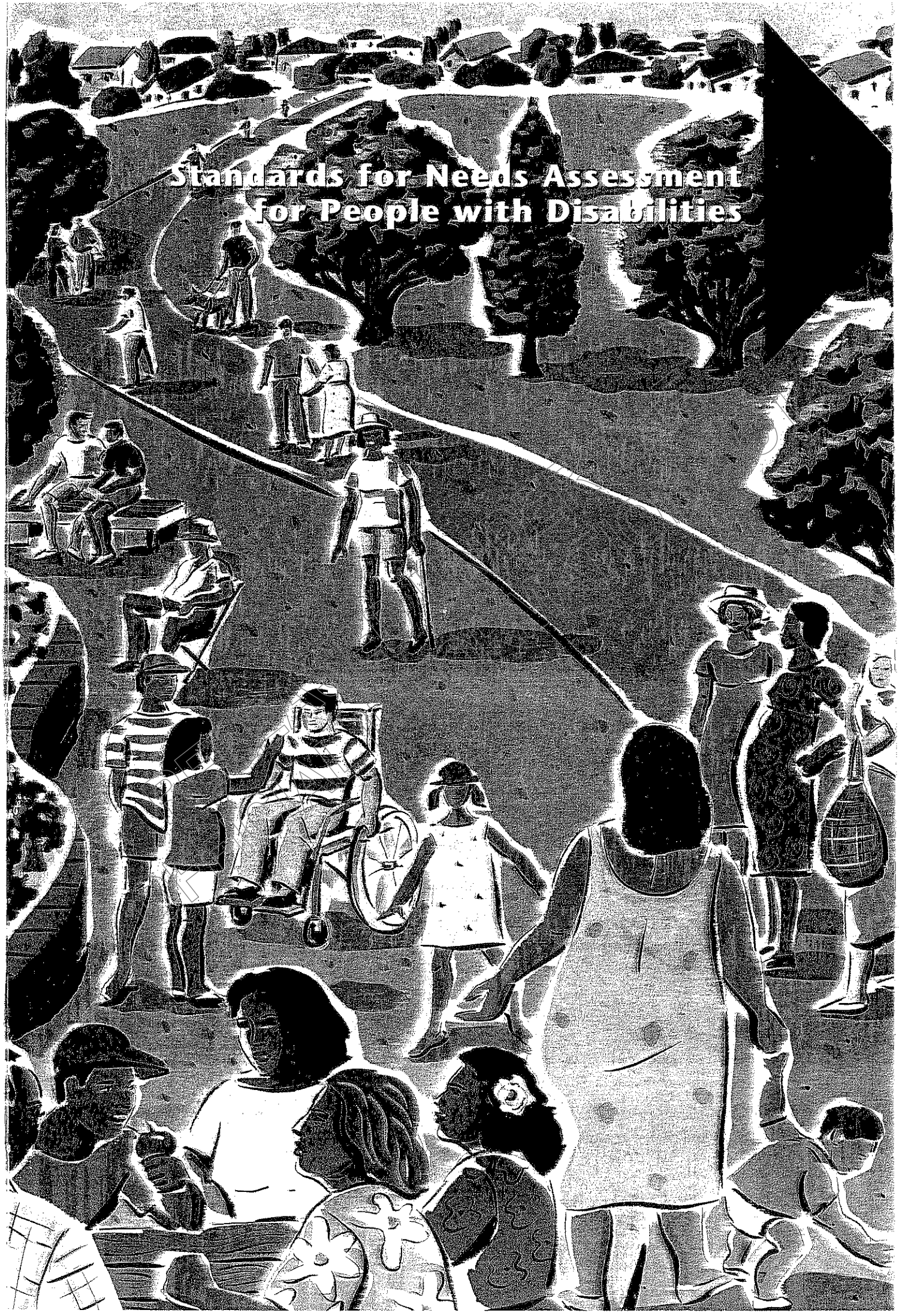
Standards for Needs Assessment for People with Disabilities



PRINCIPLE

Participation of community members and groups will support the development of assessment services which are flexible, easy to have access to, and responsive to the community they serve.

Standard 1 Entry to be easy

Standard 1.1

The assessment service will distribute clear information about the service, ensuring that it is widely known.

The assessment service will outline what assessment is, and will provide information about the service - where it is located, how to make contact and what it provides.

The service should ensure that information is available in English, Maori, Pacific Islands and other languages and in a variety of forms of communication (such as large print, braille, tape) that reflect the needs of people using the service.

Information must be widely available and promoted throughout the community. This could be achieved by providing information to community networks and organisations who specialise in communicating with particular groups - for instance Disability Information Centres or Citizens' Advice Bureaux - or people such as general practitioners or district nurses. Several assessment services could establish joint initiatives to advertise in this way.

Performance indicators 1.1

- What methods does the service use to inform people about the assessment service?
- What information is provided in these communications?
- Are pamphlets and booklets about how to contact the service available to people free of charge?
- Is this information available in the appropriate community languages and forms of communication?
- Does the service carry out promotion programmes? What are some examples?

Standard 1.2

The assessment service will action all referrals and assessments promptly and appropriately.

When a person contacts the assessment service about an assessment, the service will determine whether the person has disability-related needs, or needs arising from some other cause.

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When a person with a disability has needs not related to the disability, they should be advised which agency to contact. For example, an acute health need would be referred to another health agency; income or housing difficulties would be referred to the New Zealand Income Support Service or Housing New Zealand.

When a person contacts the service about an assessment, the service will obtain enough information from them to ensure the person receives a prompt assessment from the most appropriate person. The information will be recorded and passed on to the assessment facilitator.

The service will ensure that assessment facilitators are able to contact a range of specialist assessors (for example, vocational, mental health, special education) to provide a comprehensive assessment.

Performance indicators 1.2

- Does the service carry out assessments promptly and appropriately? How is this measured?
- How does the service gather information from people who are assessed and/or referral agencies to determine whether the service is appropriate for them?
- What type of advice/referral is provided where a person has health needs not addressed by the service? What are some examples of this?
- Does the service have access to a range of specialist assessors to provide comprehensive assessments? How does this happen?
- Do staff develop and maintain liaisons with relevant agencies and services (such as hospitals, GPs, specialists, schools, workplaces, government agencies)? What are some examples?

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Standard 1.3
The assessment service will have established procedures to ensure that people in crisis are referred to services which can provide immediate assistance.

The assessment service will have guidelines, known to all staff, which identify a crisis. The guidelines will have an after-hours contact. Staff will know the appropriate people or agencies in their area to whom they can refer people in crisis.

Performance indicator 1.3

- Does the service have an established procedure for responding to people in crisis for assessment after hours (for example, roster system, telephone diversion to local casualty unit)? How does this occur?

Standard 1.4

The assessment service will be accessible to all people with disabilities.

Wherever possible, the assessment should be carried out in the person's home. If the person being assessed has urgent needs, their preference for the location of the assessment is paramount.

The service will be located in a convenient place close to public transport. It should be well signposted in languages appropriate to the local community. Access to buildings will comply with statutory codes.

The service will obtain assistance for people who have alternative communication needs (for example, people who use sign language) and those for whom English is a second language.

Performance indicators 1.4

- Where are assessments generally carried out?

  If assessments are generally carried out at the service:

  - is the service located in a visible and convenient part of the community it serves?
  - can the service be easily reached by public transport?
  - is there an easily read signpost in the vicinity of the service directing people to its location?
  - does the service have an easily read sign prominently displayed outside the building with the service's name, telephone number and hours of operation? Does the sign have information in the appropriate community languages?

- Does the telephone system operate efficiently, and does it provide information 24 hours a day (a recorded message or call diversion unit may be required)?
- Does the service inform people in its community who have alternative communication needs of the availability of interpreters when using the service? How does this occur?
- Does the building comply with all statutory codes on access to buildings?
- Does the service have documented entry procedures which are friendly to visitors and are followed by all staff?

Standard 1.5

The assessment service will have simple, efficient and welcoming entry procedures.

Obtaining an assessment should be as easy as possible. A person should be able to initiate the assessment process through a visit or telephone call. They may refer themselves, or be referred to the service by another agency such as a GP.

The first visit should take place within two weeks following first contact with the assessment service.

Performance indicators 1.5

- What steps are taken to make people feel welcome to the service? What are some examples of this?
- How long after first contact is made does the first visit usually take place?

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Standard 2 Written policies and procedures

Standard 2.1
The assessment service will have written policies and procedures followed by all staff.

The assessment service will have documented policies and procedures which reflect current knowledge and principles of assessment. These will be consistent with the objectives of the service, and with statutory legislation and regulations (for example, the Health Information Privacy Code) and the requirements of professional bodies.

The assessment service will have policies for the assessment of Maori, Pacific Islands peoples, and other ethnic groups.

The assessment service will have clear written directives for staff regarding the scope or limitations of their responsibilities and activities.

The service will consult with consumers in the development of policies and procedures. Policies and procedures involving all aspects of the assessment process will be reviewed and updated at least annually.

Performance indicators 2.1

- Are there documented, dated policies and procedures which reflect current knowledge and principles of assessment?
- Are these consistent with the objectives of the service, statutory legislation, and regulations (for example, the Health Information Privacy Code) and the requirements of professional bodies?
- Are staff actively involved in the formulation of policies and procedures?
- How are the views of consumers and caregivers included in the formulation of policies and procedures?
- Are there policies and procedures for the care of Maori, Pacific Islands peoples and other ethnic groups?
- Do the policies and procedures provide clear directives detailing the scope and limitations of the responsibilities and activities of the service's staff?
- When were the policies and/or procedures last reviewed?

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PRINCIPLE

People with disabilities will be assessed through a process which is coordinated, culturally safe, flexible and responsive to the specific needs of people and their caregivers.

Standard 3 The assessment process will be culturally safe

Standard 3.1

The assessment service will have policies which ensure that assessments are conducted in a culturally safe manner.

'Cultural safety' can be defined as the provision of services in a way that recognises and is compatible with the person's cultural values, beliefs and needs. This may include the person's disability group, ethnicity, gender and sexual orientation.

Assessment service staff will take account of the cultural background and preferences of the person being assessed. The assessment service will consult with cultural groups in its community, and take account of the ways in which people from different cultures give and receive information and services.

The assessment service will discuss and negotiate with the person:

- the selection of an assessment facilitator who understands their cultural needs and is prepared to do what they can do meet them
- an agreed process for the assessment which is suitable to them
- the place in which they feel comfortable and would like the assessment to take place
- the people they would like to attend their assessment, recognising the importance of family/whanau, caregivers and community support, and the person's right to have an advocate present.

Performance indicators 3.1

- Is the person being assessed consulted about their preference of assessment facilitator?
- Is the person being assessed consulted about who will attend the assessment and where it will take place?
- Are assessments conducted in a place where the person feels safe? How does the service know this?
- Is the assessment process always discussed with the person to decide appropriate methods to proceed?
- Are traditional or alternative assessment practices and/or resources used where appropriate? What are some examples of this?
- Does the service consult with the appropriate cultural groups in the provisi of assessment services for them? How do this happen?

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Standard 3.2

The assessment service will ensure the needs of Maori are met throughout the assessment process.

All assessment services must have policies and procedures which enable the delivery of culturally safe services to Maori.

Where there are significant numbers of Maori consumers, services should develop effective consultative relationships to provide an understanding of the kawa (cultural etiquette) of local iwi (tangata whenua) and other Maori consumer groups.

Staff resources and the design of the service building will facilitate the participation of whanau and extended family in the assessment process.

The assessment service will ensure that all staff are aware of the impact of their own culture upon people from other cultures, particularly Maori. The service will have adequate numbers of appropriately trained staff who practice in a culturally safe manner available to meet the needs of Maori.

The assessment service will ensure that where possible, Maori people are assessed by other Maori and are able to use their own language during assessment.

Performance indicators 3.2

- Does the service have policies and/or procedures for the care of Maori?
- Are there Maori assessment staff in the service?
- Does the service facilitate the participation of a kaumatua or Maori consultant to ensure cultural safety if the person prefers this? What are some examples?
- Are all assessments carried out at the assessment centre? Where else are assessments carried out?
- How does the service ensure the participation of family/whanau in the assessment process?
- Does the service consult with tangata whenua and/or Maori consumer groups?
- Do human resource policies take account of cultural issues by:
  - inclusion of cultural knowledge in job descriptions
  - induction and continuing training?

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Standard 3.3

The assessment service will ensure that the needs of Pacific Islands peoples and other ethnic groups are met throughout the assessment process.

The service will have policies and procedures in place to ensure that assessments are undertaken in a way which is culturally safe for Pacific Islands peoples. The service will recognise that within Pacific Islands communities there are many different cultures, and they are not uniform in their language and cultural practices.

The assessment service will have policies and procedures in place to ensure that assessments are undertaken in a way which is culturally safe for people from other ethnic groups.

Performance indicators 3.3

- Are there policies and/or procedures for the assessment of Pacific Islands peoples and other ethnic groups?
- Are there any assessment staff from Pacific Islands and other ethnic groups?
- What contacts does the service have with Pacific Islands groups and other ethnic groups?
- Are non-Pacific Islands staff offered any form of cultural awareness training?
- Does the service facilitate the participation of respected individuals or consultants and interpreters from the Pacific Islands and other ethnic minorities to ensure cultural safety, if the person being assessed prefers this?

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PRINCIPLE

The assessment service will uphold the rights of people being assessed to informed decision making and independent expression, and will treat them with dignity and consideration. The person, their family/whanau and caregivers will be respected for their knowledge and experience of disability.

Standard 4 People-oriented process

Standard 4.1

The assessment service will treat the person being assessed with dignity and respect at all times.

The person being assessed and the assessment facilitator will be partners in the assessment process. In policy and in practice, the person, their caregivers and family/whanau will be respected for their knowledge and experience of disability.

The assessment process will recognise that each person and their situation is unique. Staff of the service will show proper respect for cultural and personal beliefs, acknowledging their importance to the person's well-being.

Performance indicators 4.1

- Does the service have a policy and/or procedure to ensure that staff show proper respect for a person's cultural and personal beliefs? How does it ensure that the policy is carried out?
- Are people encouraged to comment on how they respond to the service?

Standard 4.2

The assessment service will preserve the person's rights.

The service will implement appropriate measures to ensure the rights and interests of people being assessed are protected.

The assessment service will have a written procedure known to staff, which identifies when people are unable to represent their own interests. This will include identifying whether a person is of testamentary capacity or in need of the protection afforded under the Protection of Personal and Property Rights Act 1988. There will be written procedures covering the steps that should be taken if staff believe that a person being assessed cannot represent their own interests.

All assessors must have an understanding of legislation and regulations which identify the age at which a client is entitled to speak and decide on their own behalf.

The assessment service should have information available on how to obtain support for people who cannot represent their own interests.

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Performance indicators 4.2

- Are staff familiar with all aspects of the policy on the rights and responsibilities of people being assessed?
- Is appropriate information available for people who cannot represent their own interests?
- Does the service ensure that people being assessed receive written information about their rights? How does this happen?

Standard 4.3

The assessment service will provide opportunities for family/whanau and caregivers to participate in the assessment process, with the knowledge of the person being assessed.

The assessment process must respect that the person, their family/whanau and caregivers have the right to be involved at all stages of the assessment.

It is important that family/whanau and caregivers are consulted during the assessment, and that their support or service is not overlooked when developing an understanding of the person's current support system. However, the assessment service must ensure that the person being assessed knows how they will be involved. When family/whanau are involved, the assessment facilitator will ensure that they understand the purpose of the assessment, what will happen, and their role in the process.

The needs of caregivers should be considered. The assessment facilitator will assess the person with the disability, but also ensure that the caregiver knows they can refer themselves separately for an assessment of their own needs.

The assessment service will ensure that members of the family/whanau or caregivers who may wish to be interviewed separately from the person being assessed have this opportunity, but that the person being assessed is aware that this will happen.

Where people are unable to represent themselves due to the nature of their disability (see Standard 4.2), the assessment service will gather information from the person who has the right to represent the needs of the person being assessed.

Performance indicators 4.3

- How does the service ensure that family/whanau or caregivers are able to participate in the assessment?
- Is the informed consent of the person being assessed sought before family/whanau and caregivers are involved in the assessment?
- Does the assessment facilitator explain the purpose of the assessment and the role of the family/whanau and caregiver in the assessment? How is this done?
- Are the needs of the family/whanau and caregivers identified during the assessment process? How does this occur?
- Are there facilities to meet the wishes of family/whanau or caregivers who may want to be interviewed separately from the person being assessed?

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Standard 4.4

The person being assessed will agree who will be present during their assessment.

The person being assessed has the right to know the names of all people attending and the reasons for their presence.

There will be occasions when people other than the assessment facilitator ask to attend an assessment (for example, for training). The assessment facilitator should ensure that the person being assessed knows if anyone else wishes to be at the assessment, in time for them to make an informed decision about who should be present.

Some people may wish members of their family/whanau or other people to be present, or excluded, when particular information is being collected or when some sensitive topics are being discussed. The assessment facilitator must respect the person's rights to agree who will be present and help facilitate this.

Performance indicator 4.4

- Does the assessment facilitator obtain the informed consent of the person about who will be present at the assessment? How is this done?

Standard 4.5

The assessment is to be undertaken in an environment that is comfortable for the person and appropriate to their needs.

The ideal place to do the assessment is in the person's home, or in a place where the person feels comfortable (such as a marae health centre). However, for reasons such as the need for special equipment, or costs to the service, this may not always be possible. The service should be flexible in meeting the person's preference, but must achieve a balance between quality and efficiency of the service.

The assessment should be undertaken in a non-intrusive environment, which respects the person's right to privacy. Facilities at the assessment service should provide a warm relaxed atmosphere.

Performance indicators 4.5

- Are assessments carried out in people's homes? Are assessments carried out at other places (such as marae centre, school or workplace)?
- If the person being assessed cannot come to the service, are special arrangements made to meet their preferences during the assessment?

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PRINCIPLE

People undertaking any assessment will be competent, knowledgeable about the disabilities of people they assess, respectful of people with disabilities, their family/whanau and caregivers, and acceptable to the person being assessed.

Standard 5 The appropriate people will be involved in the assessment process

Standard 5.1

The assessment facilitator will work with the person being assessed to identify and prioritise their needs.

The person being assessed makes an essential contribution to the assessment. Without their full involvement the assessment will not be accurate or comprehensive.

The assessment facilitator will explain to the person their right to be fully involved in, and be acknowledged for the experience they bring to, the assessment. The assessment service will recognise the person's contribution by seeking their participation in all decisions made about the assessment process, and when gathering information about their needs.

The person's input will be sought, recorded and used to identify and prioritise their needs. At the end of the assessment process, the assessment facilitator and the person being assessed will record that they are in agreement on the outcomes.

Performance indicators 5.1

- Are people formally advised that they have a valuable role in the assessment and determination of priorities? How is this done? How does the service ensure this is always done?
- Is the person being assessed asked to participate in the assessment? How does the service ensure this happens?
- Has the person being assessed recorded their agreement or other comments regarding the outcome of the assessment process?

Standard 5.2

The assessment facilitator will ensure that people have access to advocacy services.

The assessment service will ensure that the person's right to advocacy is safeguarded. The service will have an established procedure which enables the person or their representative to obtain an advocate who is independent of the service.

Information about how to contact an advocate will be readily available in a variety of ways to meet the disability needs of all people who use the service. Specific Guideline 3 provides more information on advocacy services.

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Performance indicator 5.2

- Does the service have a policy and/or procedure to ensure that the person's access to advocacy services is preserved? How does this operate? How does the service ensure this happens?

Standard 5.3

The assessment facilitator will ensure that the person is fully informed of all steps in the assessment process.

The person being assessed must understand what is happening at all times. The assessment facilitator will provide information so that the person understands their rights and responsibilities throughout the assessment process. The person being assessed should always have opportunity to ask for clarification of what is happening.

The person being assessed should be able to withdraw from the assessment if they wish to. If a person chooses to withdraw from their assessment, the assessment facilitator will ensure they understand that this may compromise their eligibility for services funded by the regional health authority.

Performance indicators 5.3

- Are there policies and/or procedures to ensure that staff keep the person informed at all stages of the process on what is happening? How is this done? How does the service ensure it is done?
- If people want to withdraw from the assessment, how are they advised of the implications?

Standard 5.4

The assessment service will maintain continuity of personnel wherever possible.

Continuity of assessment staff helps to build a trusting relationship between the person being assessed and the people involved in the assessment.

The service will allocate an assessment facilitator to work with the person being assessed. If it is at all possible, the same assessment facilitator will work with them throughout the assessment. The assessment facilitator's name will be entered on the person's record.

Performance indicators 5.4

- Is an assessment facilitator appointed for each assessment? How does this occur?
- What steps are taken to ensure continuity of care?

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Standard 5.5

The person has the right to be assessed by someone they trust.

The person will be assessed by the most appropriate member of the assessment team. Where it is possible, they will have a choice of assessment staff and the ability to change their assessment facilitator if they wish to.

Performance indicators 5.5

- What steps are undertaken by the assessment facilitator to build a good relationship between themselves and the person being assessed?
- Where possible, is the person able to have an assessment facilitator of their choice? What are some examples? What happens when a person wants to change their assessment facilitator?

Standard 5.6

The assessment facilitator will ensure that all aspects of the assessment process are effectively coordinated.

The assessment facilitator will ensure that:

- the process of assessment is as simple or as specialised as each person requires
- all appointments as part of the assessment are coordinated and timed to meet the needs of the person being assessed
- all information is brought together and compiled in the assessment report
- the person and their family/whanau or caregivers are kept informed during the process of assessment.

For more information on the role and responsibilities of the assessment facilitator, see Specific Guideline 2.

The assessment service will ensure the assessment report is received by the appropriate service coordination function, and that only relevant information is transferred to other agencies. This protects the person's privacy and ensures that the person being assessed will not have to give information more than once.

Performance indicators 5.6

- Is there an assessment facilitator responsible for coordinating the entire process of assessment?
- Is the assessment process coordinated and timed to meet the needs of the person being assessed?
- How does the service ensure that the necessary information is sent to other agencies?
- Is the agreement of the person being assessed sought in these cases? How is this done?
- Are records kept to ensure each step of the assessment process is completed? How does it ensure this is always done?

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Standard 5.7

The assessment service will ensure that assessment facilitators hold appropriate qualifications and keep up to date with developments in their area of disability and assessment.

The assessment facilitator will:

- have appropriate qualifications and competencies in their specific field of expertise
- be able to advise the person of the range of specialist assessment options available
- explain to the person their rights and responsibilities during the assessment.

The assessment service will also ensure that assessment facilitators have opportunities to develop their skills in, and knowledge about, improving in needs assessment.

Performance indicators 5.7

- Do all assessment facilitators hold recognised and relevant qualifications in their field of assessment?
- How are staff who perform the assessment facilitation role encouraged to maintain and improve their skills in the field of assessment? Is there a budget for skills development?

Standard 5.8

The assessment service will ensure that specialist assessors hold appropriate qualifications, currently practise in a relevant field, and keep up to date with developments in their area of assessment.

The assessment service will ensure that all specialist assessors are appropriately qualified to provide a quality assessment based on established professional standards. The assessment service will also ensure that all staff have access to professional development.

Services will ensure that assessors, who may or may not be staff of the service, are available to meet the needs of Maori. Services will also provide assessors to meet the needs of Pacific Islands peoples and those of other ethnic groups.

Performance indicators 5.8

- Do all assessment staff hold recognised and relevant qualifications in their field of assessment?
- Are staff encouraged to maintain and develop their professional skills in the field of assessment?
- What forms of professional development are available to staff?
- What steps do the assessment service have to take to ensure that sufficient assessors are available to meet the needs of Maori?
- What steps do the assessment service have to take to ensure that sufficient assessors are available to meet the needs of Pacific Islands peoples and other ethnic groups?

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Standard 5.9

At the request of the person being assessed, the service will facilitate participation of a specialist in Maori tikanga from the person's iwi or other Maori group.

Services should develop effective consultation links with local iwi. The participation of a kaumatua or specialist from the iwi will ensure that the service meets the preference of Maori, where requested, to be assessed by people who from their cultural perspective are recognised, competent practitioners.

Performance indicator 5.9

- Is a specialist in Maori tikanga (as recognised by the iwi and the person) available to participate in the assessment process if the person so wishes? How does the service ensure this happens?

Standard 5.10

The service will ensure that all assessors undertake assessments only in the area of their own competence.

When a specialist assessment is required, that assessor will have proven competence in that field. If they are not competent, they will refer the person being assessed back to the assessment facilitator, who will arrange for an assessor with the appropriate skills and qualifications.

Performance indicator 5.10

- What steps are taken to ensure that assessments are only carried out by people who are appropriately qualified in the area being assessed?

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PRINCIPLE

Communicating information regarding all aspects of assessment will promote self-determination and choice for people with disabilities. This will include information about their individual rights and obligations throughout the assessment process, and the availability or choice of assessment services.

Standard 6 Information will be provided to the person being assessed

Standard 6.1
Information will be provided to the person being assessed in a way that is appropriate to their communication needs.

The assessment report will be presented in a form which is appropriate to the communication needs of the person being assessed. This may require interpretation or translation in some cases. Alternative communication forms (such as braille, tape, bliss symbols, facilitative graphics) will be used when necessary.

Performance indicators 6.1

- Are assessment forms available in languages and formats representative of the disability groups and community the service deals with?
- Are copies of the assessment forms available to the person being assessed or their caregiver and/or the person representing their interests?

Standard 6.2
The person will be given information about their rights and responsibilities. This should be explained to them before they consent to take part in an assessment.

The Rights and Responsibilities document (which can be found in Specific Guideline 1) will be given to the person at the beginning of the process, or before the assessment if possible. The document outlines the rights and responsibilities of a person during their needs assessment. The assessment facilitator will confirm that the person understands the document before the needs assessment takes place.

Information will be available in languages and forms which are easily understood by all groups in the community, including Maori, Pacific Islands peoples and other ethnic groups. The service will also obtain assistance for people who have alternative communication needs.

Performance indicator 6.2

- Does the assessment facilitator confirm that the person being assessed understands their rights and responsibilities? Show examples of how this happens.

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Standard 6.3

People will have information about the action to take if at any time they are dissatisfied with the assessment.

The assessment service will have information available to all people being assessed about the range of steps which can be taken to resolve disputes. It will be in forms which can be easily understood by all users of the service (see Specific Guideline 6 for more information).

Performance indicators 6.3

- Is there an established complaints and review system? How does this operate? Is information available on how people can use the system?
- How does the assessment service ensure that all complaints are properly handled?

Standard 6.4

The person will have access to any information recorded in connection with their assessment.

The assessment service will ensure that the person being assessed has access to any information gathered or recorded in connection with their assessment. A copy of the final assessment report will always be given to the person.

The service will ensure that only relevant information is transferred to other agencies, and is only transferred with the knowledge and permission of the person being assessed.

Performance indicators 6.4

- Are people able to have access to all written information on their assessment?
- Are people provided with a copy of their final assessment report?
- Is the knowledge and permission of the person being assessed sought before information about them is transferred to another agency?

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PRINCIPLE

People being assessed will have access to information arising from their assessment. Their privacy and confidentiality will be safeguarded.

Standard 7 Collection, storage and transfer of information will be carried out in a secure, confidential manner

Standard 7.1

All information gathered during an assessment will be subject to the Health Information Privacy Code and the Privacy Act 1993.

The assessment service will ensure that it complies with the requirements of the Code and the Act. The assessment facilitator will ensure that the person being assessed is aware of their rights under the Code and the Act. Where family/whanau or caregivers may want information they provide to be kept confidential, the service should ensure that it complies with the requirements of section 29 of the Privacy Act, as discussed in the Code.

Performance indicators 7.1

- How does the service ensure that it complies with the Health Information Privacy Code and Privacy Act 1993?
- Does the assessment facilitator inform the person being assessed of their rights under the Code and Act? How does the service ensure this is always done?

Standard 7.2

The assessor will maintain accurate records of the process and outcome of assessment.

All information collected during the assessment process will ensure the development of a full and accurate report. Everyone who enters information on a person's records will ensure that all information gathered or recorded is relevant and up to date.

Performance indicators 7.2

- Are there clear and appropriate procedures for the recording of the information collected during the assessment process?
- Are assessors provided with any training on methods of keeping records?
- How does the service ensure information is relevant and up to date?

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Standard 7.3

All information collected will be treated as confidential, and all records kept secure.

The assessment service will have established policies and procedures for safeguarding the information contained in records against loss, damage, or use by unauthorised persons.

Specific measures will be taken to ensure that computerised records are kept confidential.

There will be established procedures to ensure that appropriate information is transferred to other agencies only when permission has been given by the person concerned. Services will maintain awareness of the need for security and confidentiality when transferring information, for instance in the use of fax machines.

For further information on this principle, refer to Specific Guideline 5.

Performance indicators 7.3

- Are there policies and/or procedures to ensure the confidentiality and security of records? How is this done?
- Is there a procedure to ensure that only appropriate information is transferred to other agencies? How is this done?

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PRINCIPLE

The self-determination and choice of people with disabilities and their caregivers will be promoted by an assessment process which incorporates their views and goals, and which produces an accurate summary of their needs as the basis for informed service planning and choice of services.

Standard 8 The outcomes of the assessment will be an accurate identification of individual needs

Standard 8.1

The outcome of the assessment should not be influenced by considerations of the availability of services or resources.

Assessment should be conducted in an environment which is independent of service coordination and provision. The assessment service should be able to demonstrate that the outcomes of assessments are not influenced by existing disability structures and services.

Performance indicator 8.1

- How does the assessment service ensure that the assessments are independent of service coordination and provision?

Standard 8.2

The assessment service will produce a comprehensive and accurate assessment of the person's abilities, resources, goals and needs.

The assessment service will provide a comprehensive and accurate description of the person's needs in all the environments they participate or wish to participate in.

The assessment report will include the person's views and, where appropriate, the views of the caregiver. The assessment report will identify all areas where the person may be assisted to enhance independence and improve function by being referred to the appropriate service.

Refer to Specific Guideline 4 for details of what elements should be contained in the report.

Performance indicators 8.2

- How does the service collect the information required to identify the needs of the person being assessed? How does it place them in order of priority?
- Are the views of the person being assessed and (where appropriate) the views of family/whanau and caregivers included in the report? How is this done?
- Does the assessment report meet the criteria as listed in the Specific Guideline *Completing the Needs Assessment Report: Guidelines for Assessment Facilitators* which accompanies the Standards?
- Do assessment facilitators receive training in how to write an assessment report?

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Standard 8.3

The assessment service will ensure that people who need vocational and educational assessments receive them.

Vocational and educational needs are integral to a person's abilities, resources, goals and needs.

The assessment service will ensure that all young people under 21, as part of their assessment, have received an assessment of their educational and developmental needs. If they have not already received an assessment, or if their needs have changed, they should be referred to the Special Education Service (SES). The information from the SES assessment will form a part of the assessment report.

The assessment service will ensure all people between the ages of 14 and 65 have received a vocational assessment. If they have not already received an assessment, or if their needs have changed, they should be referred to the appropriate local vocational service. The information from the vocational assessment will form a part of the assessment report.

Performance indicators 8.3

- Does the service have access to specialist educational and vocational assessors?
- Do all people between the ages of 14 and 65 receive a vocational assessment?
- Does the information collected during the vocational assessment form part of the assessment report?
- Do all young people under the age of 21 receive an assessment of their educational and developmental needs? How does this happen?
- How is the information from the special education assessment included in the assessment report?

Standard 8.4

The person and their assessment facilitator will discuss the process and confirm that their report is accurate.

The assessment facilitator will discuss with the person (and, where appropriate, their family/whanau and caregivers) the steps of the assessment process, and confirm that the person understands the final report. This is to ensure that the views of the person, and others where appropriate, have been accurately reflected. The person being assessed will have the opportunity to record their comments on the accuracy of the report and any changes made.

Performance indicators 8.4

- Do the reports reflect all of the views expressed during the assessment process? Whose views are recorded:
  - assessor
  - person being assessed
  - whanau\family and caregivers
  - other staff
  - other people, at the request of the person being assessed.
- Do people undergoing assessment discuss with staff the accuracy of the assessment reports on their completion?

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Standard 8.5

The assessment facilitator will refer the person being assessed to the appropriate service coordination agency.

When the needs assessment report has been completed, the assessment service will have established procedures to refer people to the appropriate place for service coordination, and to check that action has been taken.

Performance indicator 8.5

- How does the assessment service ensure people are referred for appropriate service coordination?

Standard 8.6

The person will have the right of review if they are dissatisfied with the assessment.

Where the person being assessed, or the person representing their interests, does not feel that the assessment produced a full and accurate identification of the person's needs, they may ask to have the assessment reviewed. If a review is required, the person or the person representing them should apply first to the assessment service or assessment facilitator. If they are not satisfied, they may directly approach the regional health authority.

More details can be found in Specific Guideline 6.

Performance indicators 8.6

- Is the person made aware that they have the right to have their assessment reviewed?
- Is there a review system? Is information available on how to access the review system?

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Specific Guidelines to the Standards for Needs Assessment

Your Rights

1 You have the right to be treated with dignity and respect

2 Your knowledge and experience of disability must be respected

3 Your cultural and personal background, beliefs and values must be taken into account during your needs assessment

4 You must be informed about your rights and responsibilities in the needs assessment process before you agree to take part

5 You have the right to be involved in and informed at all stages during the assessment process

6 You are entitled to receive information in a form that you can understand

7 You may decide who will or will not be present at your needs assessment, for example, caregivers, family/whanau or friends

8 Your privacy and confidentiality must be respected at all times

9 You have the right to have access to all the information about your needs assessment, and to know how that information will be used

10 You can refuse to have, or to withdraw from, a needs assessment at any time

11 You have the right to raise any concerns you have about the needs assessment service and have them dealt with promptly

Office of Disability Issues

1 You have the right to be treated with dignity and respect.

You will not be discriminated against because of your culture values, or beliefs. Where possible, the needs assessment will take place in an environment in which you feel comfortable, and involve people who you choose.

You will be treated with courtesy at all times. Staff will speak politely to you, explain things fully, answer any questions you have, and be punctual in keeping appointments. If there is a delay for some reason, you will be told as soon as possible and given the choice of either making another appointment or being made comfortable while you wait.

2 Your knowledge and experience of disability must be respected.

Your knowledge and experience of disability means that you have a good understanding of what your needs are. The assessment service will respect and use your knowledge and experience to achieve the best possible assessment of your needs.

3 Your cultural and personal background, beliefs and values must be taken into account during your needs assessment.

Each service will have policies for meeting the needs of Maori, Pacific Islands peoples, and people of other cultural and ethnic groups. You should be able to have a needs assessment that is comfortable for you. This will mean:

- having an assessment facilitator who understands your cultural needs and is prepared to do what they can to meet them
- negotiating a process for the needs assessment that suits you
- having the needs assessment carried out in a place you feel comfortable
- deciding who you want to be present at your needs assessment, including support people (such as whanau, family or friends) or an advocate
- refusing permission to people you do not wish to be at your assessment.

The service will try to be flexible, but sometimes it may not be possible to meet all your needs - for example, if you live a long way from town, it may not be practical for the needs assessment to take place at your home. You should talk to the needs assessment facilitator to see what is possible.

4 You must be informed about your rights and responsibilities in the needs assessment process before you agree to take part.

As well as describing the needs assessment process and answering your questions, an assessment facilitator should give you information about your rights and responsibilities and discuss these with you. They should also provide you with information about what you can do if you are not satisfied with any aspect of the needs assessment service. This information should be in a form which you can understand, and should be provided before you have your needs assessment.

5 You have the right to be involved in and informed at all stages during the assessment process.

An assessment facilitator should explain what a needs assessment involves. This includes what will happen, how long it will probably take, what specifically will be required of you, and what options you have (such as choosing the assessment facilitator if this is possible).

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The assessment facilitator should also explain what you can hope to achieve from taking part in a needs assessment and what will happen afterwards.

You have the right to ask questions. For example, you may want to know what a facilitator's qualifications and experience are before you agree to work with any particular facilitator. You will be working closely with your assessment facilitator, and the outcome of the assessment matters to you, so it's important to find someone you can get along with and trust.

The needs assessment process is reasonably flexible, and you can come to agreement with your assessment facilitator about what will happen before and during the assessment.

6 You are entitled to receive information in a form that you can understand.

Information that is provided to you should be in a form that you can understand and use. This will usually be in some permanent form (print, large print, tape or computer disk) so that you can take it away with you. The information will be explained to you if you require it, and you are entitled to use the services of an interpreter or translator when necessary.

7 You may decide who will or will not be present at your needs assessment.

7a People to support you

You may want to have particular people (your family/whanau, caregivers and friends) present to support you during your needs assessment. This is your right, and you may invite whoever you want to be with you. However, you may have to meet associated expenses such as travel, accommodation and food costs for these people. If you invite too many people there may not be much room, or opportunities for people to contribute. Discuss this with your assessment facilitator before the assessment.

7b People not directly involved in the needs assessment

Besides you and your assessment facilitator, other people may need to be at part or all of your needs assessment because they have particular knowledge or skills that are necessary. Other people (parents, friends, professionals, students) may want to attend part or all of your needs assessment for various reasons. You should be consulted privately beforehand for your permission to have such people attend. If you do not want them to be there, it is your right to say so.

If there is a stranger at your needs assessment, you have a right to ask who they are and what they are doing there. If they do not need to be there to help with your needs assessment, and you do not want them there, you can ask the assessment facilitator to have them leave. This situation should not arise. If it does happen, talk to your assessment facilitator to ensure that it does not happen in future.

8 Your privacy and confidentiality must be respected at all times.

You should be able to control who is at your needs assessment, and who sees or hears information regarding it. Such information should only include things that are directly relevant to your needs assessment. Things such as past criminal records or previous relationships are not relevant to your present disability support needs, and should not be examined or recorded. If you do not see why the needs assessment facilitator requires some information, ask to have its significance explained.

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The needs assessment service must get your permission to share any information related to your needs assessment every time they intend to share it; for example, before passing it on to a specialist or anyone involved in service planning. You will always know who is going to see it.

The information will be stored in a safe place so that only those people who are meant to see it will have access to it.

9 You have the right to have access to all the information about your needs assessment, and know how that information will be used.

At any time you can ask to see your needs assessment records, and the service will show them to you. You may be shown the information on a computer screen but you can usually get this information printed out, so that you can take a copy away with you.

You have the right to have any information you do not understand explained to you. The service must give you a copy of the final report to keep at the end of your needs assessment.

If the information that has been recorded is not correct, you can ask to have it corrected. If the service refuses to do this you can ask to have a statement describing the correction you sought attached to the record, so that anyone looking at the record will know this. If you are not satisfied, you can take any of the actions outlined in paragraph 11 to resolve the problem.

10 You can refuse to have, or withdraw from, a needs assessment at any time.

You do not have to go through with a needs assessment. The choice is yours. The assessment facilitator will discuss your options with you. Without a needs assessment, however, you probably will not be able to receive disability support services funded by your regional health authority.

11 You have the right to raise any concerns you have about the assessment service and have them dealt with promptly.

It is important that you understand and are satisfied with what is happening. Your needs assessment facilitator will be happy to answer any questions that you have about the needs assessment at any time. You can contact the assessment facilitator between visits if necessary.

If you are unhappy with any aspect of your needs assessment service there are a number of things you can do, including using the services of an advocate. The range of actions you might take may include:

- talking to the assessment facilitator about it
- talking to the service manager about it
- using the official complaint system of the assessment service.

If the service does not respond to your satisfaction, you can approach your regional health authority.

You are entitled to receive a good service, and will not be penalised in any way if you choose to take any of these actions.

If you want an advocate to act on your behalf that is up to you, but you may have to meet any costs yourself. If for some reason it is essential for you to use the services of an advocate, then it is possible that the regional health authority will meet some or all of the costs, depending on your personal circumstances.

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Your Responsibilities

1 It is your responsibility to let the assessment service know as soon as possible if you are unable to keep an appointment

2 You must provide full and accurate information so that the best possible needs assessment can be done.

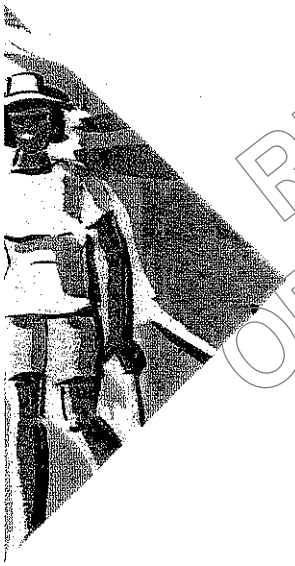
3 It is your responsibility to inform the assessment facilitator of any change in your circumstances that affect your needs

Your responsibilities explained

1 It is your responsibility to let the assessment service know as soon as possible if you are unable to keep an appointment.

Most needs assessment facilitators have many people to see, and will need to use their time efficiently and effectively. This does not mean that your time with them should be rushed, or that you should feel there is no time to ask questions or raise concerns. When making appointments, however, you should make sure that the appointment time does not clash with other commitments and that you will have enough time to complete what is necessary during the appointment. You should consult with the needs assessment facilitator about how long you will need.

If you cannot keep an appointment for some reason, let the needs assessment facilitator know as soon as possible. Someone else may be able to use your appointment time.



2 You must provide true and accurate information, so that the best possible needs assessment can be done.

The purpose of the needs assessment is to gather information about your needs and priorities to determine what assistance can be arranged to help you. It is important, therefore, that you give the needs assessment facilitator accurate information.

Any information that you give during the needs assessment will be treated confidentially.

3 It is your responsibility to inform the needs assessment facilitator of any change in your circumstances that affect your needs.

If your circumstances change during the needs assessment, or have changed since your last assessment, you should let the needs assessment facilitator know. This could include things like a change in goals, living environment or support needs.

A change in your living circumstances may affect what your needs are or your priorities. This should be recorded because the needs assessment will be of limited use if it is not up to date.

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Specific Guideline 2 The role and responsibilities of assessment facilitators

Introduction

Individual needs assessment is the first step towards receiving disability support services. It helps the person being assessed to identify their abilities, resources, goals and needs across all environments in which they currently operate, or wish to operate. The outcome of the needs assessment will be summarised in an assessment report which will provide the basis for service coordination. The whole process of needs assessment, and the link with service coordination, will be coordinated by an assessment facilitator.

The assessment facilitator has the primary responsibility for ensuring the successful outcome of assessment for the person. They will achieve this by:

- carrying out the initial assessment
- coordinating any specialist assessments and collating the reports
- serving as first point of contact for any queries the person may have during the assessment process
- conducting further general or specialist assessments when they are able to
- working with the person to decide on the priority of needs to be met
- writing up the assessment report and signing it off with the person
- making sure that the person understands the next steps to accessing services
- passing on all relevant information from the assessment process to the agreed service coordinator.

Compatibility between the person being assessed and the assessment facilitator will be a major factor in deciding which assessment facilitator should work with the person.

Functions of assessment facilitators

1 Carry out the initial assessment

The first step after contact is the initial interview between the assessment facilitator and the person (with family/whanau, caregivers and friends as appropriate). At this interview the assessment facilitator will:

- ensure that the person meets the definition of "disability" (contained in the glossary)
- explain to the person what they can expect during the assessment and afterwards
- explain the significance of assessment in the total process of getting disability support services, and make sure the person understands that a need identified will not necessarily be met by RHA-funded services
- advise people of the assessment service options
- explain to the person their rights and responsibilities regarding assessment

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- gather background information. This will include:

  basic personal information

  general description of circumstances at home

  social support networks

  work/education/leisure activities

  indication of any needs currently being met by formal services or informal support

- identify any previous initial or specialist assessments, and ensure that this information is used if it is still valid, to prevent unnecessary repetition of assessment
- on the basis of this initial information, identify whether further assessment is required or whether the person can immediately be either advised that they do not meet the requirements for disability support services or will be moved on to service coordination
- provide information of alternative sources of assistance for people who do not need a disability needs assessment.

2 Coordinate and arrange any specialist assessments

When need be, the assessment facilitator will:

- make appointments with specialist assessors
- check progress on waiting lists for assessment, including indicating apparent urgency of need
- collect and collate reports from specialist assessors
- ensure that the person has had the opportunity to read any such reports
- ensure that all necessary specialist assessments have been completed, and their results considered and included in the assessment report.

Specialist assessments include assessments of ability, resources, goals and need in the areas of:

- personal care
- household tasks and home management of environmental control
- mobility
- communication
- vocation
- education
- housing/accommodation
- employment.

3 Serve as first point of contact

The assessment facilitator will be the first point of contact for any queries the person may have about assessment, or about reassessment if their situation later changes.

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4 Conduct such further general or specialist assessments as they are qualified to

The assessment facilitator may need to work further to help the person make a more detailed assessment in the areas identified generally at time of initial interview. The assessment facilitator may also carry out specialist assessments where they are qualified to do so. However, such specialist assessments are distinct from the assessment facilitator role, even if undertaken by the same person.

5 Work with the person to decide the priority of needs to be met

When all specialist assessments are completed and all needs identified, the assessment facilitator will work with the person to determine the priority for meeting those needs. Every effort should be made to reach agreement of priorities between the person, the assessment facilitator and any appropriate caregivers or support people. If such agreement cannot be reached, the views of the person and the conflicting views of the assessment facilitator or family/whanau or caregivers must be recorded in full in the assessment report. This will assist in service coordination.

6 Write up the assessment report and sign it off

The assessment facilitator is responsible for writing up the assessment report in the format required by the Standards. The report should refer to the outcomes of any specialist assessments, and the assessment facilitator must ensure that copies of such assessments are securely attached. The assessment facilitator must discuss the draft assessment report with the person, and ensure that the report truly reflects the person's abilities, goals and needs, and the priority with which they wish these to be met. When the assessment facilitator and the person agree the report is complete, they will sign it.

7 Make sure that the person understands the next steps to accessing services

The assessment facilitator should ensure that the person understands the next steps necessary to get access to services. In most cases this will involve moving to the service coordination phase. In some situations these functions may be undertaken by the person who is the assessment facilitator. The advantages of this are that it:

- reduces the number of people with whom the person needs to relate
- makes best use of the breadth of knowledge and understanding gained by the assessment facilitator
- provides a good opportunity for continuity between assessment and service coordination
- minimises the need to transfer information and prevents delays.

Where the assessment facilitator is also the service coordinator, the assessment facilitator must take particular care to ensure that the needs assessment is not influenced by consideration of available services of state assistance.

8 Pass on all relevant information from the assessment process to the service planner and coordinator

The assessment facilitator must ensure that all necessary information is passed on to the service planner and coordinator. This will generally be the completed assessment report with all attachments. In passing on information the assessment facilitator must meet the relevant assessment standards.

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Specific Guideline 3 Advocacy Services

Introduction

The assessment service will have an established procedure which enables the person, their family/whanau and caregivers to have access to an advocate (if this is what they desire) who is independent of the service, culturally safe, and flexible and responsive to the needs of the person, their family/whanau and caregivers. The assessment facilitator will ensure that the person's right to advocacy is upheld.

The person is entitled to have a representative or advocate act on their behalf. This may be a member of their family/whanau, caregivers or friends, or a member of a professional or religious group nominated by the person.

If a person has the capacity to speak for themselves they should do so during the assessment.

A person may be unable to participate in the assessment in an informed manner. If a person is unable to represent their own interests, the assessment service will have identified the appropriate procedures to ensure that the rights of the person are preserved. This may mean referring the person to a family court and having a person with power of attorney appointed by the court to act on the person's behalf under the Personal and Property Protection Act 1988.

Informed consent is not always possible if the person is confused. However, if the process is explained sensitively to the person, family/whanau and caregivers by an advocate acceptable to them, confusion about the assessment process can be minimised.

Types of Advocacy

The types of advocacy implicit in the Standards for Needs Assessment are:

Self advocacy:
Speaking on one's own behalf in terms of ones wants, needs and desires.

Informal advocacy:
A member of the family/whanau, a friend or caregiver is nominated by the person to speak on their behalf.

Formal advocacy:
Formal advocates may or may not be paid for their services. They are members of organisations, voluntary service workers, field workers, for example, DPA, health professionals, district inspectors or official visitors who are nominated by the person to speak on their behalf.

Functions of an Advocate

The functions of an advocate are to:

- act on behalf of the person being assessed for disability support services
- ensure that the person being assessed has been made aware of their rights and responsibilities during the assessment process
- ensure a procedure for the resolution of disputes is available within the assessment service, and that the person has been informed of its existence and understands how to access the procedure
- represent or assist the person who is not satisfied with their assessment to achieve resolution of the complaint by agreement between the people concerned
- provide assistance to people who want to complain through any formal or informal procedure that exists for resolving that complaint.

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Specific Guideline 4 Completing the Needs Assessment Report: Guidelines for Assessment Facilitators

The Purpose of the Needs Assessment Report

1 The needs assessment report will contain all the information required to identify and place in order of priority the person's needs. This information will assist the planning, provision and coordination of disability support services. The report must contain the *Required Elements of the Needs Assessment Report* listed below. Assessment services whose existing reporting format contains these elements may continue to use their format. Assessment services which lack such a reporting format are required to develop a reporting format which contains these elements.

2 The *Required Elements of the Needs Assessment Report* and the *Areas of Need* will ensure that consistent information is gathered and recorded by the assessment service. Consistency will ensure that:

- the report will be useful anywhere in New Zealand
- the quality of the report will be similar for all people
- no area of need is overlooked
- consistent information is provided to regional health authorities (RHAs) for future planning.

3 The Required Elements and the Areas of Need also allow the needs assessment report to be flexible, permitting innovation by assessment services to meet the needs of people with disabilities.

Only information which is directly relevant to the assessment should be sought and recorded

Required Elements of the Needs Assessment Report

4 The needs assessment report will contain:

- biographical information including name, date of birth, age, gender, ethnicity
- the person's present living situation
- the person's current employment, education, training, recreation and social activities
- the person's current support networks, for example, family, friends, neighbours, organisations and professionals
- the person's goals and needs in each of the relevant areas outlined in the section entitled Areas of Need
- the environments in which these goals are to be met, and needs are experienced
- the benefits of having these needs met
- the desirable time frame for having these needs met (particularly a need that may be urgent)
- the person's priorities for having these needs met
- if the priorities of the person and their family/whanau or caregivers differ, or the assessment facilitator considers that the priorities of the person may not meet government objectives of service provision, the report will:

  record the priorities of the person

  record the priorities of the family/whanau or caregivers

  record the compromise priorities negotiated between the person, their caregivers, family/whanau and/or assessment facilitator

  record any dissenting view of the assessment facilitator.

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A person may not identify needs in some areas, or may choose not to discuss some areas of their life. These opinions should be respected, and should be noted in the needs assessment report.

Areas of Need

Personal care needs

nutrition - eating and drinking
hygiene - bathing, toileting
dressing
positioning (in chair, bed etc)
physical exercise
comfort
medication delivery and monitoring effects
pain relief/reduction

Domestic and household management needs

parenting
housework
cooking
gardening
environmental control (drawing curtains, turning lights, heaters, etc on and off)
personal business management (paying bills, banking, writing letters)
shopping
visits to doctors, lawyers, NZISS etc

Vocational and employment needs

Training and education needs

Communication needs

interacting face-to-face
interacting over distance
recording information

Mobility needs

at home
in the community

Rehabilitation needs

to increase functioning level and comfort in the following areas:
physical
cognitive
emotional
spiritual
social
cultural

Recreational, social and personal development needs

Accommodation needs

Income needs

Caregivers' support needs

respite
information
training
support - personal and practical

Environment(s) in which needs must be considered

the person's home
place of work/education/training
community facilities
social venues
prospective settings

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Specific Guidelines 5 Rules and Guidelines on the Collection of Information

Collection, use and transfer of information

A needs assessment report format has been developed to collect all the necessary information, and to consider how the needs assessment facilitator might determine and report the relative importance and urgency of identified needs so that service coordinators can allocate services, where limited, to those in greatest need.

A copy of the assessment report, or relevant sections, will be made available to the service coordinator if RHA-funded services are needed. The person must permit the transfer of the assessment report to the service coordinator if RHA-funded services are to be provided.

Access to Information

The person will have access to any information recorded in connection with their assessment, including information about their rights and responsibilities during the assessment. The person also has the right to obtain a correction to any information recorded during the assessment process. This should be explained to them before they take part in an assessment.

The assessment service will ensure that only relevant information is transferred to other agencies, and that the person gives their permission.

There are many people involved in the needs assessment process, and subsequent steps in getting access to services. People seeking access to information should only receive it if they can establish with good reason their need to do so under the terms set out in the Health Information Privacy Code, and they should only receive information that is directly relevant to that purpose. This may mean, for example, that a service provider only receives excerpts from the needs assessment report relating to the service they provide.

Confidentiality

The confidentiality of the person's information must be maintained. The information recorded during the assessment should be retained in their records. A copy will be provided to the person, and also to the service planner/ coordinator if the person wants to access services purchased by the RHAs.

Where needs assessment information is to be used in aggregate form (for example, for RHA service planning or accountability purposes) personal identifiers should be removed by the information holder before being passed into other hands, and all possible steps should be taken to ensure the person cannot be identified.

The Privacy Act 1993

The Health Information Privacy Code has been established to provide specific guidelines for all RHA funded agencies to assist them to comply with the Privacy Act 1993 regarding the information collected, used, held, and disclosed by the agency.

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Specific Guideline 6 Complaint and Review Procedures

The assessment service will have established procedures for dealing with complaints, in a manner which respects the dignity and independence of the person, family/whanau and caregivers.

If the person being assessed, or the person representing their interests, does not believe that the assessment produced a full and accurate identification of the person's needs, they may ask to have the assessment reviewed.

They may make a complaint or ask to have their assessment reviewed, if they are not satisfied (a) with the needs assessment process; and (b) that the outcome of the needs assessment process is a full and accurate reflection of their needs.

The complaint or review should be made by the person, or the people representing their interests to, the assessment facilitator or the assessment service. If the person is not satisfied with the outcome, they may directly approach the relevant regional health authority.

Complaint procedures are to be easy for people to use, and should comply with the following principles:

- all parties have a chance to be heard
- records of complaints and their resolutions will be included with the person's assessment information
- rights of appeal must be clearly stated
- frivolous or vexatious complaints can be screened out
- the person conducting the investigation must be impartial.

There should be no barriers to making a complaint. The special or personal needs of the complainant must be recognised and services such as interpreters or advocacy services should be provided as required. Other parties, such as caregivers and family/whanau, should also be able to make complaints, with the consent of the person being assessed.

Assessment services should ensure that complaint and review procedures are culturally safe. The assessment facilitator should be aware of the cultural needs of the person, their family/whanau and caregivers. The complaints procedure will be comfortable for Maori and Pacific Islands peoples and other cultural and ethnic groups in the service's community.

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The following definitions apply to people or roles referred to in the Standards:

Assessment Facilitator: the person who takes overall responsibility for ensuring that the rights of the person being assessed are safeguarded throughout the assessment process. The assessment facilitator assists the person being assessed to identify and place in order of priority their needs, and to summarise these needs in an appropriate assessment report. The assessment facilitator may be a person who also undertakes a specialist part of the assessment.

Assessment Service: the unit, whether one person, a group of people within a larger organisation, or a stand-alone organisation, with whom the regional health authority contracts to deliver assessment services.

Caregiver: the person or people providing continuing care to the person with the disability on an informal basis (usually a member of the person's immediate family/ whanau or a friend). This role is usually not the caregiver's formal employment.

Cultural safety: the provision of services in a way that affirms, recognises and is compatible with the person's cultural values, beliefs and needs.

Disability: A person with a disability is a person who has been identified as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.

Where a person has a disability which is the result of personal injury by accident which occurred on or after 1 April 1974 it should be determined whether they are eligible for entitlements from the Accident Rehabilitation and Compensation Corporation.

Where a person has both a disability and personal health need the services provided to address those needs are disability support services and personal health services respectively. The acute mental health services needed by people with a psychiatric disability are considered to be disability support services.

Fanau: customary Pacific Islands extended family.

Fono: a meeting of Pacific Islands peoples.

Kawa: protocol.

Service coordination: the development of a package of services which are responsive to the needs identified by the needs assessment. Planning a service package requires knowledge of which solutions are possible, and which criteria must be met to obtain services.

Tangata whenua: literally the people of the land. The local iwi or tribe who hold spiritual authority over the land are referred to as having mana whenua.

Tikanga Maori: traditional and contemporary Maori cultural practices or customs.

Whanau: customary Maori extended family.

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Operational Manual for Needs Assessment and Service Co-ordination Managers

Volume 1

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Issued by

Disability Services Directorate
Ministry of Health

May 2005

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1 Introduction

The impetus for the development of an *Operational Manual for Needs Assessment and Service Co-ordination Managers* came from a Developmental Review that was initiated and carried out by the Disability Services Directorate (DSD) of the Ministry of Health (Ministry) during 2003, prior to devolution of funding and services for older people to District Health Boards (DHBs). This provided an opportunity for all Needs Assessment and Service Co-ordination organisations (NASCs) to be reviewed against the *Support Needs Assessment and Service Co-ordination Policy, Procedures and Information Reporting Guidelines* which had been introduced by the Ministry in 2002. The Review identified there were a number of skilled and competent managers leading effective NASCs. There was also, however, a clearly identified need for additional guidance and support. This Manual seeks to provide that support. The Manual is distributed to all NASC although its intended use and focus is managers of Ministry-contracted NASC.

Development of the Managers' Manual has been the work of LIFE Unlimited, under contract to DSD, following a tender process. It has been a strongly collaborative process, as is recorded in the acknowledgements. The Ministry thanks all contributors and particularly LIFE Unlimited for their commitment to this way of working and to completion of the task.

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The explicit purpose of the manual is for all NASCs to be led and managed competently and confidently to provide facilitation of support needs assessment, service planning, co-ordination and resource allocation and budget management in a manner consistent with agreed policies and protocols.

In turn, this will support NASCs in providing equity of access nationally and in providing a NASC experience that supports potential for achievement of personal outcomes for disabled people.

This manual is for NASC managers, their teams and staff. It is intended to:

- outline the roles and responsibilities of a NASC manager
- identify source and reference documents, policies and protocols
- provide guidance to the NASC manager on the Ministry's expectations in relation to the NASC roles and responsibilities.

Depending on the size of the team, the manual may also be applicable to team leaders and senior staff within the NASC who have particular responsibilities for work such as ongoing quality.

In particular, this Managers' Manual is:

- applicable to all NASCs throughout New Zealand who are contracted by DSD
- applicable to NASCs structured as organisations providing for particular age groups or all age groups

- not applicable to NASC services for people with mental health or personal health needs
- shared for information with NASCs contracted by DHBs for people 65 years and older and those over 50 years who are assessed as 'close in interest'.

DISCLAIMER

The Managers' Manual is designed to provide guidance. It is not seeking to be prescriptive in relation to management practices. It is recognised that organisations have their own set of business requirements and practices. It does refer managers to DSD determined policies and protocols.

Information and resources have been provided by many people. The NASC manager will need to make the judgement as to whether resources are current and relevant to their need. Neither the Ministry nor LIFE Unlimited is endorsing any of the external resources referred to in the manual.

In the event of any conflict or inconsistency between the information in the manual and any relevant Act, Regulations, or contract, the Act, Regulations or the contract prevail.

Information in the manual is current as at the date of issue. Neither the Ministry of Health nor LIFE Unlimited bear any liability or responsibility for its accuracy or suitability for purpose. The manual may be updated but this is subject to resources permitting.

The manual is intended for NASC managers, their teams and staff to guide their work in relation to needs assessment and service co-ordination. It has been provided to them on a confidential basis. The Ministry of Health bears no liability or responsibility for any misuse or for any further disclosure or reliance on the information contained in the manual.

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The Managers' Manual has been designed to allow pages to be added or withdrawn as updated information becomes available. With this format the NASC manager can also provide the information they choose to team members. This volume provides the key information for managing a NASC organisation; Volume 2 supports it with detailed appendices.

The manual needs to be seen as a living document which can reflect policy and funding changes into the future. While current content has been based on suggestions received from interested parties, the Ministry of Health welcomes comment and feedback relating to content, accuracy and clarity. These should be directed to:

Development Manager NASC
Planning and Development
Disability Services Directorate
Ministry of Health
Private Bag 92-522
Wellesley Street
AUCKLAND

For further information, please contact the Development Manager NASC within the Disability Services Directorate of the Ministry of Health.

2 Government Role and Responsibilities

MINISTRY OF HEALTH DISABILITY SERVICES DIRECTORATE

The Disability Services Directorate is part of the Ministry of Health. It funds a range of disability support services for people with long-term/lifelong physical, sensory and intellectual disability (mostly aged under 65 years). The majority of its services are accessed through Needs Assessment and Service Co-ordination organisations.

DSD's main responsibilities include:

- advising the Associate Minister of Health and other Ministers
- funding and overseeing the provision of a range of disability support services provided through Vote:Health
- managing providers of service contracts, including audits and evaluations
- writing and contributing to the development of policies for disability support services and/or disabled people and their families and whānau
- planning for and undertaking developments to improve disability support services
- co-operating and working with other government departments and community organisations
- contributing to the Ministry of Health key accountabilities.

DSD has a three-year Strategic Plan, from 1 July 2003 to 30 June 2006. The vision of this Strategic Plan, based on the *New Zealand Disability Strategy* (Minister for Disability Issues 2001), is:

'To enable inclusion and value disabled people'

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Funding

DSD funds disability support services, mostly for people aged 65 years and under. These funded services include:

- NASC services
- specialist assessment for mobility equipment
- provision of mobility equipment, house and vehicle modifications
- home based support services
- community residential care
- rehabilitation
- respite and carer support
- disability information and advisory services
- rest home and private hospital services (for adults aged under 65 years)

- assessment and service delivery for people with intellectual disability who have high and complex needs
- behaviour support services
- day services for people moving to the community from institutional care (not vocational)
- child development services.

Structure

At the end of this section are two organisational charts which show the structure of DSD within the Ministry of Health and the team structure within DSD.

DSD is led by the Deputy Director-General (DDG) who reports to the Director-General of the Ministry of Health and the Associate Minister of Health with responsibility for disability support services. DSD sometimes also reports directly to the Minister of Health.

The five teams in DSD, each with a manager, are:

1. Policy team
2. Business Support team
3. Northern Operations team
4. South Operations team
5. Planning and Development team.

The team managers, the DDG, the Chief Advisor and the Māori Development Manager form the Senior Management Team. This team collectively manages Directorate activities, including approving any new funding, new projects or developments, and the Annual and Strategic Plans.

DSD Planning Cycle and Timeframes

DSD's Annual Plan is developed from February through to May. It is finalised by the end of June. It then runs from 1 July to 30 June the following year and forms part of the Ministry of Health's Annual Plan. It is reported on quarterly to the Government.

DSD service budget planning (funding for disability services) for the financial year (July to June) commences in February with identification of priorities for significant new or additional funding.

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Accountability to Government

Each year, government departments are required to produce accountability documents such as the Statement of Intent (SOI). The SOI is intended to give a clear sense of the department's service priorities and the progress expected to be made in delivering those priorities. The Ministry of Health's SOI explains why particular activities are undertaken and how those activities make a difference to improving health and disability outcomes for New Zealanders.

DSD administers the money from Vote:Health that has been designated for purchase of disability support services, on behalf of the Minister of Health (the Vote Minister) and the Associate Minister of Health. DSD recommends to the Minister how to apply funding. The Minister can agree or disagree with the recommendations.

DSD reports quarterly to the Minister of Health on progress against the Ministry of Health SOI (available at www.moh.govt.nz).

DSD also reports quarterly on progress against the *New Zealand Disability Strategy*. DSD is accountable in its role as a funder of services through the Monitoring the Ministry as Funder performance indicators which are also reported on quarterly.

Role of DSD Senior Management Team in relation to NASCs

The Senior Management Team (SMT) of DSD consists of the Deputy Director General, managers of each of the Directorate's teams, the Chief Advisor and the Māori Development Manager. It holds a face to face one-day meeting each month and on all other weeks a teleconference.

The SMT has the following roles and responsibilities.

- Funding Board

  As a funding board, it makes decisions on proposals for new or additional funding including increase in prices, increase in contracted volumes, developmental funding.

- Policy and Service Decisions

  SMT asks for and approves policy and service reviews, and changes to information systems. This includes development of new or enhanced service specifications, guidelines and prioritisation criteria.

- Directorate Planning

  The many dimensions of directorate planning range from ensuring co-operation across teams, deciding on new work to be undertaken, and allocating resources, to discussing issues to arrive at a Directorate view, particularly for cross-team/ Directorate matters.

  SMT signs off on the Directorate's planning documents such as the Statement of Intent, Strategic and Annual Plans, and the quarterly reports against progress made on these plans. It co-ordinates at least the major pieces of work and their incorporation into 'core business', as part of workload and personnel management.

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Role of DSD Service Manager in relation to NASCs

The main point of contact between DSD and NASCs is through the local Ministry of Health Operations Team Service Manager. There is also a NASC Development Manager who is in the Planning and Development Team.

The working relationship established between the DSD Service Manager (or other contract manager such as the DHB Portfolio manager) and the NASC manager is crucial in supporting the work of the NASC manager and the achievement of contractual responsibilities by the NASC organisation. The basis of this relationship is the contract. Key to the facilitation of a professional and successful relationship between the Ministry Service Manager and the NASC manager is the development of a working relationship based on trust. While this may take time, demonstrated support and a commitment to honest and respectful communications by both parties will aid this process. The knowledge and expertise both parties bring to the relationship should be valued and respected by both parties.

It is important to note that Service Managers are accountable to their organisation and at all times must try to reflect the latest Ministry policy. It should also be noted that this is a dynamic process. The Service Manager should not be involved in the day to day business of the NASC. The contract between the NASC and the Ministry outlines the obligations between the parties, and governs the relationship.

Suggestions to support the evolution of this professional relationship are shared below. They are suggestions only, and are not intended to be prescriptive on NASC operations.

- A commitment to weekly face to face meetings or telephone meetings should be agreed. These meetings provide opportunity for open and frank discussion and information sharing about relevant policy and service issues. To maximise this time, it is suggested that there be agreement regarding the meeting purpose and structure. Additionally, both parties should prepare for this time with the sharing of written information prior to the meeting. Minutes should be taken.
- An open door policy including open email access for both parties is helpful.
- A communication policy could be implemented within the NASC to determine the communication links between the NASC, the Service Manager and the Ministry of Health. This protocol could also identify at what level the NASC manager wishes to receive communications from the Service Manager and the Ministry of Health. This will lessen the risk of unauthorised communications and commitments being made by NASC staff.
- It is helpful if the NASC manager adopts a 'no surprise' policy. This means that the Service Manager should be informed of any potentially significant events at an early point. While it is not the function of the Service Managers to be involved in the day to day running of the NASC, they must be alerted to events that may escalate beyond the NASC. This is best achieved by both conversation and the emailing of a synopsis of the situation to the Service Manager.
- The Ministry of Health must, if requested, provide all relevant service specifications, established policies, existing Memorandums of Understanding and

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the like to their NASC. In turn, the NASC manager should be cognisant of this information before approaching the Service Manager with any proposals. The assurance and knowledge that all options and opportunities have been explored prior to this approach will build the Service Manager's confidence in the competence of the NASC manager.

- In the event of a request being made, the NASC manager should be very clear about what they are asking the Service Manager to do, whether they are seeking guidance, policy clarification or a decision to be made.
- While the relationship is being established, both parties need to be careful to avoid the 'shorthand' they may have developed with the previous incumbent. Jargon, abbreviations, acronyms, names and so on may all be new to the successor.
- Robust decision-making by the NASC, which is founded within DSD service specifications, guidelines and policies and is further enhanced by NASC-documented peer review, will develop the confidence the Service Manager seeks in the NASC manager.
- It is helpful for the Service Manager to ensure the NASC manager understands the mechanisms the Service Manager may utilise to respond to some issues. There may be a necessity for the Service Manager to seek the advice of DSD teams such as Policy, Health Legal, Senior Management Team. This need for the Service Manager to consult and draw on internal expertise may not always be obvious to the NASC manager. There may be occasions when the NASC requires rapid decision-making by the Service Manager, such as when a fragile situation is at risk of collapsing. An agreement by the Service Manager to provide frequent feedback to the NASC and key parties regarding progress may need to be implemented.
- Each day, new issues are presented in the NASC. This is reality and needs to be co-operatively managed.
- It is helpful for the Service Manager to attend certain community meetings that may contain the delivery of unpalatable information for the attendees. When this information is the product of DSD policy, it is essential that the Service Manager and/or other DSD staff members front these meetings. This will ensure that the information is correct and attendees' questions can be responded to by the DSD representative.
- Opportunities to work collegially should be identified and utilised. These may take the form of provider, intersectoral or DHB meetings.
- It is useful if the Service Manager develops a relationship with the umbrella organisation of the NASC such as the District Health Board. This is helpful in demonstrating the structure behind a NASC and encourages the engagement of the DHB. The way this relationship will be pitched depends on the structure of the umbrella organisation.

The relationship the NASC manager develops with the DSD Service Manager is possibly one of the most important relationships to be established. The demonstration of integrity and honesty by both parties will encourage ethical behaviours and so foster the development of a constructive and trusting relationship.

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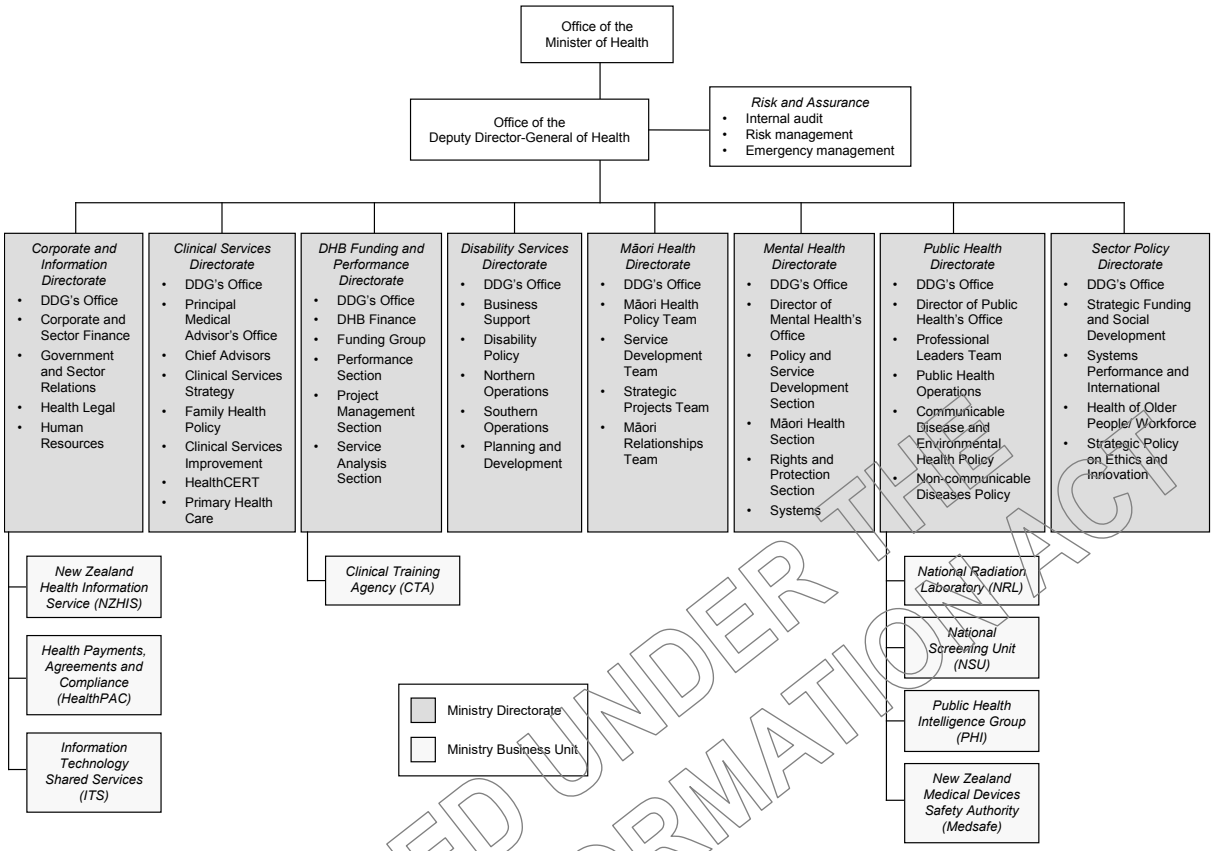
Ministry of Health Structure: Directorates and Business Units



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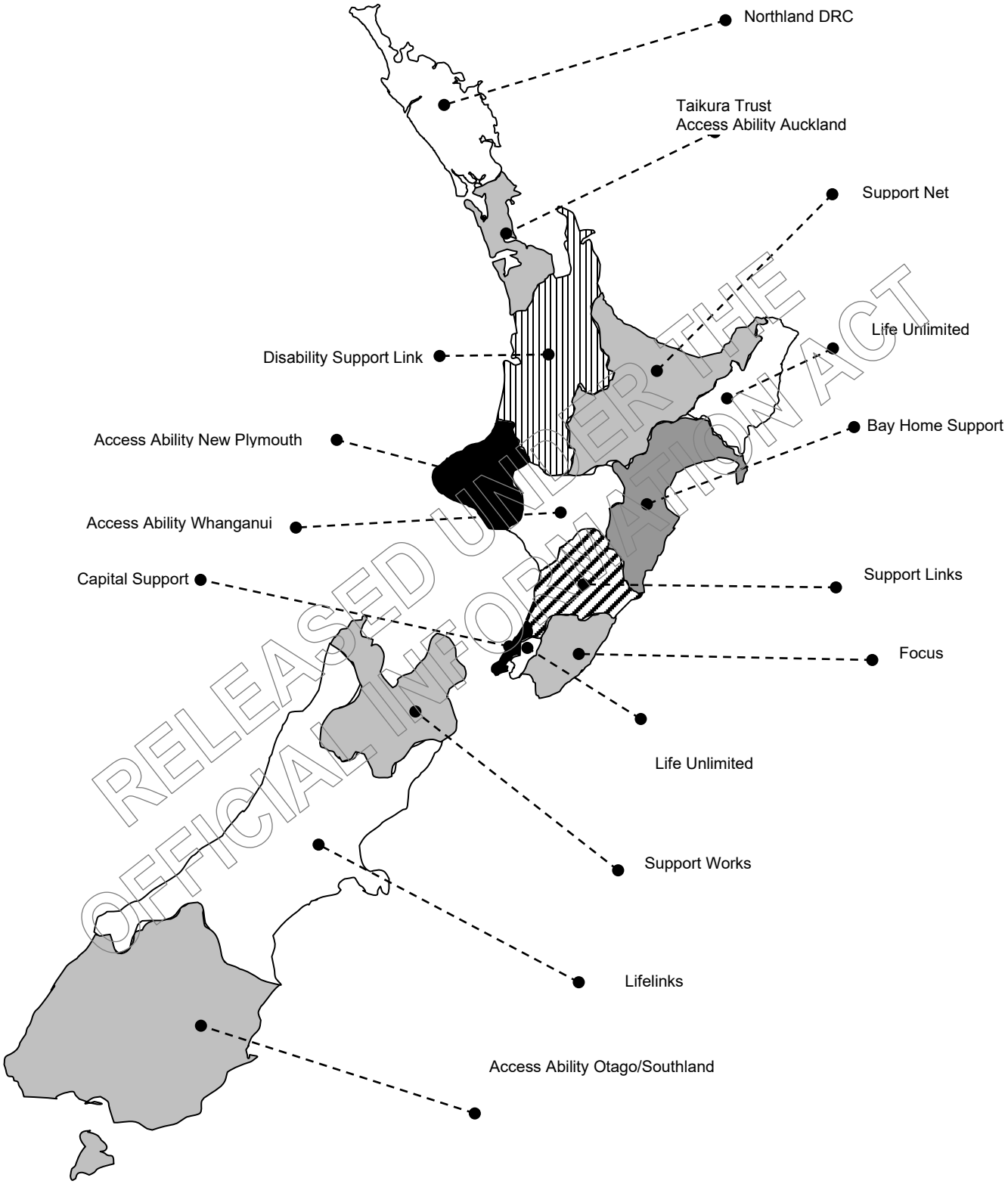
Geographical areas covered by each NASC



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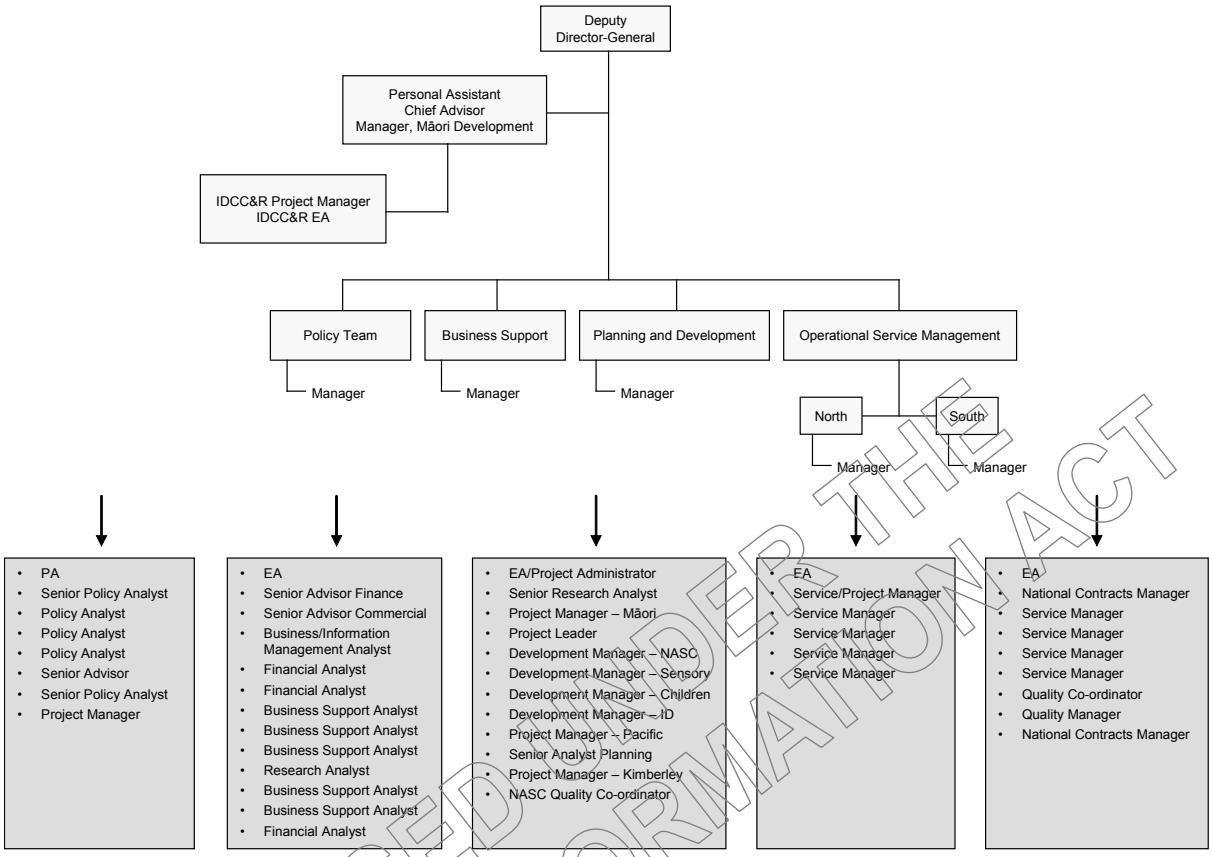
Disability Services Directorate



CONTRACT MANAGEMENT

The following section is a brief summary of key aspects of DSD's contract management as it affects NASCs.

The Ministry of Health Disability Services Directorate is responsible for the development, negotiation and management of Disability Support Services (DSS) contracts. These contracts reflect the government's focus for disability support services and the environment in which these services are being delivered.

The Ministry identifies gaps in disability support service contracts through gap analysis. The NASC manager should be cognisant of this and ensure there is full and regular reporting to the Ministry of any unmet disability support needs and service gaps. Provision of this information is integral to the process of analysis.

A prescribed Ministry format is followed when the Ministry seeks tenders for a service contract. This ensures fairness and a transparent approach to decision-making. The call for tenders will follow set Ministry guidelines. These inform decisions, including whether tenders are issued, and whether these are closed or open tenders.

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There are Ministry requirements for the issuing of tenders or Requests for Proposals (RFPs). The RFP provides potential tenders with information about the contractual requirements, the information needed to support the proposal and any other relevant information including the rules around seeking additional information, presentation of the tender, timeframes and so on.

A selection panel to identify preferred providers is established within the Ministry and generally includes:

- those with expert knowledge in an area of service sought
- those providing voice for disabled people (including those who are Pacific peoples)
- Māori representation
- DSD personnel.

When the process is complete, recommendations are made to the DSD Senior Management Team who makes the final selection of the preferred provider.

Once a preferred provider is identified by SMT, a contract is negotiated with that provider. Final agreement to the terms of the contract is signed off by SMT.

All DSS contracts are subject to the Ministry of Health standard contract Head Agreement. Review and monitoring is the responsibility of the DSD Service Manager with routine and, if need be, issue-based audits initiated through the DSD Quality and Audit team.

The Ministry's Service Specification outlines the specific requirements of the NASC in relation to reporting provider quality. Should a NASC experience difficulties with a DSD-contracted provider, or vice versa, the Ministry would expect that the managers of both the NASC and the provider organisations engage constructively to resolve the matter. Quality concerns need to be discussed with the DSD Service Manager according to the contractual responsibilities and within timelines appropriate to the level of concern.

The DSD Service Manager should provide the NASC manager with a set of the service specifications for all DSD-contracted services in their geographical region.

Resource

Volume 2 Appendices

- Appendix 1: DSD NASC Service Specification

FINANCIAL MANAGEMENT IN THE PUBLIC SECTOR

This section gives an overview of the public sector financial management system and the role of NASCs, who manage access to government funding, within that system.

Needs Assessment and Service Co-ordination organisations are funded by government money. The management of this money fits within the Government's wider financial management system.

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The broad aims of the public sector financial management system are to help the Government translate its strategy into action, to inform decision-making and accountability, and to encourage a responsive and efficient public sector.

Four major Acts of Parliament form the legislative framework for the public sector financial management system.

1. The State Sector Act 1988 defines the roles of Chief Executives of government departments and their accountability to their Ministers, and gives Chief Executives authority to manage their departments.
2. The Public Finance Act 1989 governs the use of public money, including reporting requirements for both financial and non-financial information.
3. The Fiscal Responsibility Act 1994 requires the Government to declare its short- and long-term financial intentions and establishes the principles for responsible financial management.
4. The State-Owned Enterprises Act 1986 allows the Government to conduct some of its commercial activities like private sector businesses.

The first three of these Acts impact on NASCs.

The Government, as 'owner' of government departments, wants to achieve its goals and objectives in a way that reflects the ethic of good government and fulfils the objective of public accountability. The Government wants to ensure that:

- public resources are used effectively to carry out the Government's objectives
- the Government's priorities are applied consistently across the public sector
- financial and performance risks are managed actively and promptly.

The Government wants to ensure its funds are spent wisely and well on the priorities it has identified.

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Outputs

The public sector financial management system uses specific terms to describe its activities. For example, **inputs** are the resources for producing goods and services (for example capital, personnel and equipment). **Outputs** are the goods and services (for example, policy advice or negotiation and management of contracts) that Ministers 'purchase' from government departments and other organisations. Government departments, Crown entities and other providers define their outputs according to quantity, quality, cost and delivery time.

There are two main classes of outputs:

1. Departmental outputs, which are produced by a government department such as the Ministry of Health

2. Non-departmental outputs, which are goods and services purchased by a Ministry from a provider that is not a government department. Needs Assessment and Service Co-ordination services are an example of non-departmental outputs as are disability support services.

A **Vote Minister** seeks appropriation (money set aside for a specific purpose) from Parliament to purchase departmental and non-departmental outputs. Money to purchase NASC services comes from Vote: Health (the amount of money allocated by Parliament, at the beginning of the financial year, to be spent on the health sector).

Accounting System

Under the Public Finance Act 1989 and the Fiscal Responsibility Act 1994, government departments moved to accrual accounting in preference to cash accounting.

Accrual accounting recognises expenses when an obligation arises and not simply when cash is paid. Similarly, revenue relates to the Crown's entitlement to future benefits, not the point at which cash is received. Assets and liabilities are separated from current revenue and expenses in a Balance Sheet or Statement of Financial Position.

NASCs are responsible for managing access to government funding. They need to have good accrual systems so the Ministry of Health gets accurate information for its overall management of its budget.

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Government Contracting with Non-governmental Organisations

Principles affecting contract management within the public sector affect more than just government departments. They apply also to alternative organisational structures such as companies who contract with Government. NASCs are included in these alternative organisational structures. The broad principles of public sector financial management apply to these organisational structures because they are responsible for spending public money.

The Government has expressed a wish for good working relationships with the community and voluntary sector including NASCs. Its funding arrangements with these organisations usually take the form of contracts. The Government has set down the following principles of good contract management.

- Services purchased through contracts and other types of funding relationships should contribute to the achievement of government outcomes and objectives.
- Contracting should reflect the needs of the ultimate users or recipients of the service.
- Contracts should provide appropriate accountability for public money.
- The quality of service delivery will usually be of central importance.

- The Crown and its organisations should act in good faith.
- Government agencies should understand the nature of the organisations with which they and the Crown contract.

Signing the contract is only part of the government agency's responsibilities for contract management. It is also responsible for the ongoing management of the contract once it has been signed, and of the relationship with the organisation providing the service. This involves:

- monitoring delivery against the contract
- assessing the effectiveness of the services delivered
- approval of payment, and making payment according to the contract
- ongoing relationship management
- negotiating changes to the contract
- in extreme cases, taking action to enforce compliance with the contract including exercising any rights to terminate the contract.

These requirements provide the basis for:

- assessing whether the organisation has delivered contracted requirements
- accountability for public money
- paying money to the contracted organisation
- making decisions about how to proceed at the expiry of the contract.

When the Government contracts with organisations such as NASCs, there are several, sometimes competing needs that must be taken into account. These include:

- the needs of the contractee
- the needs of service users
- the need for accountability for, and wise management of, public money.

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Disability Services Directorate Contracting

DSD enters into contracts with providers and with NASCs. These providers and NASCs manage the demand-driven side of the services funded through DSD.

On behalf of the Ministry, DSD has developed a budget for each NASC. These are 'indicative' budgets.

It is expected that NASCs will manage within these indicative budgets. In fact, under the Public Finance Act 1989, government departments (and organisations with whom they contract) are required to work within appropriations and any overexpenditure is in violation of the Act. To assist NASCs to manage within these budgets, the Ministry will provide regular information on expenditure to each NASC. This reporting will let the NASC know how they are tracking against the budget and gives them service utilisation information.

In the long term, it is hoped that the information provided by the Ministry to the NASCs will:

- lead to more nationally consistent needs assessment and service co-ordination
- form the basis of discussions between NASCs and DSD and among NASCs
- lead to more consistency in the way clients are referred to and receive these services
- better enable the Ministry to make future projections of service utilisation and potential service gaps.

DSD is developing a budget management framework to assist NASCs. It will include protocols that outline budget management requirements, a detailed set of the skills NASCs will need in order to be effective budget managers, and practice guidelines. Some NASCs have undertaken budget management responsibilities previously, while for others this is a new area of responsibility. Part of this framework includes an opportunity for NASCs to exchange skills with one another. The Ministry will facilitate ways for NASCs that have put successful budget management processes in place already, in particular, to mentor those NASCs that need some assistance to develop the required budget management skills.

Resource

Treasury. 1996. *Putting It Together: An explanatory guide to the New Zealand public sector financial management system*. URL: www.treasury.govt.nz/publicsector/pit/

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MONITORING AND AUDITING

The following section is intended as general guidance to monitoring and auditing of NASCs, which is performed under the Ministry's contract with the NASC.

Auditing provides an opportunity for an independent overview of the organisation and identification of those areas that require development. Auditing should be anticipated by the manager and should be accepted as a means of an ongoing quality improvement process. The NASC manager should develop and implement self auditing mechanisms as early as possible. Such mechanisms will provide an ongoing measurable reflection of the organisation's performance.

Routine Audits

NASCs will usually be audited by independent, designated audit agencies, ensuring providers are safe, outcome focused and continuously improving service quality.

A routine audit comprehensively evaluates the ability of the NASC to provide a service. It can cover all parts of the service outlined in the contract the NASC holds with the Ministry of Health.

Audits assure the Ministry of Health that the organisation has the necessary capability, resources, processes and procedures to provide the service as required by the contract. They can also identify any key risks that should be managed and identify the remedial work required to achieve compliance with contractual responsibilities.

NASCs should:

- confirm the audit, the audit process and other arrangements with the Lead Auditor
- comply with requirements of auditors during the process
- sign that findings were presented by the Quality Auditor on completion of site visit and indicate agreement with the findings
- return the draft findings report with comments to the auditor within the timeframe stipulated
- if non-compliant, meet the requirements of the report within the timeframe agreed.

Issues-based Audits

While routine audits are a planned activity, issues-based audits usually result from ongoing complaints about the service the NASC is delivering. These audits follow the DSD audit methodology. Audits for DSD-funded NASCs are approved and commissioned by the DSD Quality and Audit team. These audit reports are a public document and can be accessed via the Official Information Act 1982.

Audit Team Members

The following individuals and organisations may become involved in an audit as part of the Audit team as or stakeholders providing feedback:

- Ministry of Health
- complainant
- operations staff
- clinicians
- provider
- Health and Disability Commissioner
- consumer representatives
- Needs Assessment and Service Co-ordination organisations.

MINISTERIALS

The ministerial process supports the Government's goals for open, transparent and accountable government. Agencies, groups or individuals may seek responses from Ministers to a wide range of issues. These might include sharing new ideas, current experiences and information on the health and disability system, requesting services or funding, or complaining about government policy or the way services are provided.

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Ministers place a lot of importance on ministerial work. It is a means of keeping them informed about current sector issues and being alerted to emerging issues or potentially controversial matters.

The Ministry has a dedicated Ministerial Services Unit (MSU). Ministerial work is driven by strict timeframes. Some deadlines are very tight, such as an hour to respond to oral parliamentary questions.

The Ministry can make requests for information from NASC organisations on their services and clients to support ministerials, parliamentary questions, briefings, complaints, human rights issues and the like. Most ministerial-related requests should come in the first instance from their DSD Service Manager. Occasionally, however, the MSU writer/analyst assigned to the work may have to contact NASCs directly for information, for instance if the DSD Service Manager is unavailable to support an urgent request. NASCs should have their own internal processes for dealing with information requests from the Ministry.

NASCs must comply with relevant legislation that protects privacy of the person and service information on them. This is outlined in the Privacy Act 1993 and the Health Information Privacy Code 1994.

NASC managers should contact their DSD Service Managers if they have any queries or concerns about the ministerial process or seek training. Alternatively, the DSD Policy Team can respond to queries, if the Service Manager is unavailable. Finally, MSU team leaders can also advise generally on the Ministry's ministerial or wider government processes.

Resource

Volume 2 Appendices

- Appendix 2: Ministerials

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NASC CONTRACT, PERFORMANCE AND LIABILITY

The NASC contract governs the relationship between the Ministry and the NASC and their respective obligations. DSD expects managers of NASCs to be familiar with the contract and the NASC obligations under it. DSD expects managers of NASCs and NASCs to meet their contractual obligations generally and in relation to any specific issue. DSD expects managers of NASCs that are having trouble meeting contracted requirements to inform it at the earliest opportunity so that corrective action can be taken. It is also expected that stakeholder involvement in the service will assist in ensuring the contract is met.

Ultimate failure to perform may result in the NASC being held in breach of contract, resulting in possible termination of the contract by the Ministry.

HEALTH OF OLDER PEOPLE

The Ministry of Health was responsible for developing the *Health of Older People Strategy* (Associate Minister of Health and Minister for Disability Issues 2002). The Ministry of Health and DHBs now share responsibility for implementing the Strategy. It is basically an Action Plan to 2010. They are developing a joint DHB/Ministry work programme to manage implementation up to 2010. DHBs' progress on the implementation of the Strategy is monitored against their annual plans. There are also reviews of progress every three years to coincide with Ministry of Social Development status reports on implementing the *Positive Ageing Strategy* (Minister for Senior Citizens 2001).

The Sector Policy Directorate of the Ministry has responsibility for the *Health of Older People Strategy*. It has established a Health of Older People section which is involved in:

- policy advice and development
- service coverage and the Nationwide Service Framework for services affecting older people
- working with DHBs on service development when appropriate.

The Strategy poses challenges to service providers and health sector workers to change the way services are delivered to meet the needs of older people. The Ministry of Health and DHBs need to work closely with these groups on ways they can contribute to a more integrated approach to health and disability support programmes for older people.

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Assessment of Older People

In October 2003 the New Zealand Guidelines Group published the *Assessment Processes for Older People: Best practice evidence-based guidelines*. The Ministry of Health funded this publication. A project to implement the recommendations from the Guideline has been established with District Health Boards, Accident Compensation Corporation (ACC) and the Ministry of Health.

One of the recommendations from the Guideline was the development of a new minimum dataset and a new national assessment tool. A review of assessment tools was completed by the University of Otago. The outcome is that the InterRAI suite of assessment tools will be trialled in New Zealand over 2005/06 for possible future mandate as the national tool for New Zealand for people aged over 65.

The Ministry of Health and DHBs are also working over 2004–2006 to develop a new service specification for assessment services for older people. The devolution of funding for disability support services for older people from the Disability Services Directorate to DHBs on 1 October 2003 has created a greater opportunity to use the needs assessment and service co-ordination system across personal health and disability support services and so achieve better integration of services and support for disabled people.

Resources

Associate Minister of Health and Minister for Disability Issues. 2002. *Health of Older People Strategy*. URL: www.moh.govt.publications/hops

New Zealand Guidelines Group. URL: www.hzgg.org.nz

DISTRICT HEALTH BOARDS

In 2000 the Government decentralised decision-making to community-focused District Health Boards. The Ministry of Health:

> *enters into accountability arrangements with DHBs, determines the Health Strategy and agrees with government colleagues how much money will be spent on the public delivery of services. The Minister with responsibility for Disability Issues determines the disability strategy.*

Structure

District Health Boards are Crown entities responsible to the Minister of Health. The administration is conducted through the Ministry of Health. DHBs were established under the New Zealand Public Health and Disability Act 2000. There are 21 DHBs throughout the country charged with funding and providing services for geographically defined populations.

Each DHB may have a slightly different structure, based on factors such as the size of the DHB. Each Board has up to 11 members, seven of which are elected by the community. A minority of members (up to four) are appointed by the Minister of Health. In recognition of the Crown's partnership with Māori, each board must have at least two Māori members, and preferably more if Māori make up a higher proportion of a DHB's population.

Role and Function

All DHBs are responsible for working within allocated resources to improve, promote and protect the health of the population within their district and to promote the independence of disabled people. This requires them to consider all needs and services including promotion, early intervention, treatment and support services and how these services can be provided to best meet the needs of the population.

The role and function of each District Health Board are split into two: a Planning and Funding function and a Service Provision function. However the organisational structure of each District Health Board may vary. Generally there will be a team associated with the Planning and Funding function who will be responsible for services for older people. This team will have linkages with Ministry of Health. The Service Provision arm is responsible for the delivery of DHB services to the population. These might include Assessment Treatment and Rehabilitation, community, mental health and child development service as well as needs assessment and service co-ordination services.

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DHBs provide some NASC services. They either report to Community Services managers or to Planning and Funding managers of the DHB. In instances where the NASC is part-funded by the DHB and part-funded by DSD there will need to be clarity in relation to the requirements of each contract. In all situations there need to be working protocols between:

- jointly funded DHB and DSD NASCs
- separately funded DSD and DHB NASCs
- DSD-funded NASCs and DHB disability services such as Child Development Centre, Assessment Treatment and Rehabilitation
- DHB-funded NASCs and DHB disability services such as Child Development Centre, Assessment Treatment and Rehabilitation
- NASCs and other DHB services including Mental Heath and Personal Health.

DHB Funding

Funding is allocated to DHBs using a weighted population-based funding formula.

Funding for disability support services for older people was devolved to the DHBs in October 2003. Prior to this, each DHB needed to demonstrate to the Ministry of Health that it had the capacity and intent to develop a Continuum of Care and respond to the *Health of Older People Strategy*.

A map of District Health Board regions is available from DHBs or DSD Service Managers.

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GOVERNMENT STRATEGIES TO GUIDE NASCS

The New Zealand Government is charged with the responsibility of establishing strategies that help guide service delivery and development. These strategies should form part of the NASC vision, mission and Strategic Plan. Additionally, NASC practice should be informed by the strategies so that the NASC philosophy and culture reflect and support the strategy vision, and services align with strategy principles.

This section outlines a number of government strategies that are already in place to guide the development of services for disabled people.

The New Zealand Disability Strategy April 2001

> 'A society that highly values our lives and continually enhances our full participation.'
> (Minister for Disability Issues 2001)

The New Zealand Disability Strategy: Making a world of difference – Whakanui Oranga (NZDS) (Minister for Disability Issues 2001) was released following extensive

consultation with the disability community by the Government. In line with the social model of disability, the NZDS strongly supports the vision of a fully inclusive society. Achieving this vision involves ensuring that disabled people have a meaningful partnership with the Government, communities and support agencies, based on respect and equality. Disabled people will be integrated into community life on their own terms, their abilities will be valued, their diversity and interdependence will be recognised, and their human rights will be protected. Achieving this vision will involve recognising the principles of the Treaty of Waitangi.

The NZDS is central to the direction of future policies for disability. It outlines 15 key objectives to reach before its vision is realised. The Government has continued to consult with the disability sector, and particularly disabled people. Disabled people are increasingly independent and are relying less on their parents, carers, professionals or providers of services to speak on their behalf. This growing independence can be attributed to the move away from the medical model to the incorporation of a social model of disability.

Resources

Minister for Disability Issues. 2001. *New Zealand Disability Strategy: Making a world of difference – Whakanui Oranga*. URL: www.nzds.govt.nz

Ministry of Social Development. URL: www.msd.govt.nz

The Positive Ageing Strategy April 2001

Towards a society for all ages – he anga oranga kau mo nga whakatipuranga.

> *A society where people can age positively, where older people are highly valued and where they are recognised as an integral part of families and communities. New Zealand will be a positive place in which to age when older people can say they live in a society that values them, acknowledges their contribution and encourages their participation.* (Minister for Senior Citizens 2001)

The aim of the *Positive Ageing Strategy* (Minister for Senior Citizens 2001) is to improve opportunities for older people to participate in the community in the ways they choose. This will be achieved by identifying barriers to participation and working with all sectors to develop actions to address these, while balancing the needs of older people with the needs of younger and future generations.

The *Positive Ageing Strategy* establishes a set of principles as a framework for integrating policies and programmes across the government sector. Ten positive ageing goals and key actions are identified within the Strategy. The NASC manager should be cognisant of these when developing policies and quality service. Of particular relevance to NASC organisations are:

- Goal 5 Older people can feel safe and secure and age in peace.
- Goal 6 A range of culturally appropriate services allows choice for older people.

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Resource

Ministry of Social Development. URL: www.msd.govt.nz

NZPAS. *Annual Report 2002–03*. URL: www.beehive.govt.nz

Ministry of Health. *Disability in New Zealand*. URL: www.moh.govt.publications.disability

Health of Older People Strategy April 2002

> *Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes.* (Associate Minister of Health and Minister for Disability Issues 2002)

The primary aim of the *Health of Older People Strategy* (Associate Minister of Health and Minister for Disability Issues 2002) is to develop an integrated approach to health and disability support services that is responsive to the varied and changing needs of older people. This approach, an integrated continuum of care, means the older person is able to access needed services at the right time, in the right place and from the right provider.

Resource

Associate Minister of Health and Minister for Disability Issues. 2002. *Health of Older People Strategy*. URL: www.moh.govt.publications/hops

He Korowai Oranga: The Māori Health Strategy November 2002

> *The overall aim of He Korowai Oranga is whānau ora: Māori families supported to achieve maximum health and wellbeing.* (Minister of Health and Associate Minister of Health 2002)

He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002) sets the direction for Māori health development in the health and disability sector for the next five to 10 years. Accompanying the strategy is *Whakatataka: Māori Health Action Plan 2002–2005* (Ministry of Health 2002c). This outlines what the Government will do to implement the Strategy.

He Korowai Oranga recognises that both Māori and the Government have important roles to play in making health and disability strategies work for Māori. It recognises that Māori want to direct and shape their future and that the Government is committed to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi.

The *New Zealand Health Strategy* and the *New Zealand Disability Strategy* are the Government's platforms for action on health and disability. *He Korowai Oranga*

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expands on the principles and objectives for Māori in both strategies. It takes them to the next stage by providing more detail on how Māori health objectives will be achieved. *He Korowai Oranga* also sets the direction for Māori health in other strategies for a particular service or population group including the *Health of Older People Strategy*.

He Korowai Oranga places whānau at the centre of public policy. At the heart is the achievement of whānau ora or healthy Māori families supported to achieve their maximum health and wellbeing. This requires an approach that recognises and builds on integral strengths and assets of whānau, encouraging whānau development as a means to advance the wellbeing of the person, iwi and nation.

Four pathways are proposed to achieve this aim:

1. whānau, hapū, iwi and community development focusing on what it takes to ensure whānau stay or become healthy
2. support for Māori participation at all levels of the health and disability sectors including workforce development, and partnerships with iwi and Māori communities
3. effective service delivery through development of services to better provide culturally safe and effective health and disability services for Māori
4. an intersectoral approach to service delivery to address the wider issues impacting on Māori health.

The Government, in fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi, must adhere to the following principles derived from the Royal Commission of Social Policy.

- **Partnership**
  Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation**
  Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services.
- **Protection**
  Working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori concepts, values and practices.

He Korowai Oranga challenges NASC managers to create environments that are liberating and enable whānau to shape and direct their own lives, to achieve the quality of life Māori are entitled to as mana whenua in Aotearoa New Zealand.

Resource

Māori Health Directorate. URL: www.Māorihealth.govt.nz

Ministry of Health. URL: www.moh.govt.nz

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The Pacific Health and Disability Action Plan 2002

> *Healthy Pacific peoples achieving their full potential throughout their lives.* (Minister of Health 2002).

Of the New Zealand population 6.5 percent identify themselves as Pacific peoples. Statistics show that, like Māori, Pacific peoples have poorer health and disability outcomes than non-Pacific New Zealanders. The *Pacific Health and Disability Action Plan* (PHDAP; Minister of Health 2002) sets out to reduce inequalities between Pacific and other communities and to improve health outcomes of Pacific peoples.

This Action Plan 'aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders'.

The principles of the PHDAP are that:

- dignity and the sacredness of life are integral in the delivery of health and disability services
- active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

Priority 5 of the Action Plan is to *'promote participation of disabled Pacific people'*.

It notes that:

> *the area of disability and disability rights is underdeveloped in the Pacific population of New Zealand ... this is an area where leadership needs to be fostered to promote greater inclusiveness within the Pacific community and throughout society.*
>
> *Pacific peoples are typically low users of support services, which reflects the poorer access of people from low socioeconomic areas. It also reflects the need for greater responsiveness from mainstream services, as well as for Pacific-led service delivery models that more actively engage the Pacific population and its community of disabled people.*
>
> *The provision of quality education and promotion of the needs of disabled Pacific peoples, their families and caregivers will better inform issues of communication, mobility and how best to develop responsive mainstream and Pacific-led services.*

Resource

Pacific Health. URL: www.moh.govt.nz/pacific

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To Have an Ordinary Life September 2003

The National Advisory Committee on Health and Disability (NHC) undertook a project to look at the lives of adults with an intellectual disability who need regular support for living. Much of the information collected was through direct dialogue with intellectually disabled adults giving a comprehensive insight into their lives. The project focused on all areas of a person's life, not just the aspects relating to health-funded services.

The NHC's findings indicate that although services in New Zealand have moved away from institution-based services, funded support continues to reflect an institutional bias rather than international best practice of integrated community support. The limited range of service options, coupled with a limited appreciation of the potential of adults with an intellectual disability and the narrow focus of assessment and planning, contribute to this situation.

Of particular interest to NASC managers and their team is recommendation 24: *'to shift the focus of needs assessment and service co-ordination from allocating pre-purchased services to ensuring each adult with an intellectual disability has support to meet their needs'* (NHC 2003).

Resource

NHC. 2003. To Have an Ordinary Life. URL: www.nhc.govt.nz

There is also a plain English version available.

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3 NASC Roles and Responsibilities

DEVELOPMENT OF NEEDS ASSESSMENT AND SERVICE CO-ORDINATION

A public consultation process was initiated by the Government via *Support for Independence for People with Disabilities* (Minister of Social Welfare and Minister of Health 1992). The aim of this process was to determine how the community perceived the existing framework for disability support. People saw that services were largely fragmented and delivered in isolation from other services. Subsequently, the Government made a number of important changes to the way in which the funding and delivery of health and disability services were delivered.

Important components of the change included:

- the purchasing of services by one agency (the Regional Health Authority)
- improved access to assessment
- a holistic approach to assessment
- better support for people to remain at home
- the promotion of culturally appropriate services
- financial accountability of the service.

Additionally, it was identified that disability support services needed to: have a more positive attitude to disability; involve the disabled person in all decision-making; have a community focus; be culturally sensitive, accountable, flexible and innovative; have an intersectoral approach; and use financial resources responsibly.

A number of models for service delivery were considered. The Needs Assessment and Service Co-ordination model was selected as best to meet the above requirements. There were several more consultations which led to further enhancement of the model, the development of the *Standards for Needs Assessment* (Ministry of Health 1994b), *Service Co-ordination* guidelines (Ministry of Health 1995) and the subsequent development of the *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002b).

Role and Function of the NASC

A fundamental objective of NASC is to maximise and support the abilities of disabled people by enabling them to identify their needs and goals, and make decisions on how these both can be met.

For disabled people and full-time carers, NASC is the means of assessing needs, identifying support options and accessing support services. Meeting these objectives needs to include but not be restricted to:

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- responsiveness to clients and communities
- minimum waiting times
- being community focused
- supporting the enhancement of the person's natural strengths, resources and independence.

The Ministry of Health has not been prescriptive about models of needs assessment and service co-ordination. Consequently several NASC models exist including:

- those where the functions of facilitated needs assessment and service co-ordination are the role of one person
- those where the two roles are facilitated by two separate people.

The *DSD Service Specification* (Ministry of Health 2005) defines three key functions of NASC.

1. **Needs assessment** is a process of defining the current abilities, resources, goals and needs of a person and identifying which of these is the most important. The purpose is to decide what is needed to maximise a person's independence so they can participate as fully as possible in society in accordance with their current abilities, resources, culture and goals.
2. **Service co-ordination** is a process of identifying, planning and reviewing the package of services required to meet the prioritised needs and goals of the person and, where appropriate, their family, whānau and carers.
3. **Budget management** involves allocating cost-effective packages of services within an indicative budget, according to the Support Package Allocation tool, and within benchmark indicators determined by the Ministry, for the identified population for a region.

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It is the responsibility of the NASC manager to implement and demonstrate the specific requirements within the NASC contract. These requirements include:

- a clear vision of the NASC as being the dynamic combination of a service working in partnership with disabled people and the funder, to achieve the best possible outcomes within the available resources
- responsiveness to the visions contained within the *New Zealand Disability Strategy* (Minister for Disability Issues 2001), the *Positive Ageing Strategy* (Ministry of Social Policy 2001), *He Korowai Oranga* (Minister of Health and Associate Minister of Health 2002) and *The Pacific Health and Disability Action Plan* (Minister of Health 2002). The NASC should demonstrate a commitment to the promotion of a person's quality of life, the enabling of community participation and the maximising of autonomy
- a clear, auditable separation between the function of assessment and that of service co-ordination. This is to ensure that assessment is an objective process that clearly identifies the person's need irrespective of resource.

Services should create internal and external linkages that allow a person's needs to be addressed holistically, in an environment most appropriate to the disabled person.

An integrated approach needs to be developed within the NASC. This would be a clear service delivery pathway with a person-centred approach. All members of the NASC team would understand this approach supports the delivery of a coherent service to disabled people at whatever point of the journey they are.

Strong external linkages support the NASC's ability to respond to the many opportunities for developing holistic approaches to service delivery.

- The successful NASC manager ensures that disabled people have real control over their own lives. The manager encourages support options that are flexible, responsive, needs based and focused on the person and, where relevant, their family/ whānau/ carers.
- The service must support and deliver agreed outcomes to all stakeholders, particularly disabled people and their family/whānau and carers. To have any certainty that this is occurring, the NASC manager needs to establish a self monitoring function and listen carefully to the experiences of people using the service.

Resources

Volume 2 Appendices

- Appendix 1: DSD NASC Service Specification

Ministry of Health. 2002b. *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines*.

NASC PRACTICE REQUIREMENTS

There are key documents (as identified in the DSD NASC Service Specification, Volume 2, Appendix 1) that guide service delivery and provide a vision and direction for the future.

Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines (Ministry of Health 2002b)

The *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Guidelines) were developed by the Ministry of Health. This document provides guidance for the processes and requirements of facilitated needs assessment and service co-ordination.

Following a review, it became evident that a greater level of consistency and transparency of needs assessment and service co-ordination processes was required, particularly in the flow of information between disabled, older people and carers, the NASC organisation, specialised assessors, service providers and the Ministry of Health.

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The Guidelines identify:

- policy and procedures that apply at each point of the disabled or older person's contact with the NASC organisation
- information that needs to be collected and disseminated at each point of the process.

The Guidelines specify minimum requirements. Organisations will have additional policy, procedures and information needs that should be integrated into these Guidelines.

In the future, DHB-funded NASCs may have different or additional requirements and the Guidelines may therefore require adaptation. NASC staff must receive appropriate training and support in order to demonstrate competence to meet Guideline requirements as well as those requirements of their organisation.

Consistent policy and procedures will help to promote equity of access to services and outcomes across different disability groups, ages and geographic regions. They will also strengthen consistency in information collection and ensure that the disabled or older person and their carers do not have to repeat information.

Resource

Ministry of Health. 2002b. *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines*.

Standards for Needs Assessment for People with Disabilities (Ministry of Health 1994b)

These Standards were first published in 1994 by the Ministry of Health. In June 2004 they were reviewed by the NASC Reference Group who considered the content to be still valid. There are however some limitations, the most significant being that the Standards assume the disabled person is cognitively able. In some situations this is not so but there is no reference to the role and responsibilities of the carer in such instances. In addition, the language used in the document reflects thinking and practice of 1994 and the Standards are not available in plain English.

> The *Standards for Needs Assessment for People with Disabilities* remain the minimum national standards for assessment services for disabled people. The Standards describe what is required for a high quality and effective NASC service.

The Standards have been designed to ensure that assessment services provide nationally consistent, high quality assessments while allowing for flexibility and innovation in the delivery of these services. The Standards reflect the kind of assessment disabled and older people have asked for. This assessment recognises, and is compatible with, the person's cultural beliefs, values and aspirations. Disabled

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people, carers, family/whānau and groups representing or advocating for disabled people are able to use the Standards to evaluate the service received.

The Standards are based on seven key principles which embody the objectives of the assessment process. Each standard has performance details and performance indicators.

The NASC manager is responsible for ensuring needs assessment facilitators and service co-ordinators are trained in understanding these Standards and in integrating them into workplace practice. The NASC manager would monitor against these standards. A video is available to supplement the training programme. Ask your DSD Service Manager.

Resource

Ministry of Health. 1994b. *Standards for Needs Assessment for People with Disabilities*.

Service Co-ordination for People with Disabilities (Ministry of Health 1995)

In 1995 a booklet was produced by the Ministry of Health discussing service co-ordination requirements, processes and the need for interfacing with agencies such as ACC, vocational services and the Department of Education. This booklet is no longer produced but copies are still in circulation. It is suggested that the Needs Assessment and Service Co-ordination Association (NASCA) might guide you in obtaining a copy of this or the text can be secured from the DSD Service Manager.

Principles for Needs Assessment and Service Co-ordination Agencies (Health Funding Authority 1999a)

Standards and Competencies for Needs Assessment (Health Funding Authority 1999b)

Standards and Competencies for Service Co-ordination (Health Funding Authority 1999c)

The *Principles for NASC Agencies* (Health Funding Authority 1999a) contain 12 principles, standards and outcomes which provide the NASC with a useful benchmark to meet.

There has not been extensive consultation on the *Standards and Competencies* documents (Health Funding Authority 1999b, 1999c), which remain in draft format. However they contain useful information. The competencies and standards for service co-ordination are of particular relevance. These draft competencies will be used to inform the work of training requirements and the development of formal qualifications for NASC staff. They may be helpful to managers aligning competencies with the 1999 standards.

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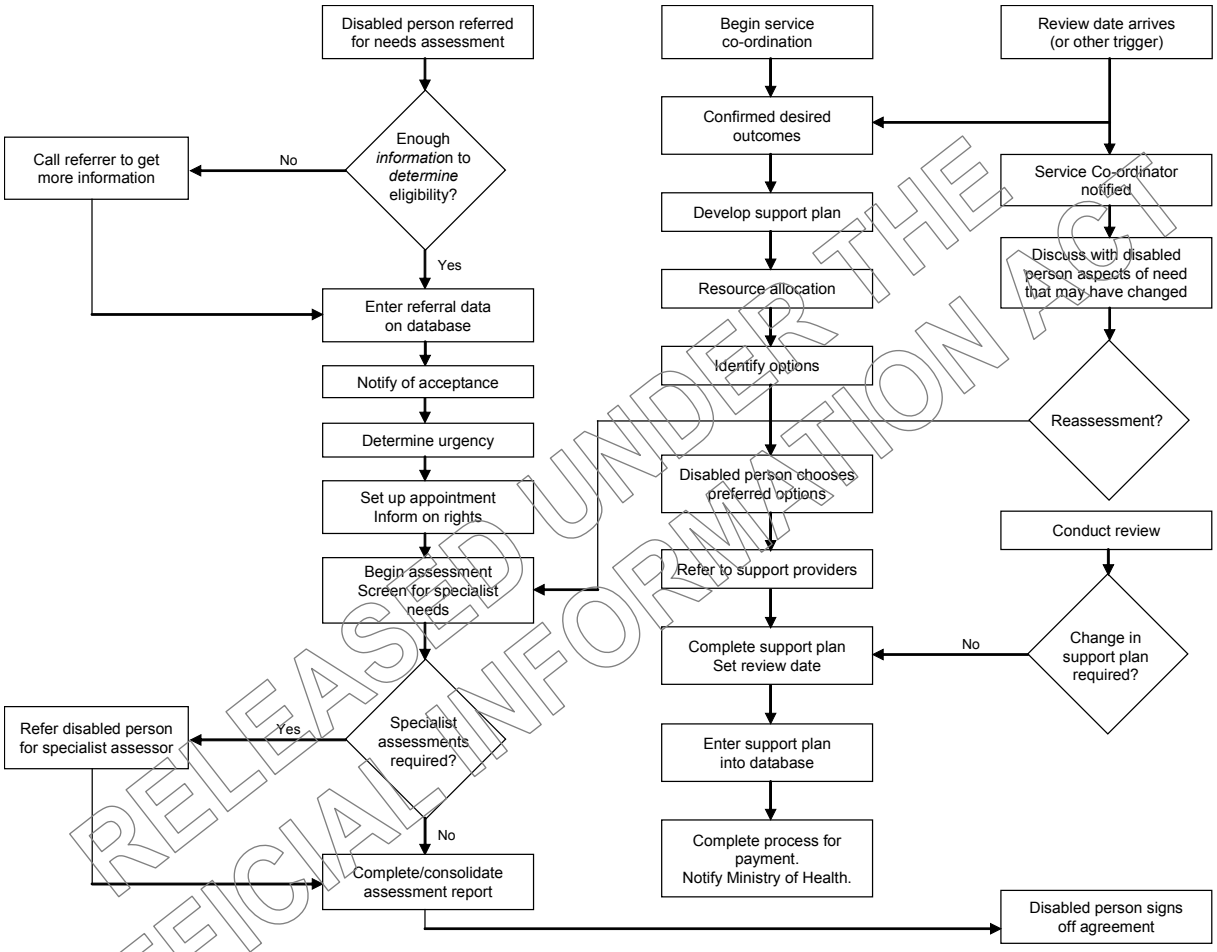
Resource

Volume 2 Appendices

- Appendix 3: Competencies for Needs Assessment Facilitators and for Service Co-ordinators

THE NASC PROCESS



Source: Ministry of Health 2002a.

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INFORMED CONSENT

The *Code of Health and Disability Services Consumers' Rights Regulations* (Health and Disability Commissioner 1996) clearly outlines the right of disabled people to make an informed choice and to give informed consent. Consent can be oral or in writing or implied.

Informed consent is a requirement that starts at the point of referral. Informed consent serves a number of purposes, including reflecting the individual's rights and confirming service eligibility. Communicating information effectively to disabled people supports the *New Zealand Disability Strategy*, which envisages a society where disabled people have a partnership with support agencies based on respect and equality, and where rights for disabled people are upheld. This is an important focus for training of all NASC staff.

In facilitating a needs assessment, it is the Ministry of Health's preference that consent in writing is obtained from the disabled person (or their carer/representative) wherever possible. The assessment has future fiscal consequences. It may be used by NASC organisations for making decisions about government-funded assistance in accordance with government policy and relevant service specifications, and thus the extent to which the individual or their carer is responsible for the individual's own needs.

A person is free to sign a consent or not. Ultimately the disabled person has the right to refuse services and to withdraw consent to both the NASC processes and/or any services. It should be documented when such refusal or withdrawal occurs.

> Informed choice and informed consent are not a "one-off" event. What is important is the process by which sufficient information is given to the disabled person to make an informed choice. If circumstances suggest that the person did not understand or insufficient information was given, then the consent could be held to be invalid.

Resource

Health and Disability Commissioner. 1996. *Code of Health and Disability Services Consumers' Rights Regulations*.

ELIGIBILITY

Note: Draft Eligibility Section subject to further work within the Ministry of Health.

The purpose of this section is to support NASCs in determining client eligibility and access to disability support services funded by the Ministry of Health via a NASC in the context of the Ministry's current funding policy and practice, and in managing health referrals and boundary issues with other service areas.

The Ministry is currently drafting eligibility criteria in response to the need for:

- a practical and workable interpretation of the Government's definition of disability
- clarity as to who comprises the client group that the Ministry funds for DSS
- clarity over the boundary between Ministry-funded DSS and other service areas.

Implementation of the proposed criteria is expected in 2005. Longer-term policy work is expected on the underlying boundary problems. Work is planned to update the Government's definition of disability to reflect recent Cabinet decisions on funding responsibilities for DSS, including CAB (03) 5/5 *Devolution of Disability Support Services Funding for Older People* (17/2/03) as well as current funding policy and practice within the DSS *Framework for Service Delivery* (Ministry of Health 1994a).

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General Overview of Responsibility for Funding DSS

The **Ministry of Health** is responsible for DSS for people with long-term disabilities (largely under the age of 65) and some national contracts.

District Health Boards are currently responsible for all services except public health. In October 2003, DHBs took on responsibility for DSS for older people. Although funding responsibilities for DSS for older people are now separated from those for younger people with disabilities, two key exceptions to the general rules can be applied.

1. The Ministry will continue to fund people with a long-term impairment who were receiving DSS from the Ministry at the time of the funding separation (even if they are over 65), unless they are assessed as requiring aged residential care, at which time the DHBs will take over funding responsibility.
2. DHBs will fund people between 50 and 65 who have been clinically assessed by a DHB and/or needs assessed as close in interest to persons 65 and over and require access to DSS. CAB (03) 5/5 *Devolution of Disability Support Services Funding for Older People* (17/2/03).

It is the Ministry's view that DHBs are also responsible for meeting the support needs of people during, or after, episodes of medical or surgical treatment and long-term support needs of people with chronic health conditions such as diabetes.

Who Can Access Ministry-funded Disability Support Services?

NASC should ensure services are provided only to those disabled people who are eligible to receive them, as required by the Guide to Eligibility for Publicly Funded Health and Disability Services in New Zealand (see Ministry website www.moh.govt.nz) and DSD NASC Service Specification (see Volume 2, Appendix 1).

The Government's definition of disability [CAB (94) M 3/5(1a) refers] determines who is eligible for Ministry-funded DSS via a NASC. The definition states that:

> *A person with a disability is a person who has been identified as having a physical, psychiatric, intellectual, sensory, or age-related disability (or a combination of these), which is likely to continue for a minimum of six months and result in the reduction of independent function to the extent that ongoing support is required.*

In applying the definition, the Ministry will fund a range of DSS for people who have been assessed as having a physical, intellectual or sensory disability (or a combination of these). Clients with these disabilities constitute the Ministry's main client group given that DSS funding for people with psychiatric disability and age-related disability has been devolved to DHBs.

The Ministry will also fund DSS for people with certain neurological conditions that result in permanent disabilities, certain developmental disabilities in children and young people, and physical, intellectual or sensory disability that co-exists with a health condition and/or injury. A NASC can clarify these by contacting its DSD Service Manager.

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Who is Excluded from Ministry-funded Disability Support Services?

In principle, no person is excluded from accessing Ministry-funded DSS if they are assessed as having a disability-related need under the Government's definition of disability and if their needs can be met within the existing range of services. The latter criterion means having a disability or clinical diagnosis is itself not an automatic entitlement to accessing Ministry-funded DSS. For example, some people with a mild disability may not require Ministry-funded supports.

The Ministry will not fund DSS for people whose primary needs are driven by acute or chronic health conditions, mental health, health conditions more commonly associated with ageing, or injury or accident. The Ministry expects that support services for these people will be funded by DHBs and ACC (Injury, Prevention, Rehabilitation and Compensation Act 2001) respectively.

In summary, the following client groups are generally ineligible for Ministry-funded DSS:

- mental health and addiction conditions including dementias, attention deficit disorders
- acute and chronic health conditions including epilepsy and morbid obesity
- palliative care conditions
- conditions more commonly associated with ageing including 'close in interest' (see below)
- injury or accident resulting in permanent disabilities (since 1974).

The Ministry of Health does not provide DSS when a client's needs might reasonably be met from another service area or where there is no existing service in that area for meeting the client's needs.

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How is Eligibility Determined?

Determining eligibility for disability support services will involve some or all of the following processes.

- Ministry-funded NASCs should have protocols in place with their funding agencies to support **decision-making** on eligibility as required (see Pathway for accessing Ministry-funded DSS below). A NASC should contact its DSD Service Manager if there is any doubt about a person's eligibility.
- Ministry-funded NASCs should have a standard procedure for screening **referrals** and a clear communication process for responding to referrals that are ineligible for NASC services. All referrals should be screened to establish/confirm eligibility for DSS before commencing needs assessment. This may require some investigation of the nature and extent of disability. Referrals should be rejected at either initial screening, or subsequent facilitated needs assessment, if screening indicates clearly that the person's needs should not be met within Ministry-funded DSS.

- A facilitated **needs assessment** may be required to help establish eligibility for DSS as well as determine support need. This may require a referral between service areas for a specialist functional assessment or other clinical assessment. A specialist assessment may also be required to determine eligibility and access to environmental support services (ESS).
- A **diagnosis** may be required to help determine eligibility. Some conditions such as autism will require a diagnosis to enable the client to access Ministry-funded DSS.

Close in Interest Protocols

Ministry-funded NASCs should follow any local protocols developed to manage referrals for clients who require DHB clinical assessment as close in interest to persons aged 65 and over and who require access to DSS.

Shared Funding Arrangements

Clients with co-existing health and disability needs may require services from different funders such as the Ministry, DHBs and ACC. Ministry-funded NASCs should discuss with their DSD Service Manager the need for any formal agreement with other funders on the relative funding responsibilities to address co-existing needs.

Boundary management

Ministry-funded NASCs should not provide DSS to clients whose support needs should be met by other service areas. Health referrals should not be accepted until a clear position is reached on eligibility of the person concerned. This is to save on unnecessary facilitated needs assessments and ensure clients are not wrongly accepted for Ministry-funded DSS. Boundary cases should be investigated carefully to determine whether they fit with the DSS framework or elsewhere. Compelling clinical and case history evidence will therefore be required to indicate presence of disability or disability-related need under the definition of disability and for a needs assessment to be undertaken to confirm eligibility.

Transfer of Clients from Ministry-funded DSS

Existing Ministry-funded clients who are subsequently found to be ineligible for Ministry-funded services should not have their services terminated until a transfer/exit process has been established with the client and the appropriate service area.

In 2005 the Ministry will be working with NASCs and DHBs to identify a transfer process and ensure that it occurs. In the interim, NASCs should continue any existing services to clients in order to protect the client's interests while transfer issues are being resolved.

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Dispute Resolution

Services to disabled people should be continued while boundary issues are being resolved. Any disagreement between services over the funding stream to which the disabled person is allocated should be resolved at the lowest level of management, by informal means first, as far as possible. This means that in the first instance, boundary issues should be resolved between a Ministry-funded NASC and DHB-funded NASC or health service or other referring agency. Where the NASC cannot reach agreement with the referring agency, the issue should be escalated to the Ministry's DSD Service Manager or Northern or Southern Operational Team Manager and to the DHB (Planning and Funding Manager) or ACC or other agency.

In 2005 the Ministry of Health will work with NASCs on developing dispute resolution processes to help NASCs manage the more/most difficult boundary issues with DHB-funded older people's services, personal health, mental health services and other services where agreement cannot be reached on which agency is responsible for the client's support needs.

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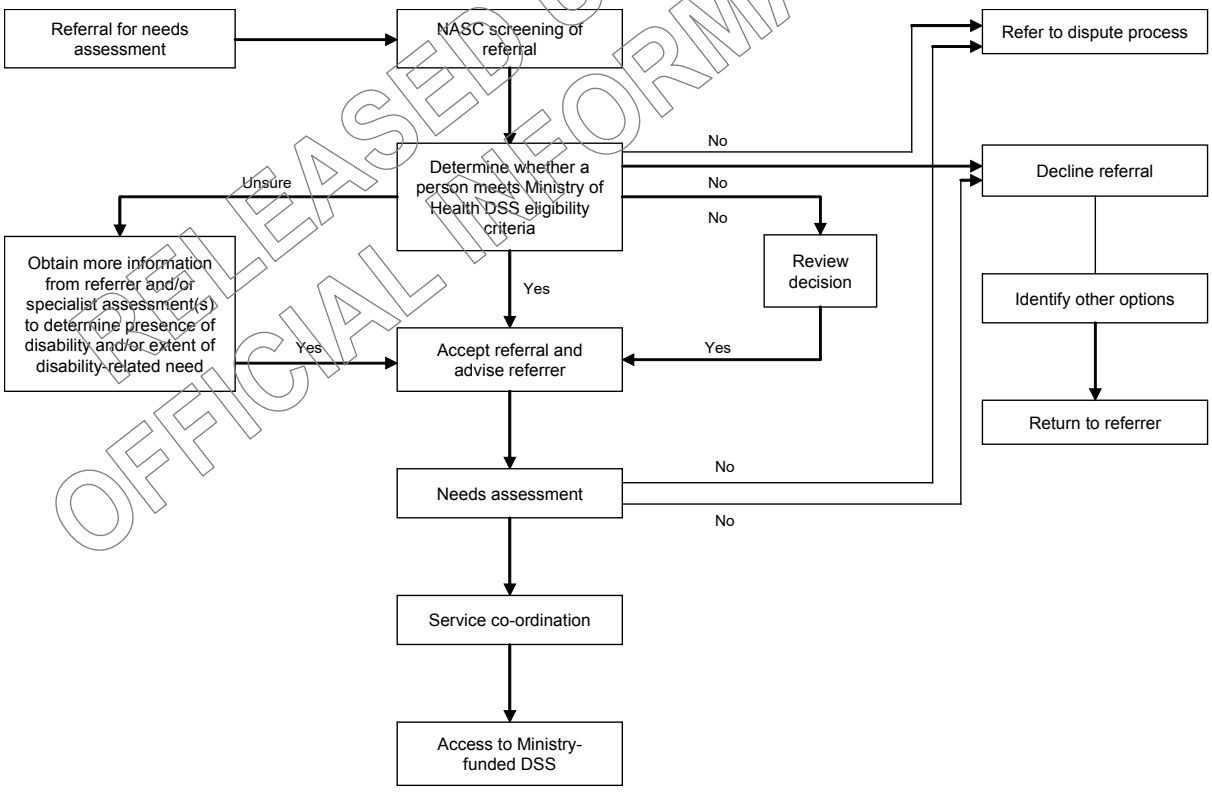
Pathway for Accessing Ministry-funded DSS

The flow chart shows the process that NASCs use to determine eligibility for Ministry-funded DSS. Access to Ministry-funded ESS is via a separate assessment process.



Eligibility Assessment Guidelines for People with an Intellectual Disability

The *Intellectual Disability Eligibility Assessment: Guidelines for Requests and Reports* (Ministry of Health 2003) have been developed to establish a collaborative

effort between NASC organisations and psychologists working in the area of intellectual disability.

The purpose of this document is to establish accurate and consistent practice in assessing intellectual disability for the purposes of establishing eligibility to receive services specifically targeted by Ministry of Health intellectual disability service contracts. National clinical representation has been sought and both national and international standards used in relation to these Guidelines.

An Eligibility Assessment is the formal evaluation undertaken by a psychologist or other suitably qualified professional to establish if a person has an intellectual disability. This process is undertaken in order to establish eligibility for services specifically contracted by the Ministry of Health for people with intellectual disabilities and NASC disability services in general.

Resource

Volume 2 Appendices

- Appendix 4: Ministry of Health. June 2003. *Intellectual Disability Eligibility Assessment: Guidelines for Requests and Reports*.

SCREENING

The purpose of screening referrals is to promote the entry of disabled people into a process for which they may be eligible.

In some instances the determination of eligibility may be unclear. The possible reasons for this uncertainty include incomplete information, unconfirmed disability, being outside the Ministry definition of disability, or boundary confusion. It is therefore helpful to have staff at this interface who have a clear understanding of the eligibility criteria and possess excellent communication skills to guide and support disabled people and those people who make referrals through the process.

To support this process the NASC manager should develop a standard procedure for the screening of referrals. Issues – including what constitutes an urgent referral such as safety issues, timeframes for response, resources such as the use of standardised letters – should all form part of this procedure.

The NASC manager needs to establish a clear process for response to referrals that may be ineligible for NASC services. In these instances the identification of more appropriate services and knowledge of their referral process is essential to facilitate a seamless transfer for the disabled person. The recording and subsequent analysis of inappropriate referrals received may prove useful, identifying areas that continue to generate inappropriate referrals so that both referrers' and staff's understanding of the NASC eligibility criteria can be enhanced.

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RESPONSE/WAITING TIMES

The Ministry of Health expects all referrals to be responded to in the contracted timeframes as follows.

- First contact with the person should be made within two working days of receipt of the referral or enquiry.
- Time to complete a facilitated needs assessment should be:
  - within 24 hours in a crisis where a person's safety is at risk
  - within 24–48 hours for urgent referrals, depending on the degree of urgency
  - within five working days in 40 percent of cases
  - within 14 working days in 40 percent of cases
  - within 20 working days in 20 percent of cases.
- Time to complete service co-ordination should be:
  - within 10 working days of completion of the needs assessment in 80 percent of cases
  - within 20 working days of completion of the needs assessment in the remaining 20 percent of cases.

Resource

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- Appendix 1: DSD NASC Service Specification

MANAGEMENT OF WORKLOADS

There may be occasions when the volume of referrals is greater than the capacity of the NASC to respond within the timeframes as outlined in the previous section. Areas of delay may include the initiation of facilitated needs assessment or the completion of service co-ordination activity. The NASC manager should have established procedures in place to manage all eventualities. This will keep the disabled person informed and support the staff to manage their workloads and respond consistently and professionally to workload tensions.

Reference to the Ministry's NASC Service Specifications (Volume 2, Appendix 1) and the *Support Needs and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002b) will inform development of these procedures. Written procedures should be established for:

- referrals – including defining urgency and priority
- facilitated needs assessment
- service co-ordination
- routine review
- reassessment.

In all instances there would need to be:

- established documented processes
- mandatory communication resources

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- a staff member with delegated authority to implement the procedure
- an information loop back to the disabled person and referrer
- capacity to review the wait list
- tracking mechanism to account waiting times
- mechanism to report wait times to NASC manager.

Should there be constant pressure on any wait list, this must be brought to the attention of the DSD Service Manager.

Resource

Volume 2 Appendices
- Appendix 1: DSD NASC Service Specification

FACILITATED NEEDS ASSESSMENT

The role of the support needs assessment facilitator is to work directly with the disabled person to confirm eligibility and to identify the disabled person's current strengths and abilities and their disability support needs. This approach promotes the inclusive social model of disability and acknowledges the disabled person's existing competencies and networks. Key people that the disabled person identifies may contribute to the process.

Skills of communication, engagement, disability competence, cultural competence and facilitation are requirements of the support needs assessment facilitator.

> *A facilitated needs assessment is the process of determining the current abilities, resources, goals and needs of disabled person and identifying which of these needs are the most important. The purpose of the process is to decide what is needed to maximise a person's independence so they participate as fully as possible in society, in keeping with their abilities, resources, culture and goals.* DSS1004 and DSD1005 and DSD1004D (Ministry of Health 2005)

A facilitated needs assessment should be holistic, comprehensive and reflect the individuality of the disabled person. It would include consideration of the disabled person's recreational, social, personal development, training, educational, employment and personal care needs. The disability support needs of the disabled person's family/whānau and carers should also be considered, although it is not necessarily the responsibility of the NASC to fund all these areas of support.

The Guidelines (Ministry of Health 2002a) provide a minimum requirement for information to be collected. It is essential that a person-centred and client-directed approach is maintained at all times.

A strengths-based assessment and reporting approach should be adopted and utilised throughout the process. This approach reflects changing attitudes away from

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a deficit- and problem-based focus to a focus on the integration, resilience and abilities of disabled people.

Resources

Volume 2 Appendices

- Appendix 1: DSD NASC Service Specification

Ministry of Health. 2002b. *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines*.

Assessment of Disabled People as They Become Older

The NASC manager should prepare staff to develop the knowledge and competencies required to support disabled people as they grow older. While core service delivery principles will always apply, there are requirements specific to older people. The *Positive Ageing Strategy* (Minister for Senior Citizens 2001) is a useful resource to guard against ageism compromising service delivery.

> Knowledge of disabilities and the ageing process and the consequences of the combination of these as they apply to individuals and their whānau/family/carers are required.

The *Assessment Processes for Older People: Best practice evidence-based guidelines* (New Zealand Guidelines Group 2003) provides useful guidance for the NASC manager in ensuring their service responds proactively and positively to the older person.

The NASC must have the capacity to:

- provide comprehensive and multidimensional assessments that are relevant and culturally safe
- identify clinical needs
- make referral to the appropriate specialised service
- work with providers to encourage and support them to meet the needs of ageing disabled people.

Service co-ordinators may need to extend their knowledge base to include services that are designed for older people.

In all instances the NASC manager should be anticipating and facilitating the changes required within the NASC to support older people, enabling them to age positively.

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Access to Specialised Assessments

A disabled person may require further investigation by a specialised assessment service with particular skill or expertise if:

- the disability is unconfirmed but, based on evidence, the assessment facilitator considers it is likely that the person is eligible for disability support services and a clinical assessment is required to confirm this
- there is a particular need that requires clinical assessment
- there is potential for gain through specific therapy or equipment or environmental adaptation
- there is a need for medical specialist intervention to assess/investigate and/or manage/treat the disabling condition.

> The NASC manager should establish a relationship with specialised assessment services so referrals can be made in a timely and useful manner. The development of agreed referral protocols, feedback loops and opportunities for joint planning to best support the disabled person has the potential to significantly improve levels of independence and interdependence for people.

Internal protocols should identify the point when referrals for specialised assessment can be made and who has delegated authority to do so. The NASC manager must have a clear understanding of what the specialised assessment services are contracted to do. This understanding is best gained through:

- knowledge of service specifications of particular services
- the development and maintenance of a relationship with providers of specialised assessment services.

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Interface with Accredited Assessors of Environmental Support Services

> People who access services and funders want support services to be delivered in a co-ordinated manner. An intersectoral approach to service delivery, and collegial relationships with other providers of support, are essential in achieving this.

One domain requiring an integrated approach to the provision of support is environmental support services.

Access to ESS is gained through Specialised Assessors. These are primarily occupational therapists, physiotherapists and speech language therapists. Sensory (vision and hearing) accredited assessors in the sensory area are generally audiologists and optometrists. A list of assessors is available from Enable New Zealand or *accessable*.

Funding for ESS is accessed by Specialised Assessors (who may be employed by the DHB, private providers or independently) from one of two Ministry-contracted providers: Enable New Zealand (Midland, Central and Southern regions) and *accessable* (Northern region).

Specialised Assessors hold certain areas of accreditation/registration that relate to their qualifications and experience within that field. The areas of accreditation/ registration refer to the types of equipment/housing modifications that the Specialised Assessor has the skills to prescribe. These types include:

- wheelchairs, seating and mobility
- housing modifications
- equipment for daily living
- vehicles
- communication and information technology.

When Specialised Assessors lodge applications for high-cost housing modifications or personal care equipment, Enable New Zealand and *accessable* seek evidence of meaningful liaison with the NASC. This liaison is expected to develop between the two parties at the beginning or at the earliest possible stage of the assessment process.

This approach offers the opportunity to better serve the needs of the disabled person, to identify sustainable long-term outcomes and to manage available resources effectively. While the Ministry of Health has identified this piece of work in its work plan, the NASC manager is charged with the responsibility of responding to Objective 7 of the *New Zealand Disability Strategy* (Ministry for Disability Issues 2001), 'Create long term support systems based on the individual', and so must consider how best to achieve this.

Enable New Zealand and *accessable* have, in conjunction with the Ministry of Health and NASCA, recently completed a form to reflect liaison between the Specialised Assessor and the NASC.

The form has been framed to ensure that the following points are covered:

- the principle of joint attainment of person-centred outcomes
- the solution will be cost-effective use of Ministry resources
- the care environment is sustainable and long term
- key support issues are considered
- all support options have been explored.

Further information about this process, including a copy of this form, can be found at the website identified below.

It may be necessary for the NASC manager to build this collegial relationship and facilitate the joint development of protocols and processes to support these requirements with Specialised Assessors. While the manager may initiate this, the service co-ordinator will be the key contact best able to work with the Specialised

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Assessor to plan long-term supports for disabled people. The service co-ordinator's involvement in establishing these networks will thus be essential.

Resource

Enable New Zealand. URL: www.disabilityfunding.co.nz

SERVICE CO-ORDINATION

> Service co-ordination is a process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals of the person and, where appropriate, their family/whānau and carers. Service co-ordination also determines which of the assessed needs can be met by government funded services and which can be met by other services, and will explore all options and linkages for addressing prioritised needs and goals. (Ministry of Health 2005)

In conjunction with the disabled person, the service co-ordinator will:

- explore all options and linkages for addressing prioritised needs and goals
- determine how support needs can be met by natural resources and supports
- determine how support needs can be met by through non-DSD resources
- determine how support needs can be met by DSD resources.

While the service co-ordinator is required to respond to all identified needs, there may be instances where it is important to involve other agencies in providing support and services. In these instances it is important that a lead co-ordinator is identified. This need not be the NASC. Formal processes need to be developed if involving other agencies in this way becomes a regular occurrence.

Skills of facilitation, innovative thinking, creative problem-solving, negotiation and networking are all requirements of the service co-ordinator.

The service co-ordinator has responsibility for the allocation of DSD resource at an individual client level on behalf of the Ministry.

The Discretionary Funding is the last resort of service co-ordination. It needs to follow delegated authorities and guidance agreed with the DSD/DHB Service Manager of the NASC.

The service co-ordinator is responsible for allocation of resource at an individual level; the entire NASC team has responsibility for the allocation of DSD resource; and the NASC manager is ultimately responsible for management of the indicative budget on behalf of the population served. This budget management involves managing cost-effective packages of services within an indicative budget as determined by the funder.

> *'The NASC manages, on behalf of the Ministry, a defined indicative budget based upon an annual allocation. Performance against the budget will be reviewed, at least, on a monthly basis by the NASC and the Ministry.*

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The NASC needs to ensure that people with the highest priority needs receive access to services first. The NASC must also ensure that commitments made to fund service packages for people are such that they will not exceed the indicative budget for the current and out years.

Budget management involves allocating cost effective packages of services within the indicative budget, according to the Support Package Allocation tool, and within Benchmark Indicators determined by the Ministry for the identified population for a region. (Ministry of Health 2005)

Every part of the NASC process must be robust in meeting need within these Ministry/NASC and contracted limits.

Resource

Volume 2 Appendices

- Appendix 1: DSD NASC Service Specification

Service Co-ordination for Children

Service co-ordinators need to work to service specifications, guidelines and all other required standards of practice. Children are subject to specific operational policy and protocol.

- Children's developmental needs are specific and arise from achieving developmental tasks within families en route to adulthood.
- Under the overarching *New Zealand Disability Strategy*, the Ministry of Health has committed to national consistency and equity of access across the population groups.
- Children at present are a unique population group in DSS. This population has a huge interface with education and health resulting in a direct shift in focuses and service use that is not experienced by other population groups.

In some circumstances parents have difficulty looking after their disabled children or young people. The necessity for an out of home placement is most likely to occur for children and young people with disabilities who have high and complex needs, requiring a level of care that is beyond the coping abilities of the family and where all options for supporting the family for the child or young person to remain at home have been explored and exhausted by the NASC.

DSD has developed policy requirements for children and young people who have complex needs and may require placement outside the family home. The NASC manager needs to ensure that staff working with children and young people have knowledge of, and are working to, the policy.

Current operational policy and the Memorandum of Understanding (MoU) between the Health Funding Authority and the Department of Child, Youth and Family Services (CYFS) are being reviewed.

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Memorandum of Understanding between Department of Child, Youth and Family Services and Health Funding Authority, July 1999

This MoU was developed to assist in managing and funding services to children and young people with disabilities and their family/whānau who have a relationship with CYFS and are eligible for DSS. It aims to facilitate comprehensive service provision for this population group in the context of their families.

This MoU is a comprehensive document that outlines the roles and responsibilities of both agencies, in particular funding responsibilities. It also provides case studies and protocols for both parties to follow. It can be obtained from the DSD Service Manager.

Resources

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- Appendix 5: Out of Home Placement for Children and Young People

Memorandum of Understanding between the Department of Child, Youth and Family Services and the Health Funding Authority

Intensive Service Co-ordination

The NASC is responsible for providing intensive service co-ordination for the few people with high and complex needs. This usually requires the involvement of multiple providers and ongoing problem-solving. Intensive service co-ordination requires an ongoing relationship between the disabled person and the service co-ordinator. The NASC has a responsibility to work with others supporting the person to ensure everyone has a common understanding of the needs and goals of the person and is working co-operatively to achieve these.

The NASC manager must be mindful that the NASC focus is on its core responsibilities and the organisation does not act for other services. Intensive service co-ordination is not social work. NASC managers need to be alert to the contribution social workers play in assisting disabled people. There should be clear referral paths and agreed protocols to access these services. Referral to community-based services, including social work, will assist in ensuring that the disabled person receives the best possible service.

Where there is assessment and/or co-ordination across different sectors, there needs to be agreement as to who acts in a lead co-ordination role. Agreed protocols could be useful if such cross-sectoral work becomes a frequent occurrence.

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Natural Resources and Supports

The term **natural resources and supports** is replacing what was previously described as **informal support**.

Natural resources and supports are supports that can be accessed by all people who live and work in any community within New Zealand. They are readily available and reasonably easy to access. They describe the personal resource an individual has within them. They describe the support that is available from family members, neighbourhoods and community/social groups, schools, church groups, Scouts, Girl Guides, service groups, sports clubs and so on. They are supports that people access on a very informal basis and in reality are accessed by most New Zealanders.

During the facilitation of the initial needs assessment, it is essential that all family connections, regardless of geographical location and/or availability, are identified. All past and present connections to community must be discussed and identified, if relevant and required. It is essential that it is only connections that are discussed at this point and no expectation of support is identified or established.

At the service co-ordination stage, the support need is clearly identified. A plan is developed identifying the roles and functions of the person's natural supports that would be required to establish a holistic package of support. A facilitation process is entered into with people who would have the potential to form a circle of support with the person and a strategy is developed to identify outcomes and any gaps. Ongoing needs and supports are initially addressed by the group who formed the circle of support. Once this had been facilitated, the service co-ordination function considers the gaps and the need for funded and/or other services to support the package. The NASC facilitates resolution of outstanding needs through these other supports and services, both funded and non-funded.

There are a number of advantages to natural resources and supports.

- The disabled person is directing their own support.
- There is continuity of support that is possibly already being offered.
- People offering natural support have a clear idea of their role and function.
- A sense of meaningfulness can be gained by people who are sharing a responsibility.
- People will always be able to provide natural support when they are able to identify their own strengths.
- A 'want to do', rather than 'have to do' feeling is created, which moves the person who is being supported out of 'I'm a burden' thinking.

This is based on the disabled person's own strengths or natural supports.

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BUDGET MANAGEMENT

Support Package Allocation Tool

The service co-ordinator's task is to identify solutions that meet the disabled person's identified support needs within the NASC organisation's available resource. It is probable that there will be tension between the management of finite resource and the realities of being of service to the disabled person. It is a challenge for service co-ordinators to address this tension.

A review of NASC organisations identified the need for a nationally consistent approach in the allocation of resource to promote equity of access to services.

A consistent understanding and approach to resource allocation have been promoted by the Ministry through provision of the Support Package Allocation (SPA) tool. This is found within the *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002a). It provides a framework for the allocation of resource. It is expected that the NASC manager will ensure the SPA tool is used with understanding and competence and that there are internal audit mechanisms.

Within the SPA tool are four age groups:

- Birth to five years 'Focus on the Best Start'
- Five years to school leavers 'Focus on Personal Goals and Development'
- School leavers to 65 years 'Focus on Personal Goals and Development'
- 65 plus and age related 'Focus on Personal Goals and Development'

Within each of these age groups there are five descriptions of level of need and desired outcomes as well as a range of dollar allocations for each level.

The allocation amounts, specified in the SPA tool, guide the maximum spend at each particular level of need and outcome for the disabled person. These amounts are not an automatic allocation but guide total budget management. There will be distribution of spend within each band. In some instances, the spend may fall below that band's allocation and in others the support package cost exceeds the allocation amounts.

In instances where the support package costs exceed the NASC manager's delegated authority, sign-off from the funder is required. The NASC manager must have a process to approve support packages that is clearly understood and adhered to by staff.

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The NASC manager must also ensure that the SPA tool is being applied within the service co-ordination process. There must be documented evidence of this activity. The two reasons for this requirement are that the use of this tool:

1. will support a decision-making process by the service co-ordinator that is transparent, and will enable audit review
2. will promote a nationally consistent approach to the allocation of resources.

Discretionary Funding

There are occasions when the disabled person's support needs cannot be met through DSD-contracted services. To enable the NASC to respond in a positive and innovative manner, the Ministry has provided a mechanism that enables NASCs to access other support options that are tailored to meet an individual's need. Discretionary Funding enables the NASC to purchase more flexible and innovative supports to meet the needs of a small group of people.

This Discretionary Funding is not to be used to:

- purchase services that are the responsibility of another funder such as ACC or CYFS
- provide services/support already funded through other DSS contracts, for instance environmental support, residential care, home based support, supported independent living
- reimburse payment for services that require a user charge.

Essential Requirements for NASCs entering into Subcontracts

The NASC will ensure that agreements with service providers clearly specify:

- the services/support to be purchased
- the role and responsibilities of both parties
- price and volume
- Ministry access to premises and records
- any specific quality standards
- terms of agreement
- start and end date
- review dates
- information and reporting requirements
- method of payment
- dispute and termination processes.

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The NASC manager is responsible for monitoring the Discretionary Funding to ensure appropriate use. This will also provide opportunity to analyse what the Discretionary Funding is being used for, the frequency of a particular service being accessed and the effectiveness of the support being purchased. The manager should consult with the DSD Service Manager if it becomes evident to the NASC manager that a particular service is frequently being accessed and funded by the Discretionary Funding. It may be more appropriate that the DSD explore initiating an RFP process to contract directly with a provider. This contracting mechanism will ensure requirements of the Commerce Act 1986 are met and issues of quality and accountability addressed.

Full requirements in relation to Discretionary Funding are within the DSD NASC Service Specification.

Resource

Volume 2 Appendices

- Appendix 1: DSD NASC Service Specification

Individualised Funding

Philosophy and Principles

> Individualised Funding is an administrative arrangement developed by the Ministry of Health for some disabled people to enable them to hold, manage or govern their own needs-assessed budgets.

In practical terms this means that some disabled people will be able to hire, manage, pay, train and make their own contracts with support workers or choose to manage some aspects of this process. It provides opportunity for some disabled people to manage the personal support services they require in a way they believe meets their needs best. There will be reasonable limits on how the budget may be spent to provide personal support services. For example, this budget may not be used to purchase major capital items such as a car.

Initially a two-year programme will be undertaken, in which only younger people with complex needs will be eligible for Individualised Funding. Complex needs will be identified within the assessment process taking into account factors such as the ability to perform basic tasks, communication, mobility, personal care, household functions and the availability and extent of support systems. An evaluation of the ability and determination of the disabled person to take on Individualised Funding responsibilities will be included in the assessment process.

The Individualised Funding system requires that a disabled person has the competence and confidence to manage their support budget. In certain circumstances a relative or appointed person may manage the budget on their behalf. Not all disabled people with complex needs will wish to pursue this option.

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An Individualised Funding agency, Manawanui in Charge (the agency), has been established. Its two main functions are to:

1. support disabled people with complex needs who wish to manage their own Individualised Funding budget
2. ensure comprehensive and consistent information, training and the like are available to NASCs, disabled people and disability interest groups.

The agency's work and the development of Individualised Funding will be subject to ongoing Ministry evaluation. The agency will be accountable for its activities to the Ministry and will be monitored by the Ministry.

In line with a commitment made in the *Health of Older People Strategy* (Associate Minister of Health and Minister for Disability Issues 2002), introducing this option to older people will be a matter for the Ministry of Health and DHBs to consider when the Individualised Funding programme has been evaluated. Older people who already hold their own personal budget under existing schemes will be considered by the DHBs.

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NASC Responsibilities

NASCs will continue to be the access point for services for disabled people. Once assessment has been facilitated, complexity of need established, and the option of Individualised Funding considered and selected by the disabled person, then the NASC will refer the disabled person to the Individualised Funding agency, Manawanui in Charge.

Manawanui in Charge

Manawanui in Charge is the result of collaboration among Auckland Disability Resource Centre, LIFE Unlimited, Ripple Trust and Standards Plus. Manawanui's vision is 'A world where disabled people have absolute authority and autonomy over their disability related support'. Their mission statement is 'to create an individualised funding system owned and governed by disabled people'.

While the inception of Manawanui in Charge is reasonably new, it is envisaged that the disabled person will have access to and be supported by an Individualised Funding coach. The coach will:

- consult with the disabled person to clarify needs and expectations
- assist in the development and implementation of an individual support plan
- provide face to face mentoring for Individualised Funding self managers
- assist with resolving problems where appropriate.

Resource

Ministry of Health. 2003. *Individualised Funding: Guidance and Good Practice*. URL: www.moh.govt.nz

Pricing Mechanisms

The Ministry of Health has developed pricing models for informing contract pricing with providers for some services in certain parts of the country.

Current pricing models cover only residential care for people with intellectual disabilities.

Pricing models in use are:

- IHC Transparent Pricing Model (known as Allocation Resource Tool (ART) Pricing Model)
- ID Transparent Pricing Model (updated version of Midland's ID Pricing Model for people who left Tokanui Hospital)
- High and Complex Transparent Pricing Model.

The following table provides more details for each model.

Model	Background and Details	Areas/Providers Currently Using This Model	Coverage
IHC Transparent Pricing Model	• Developed by Deloitte Touche Tohmatsu in collaboration with the then Health Funding Authority and IHC. Work commenced in 1998 has been fully implemented since April 2004. • This model is applicable only to residential group homes and contract board services. • This pricing model is based on a service co-ordination tool, Allocation Resource Tool applied by NASCs and the provider to identify the level of support needed by each client. This is based on 11 categories of support requirements. • The results from the 11 categories are fed into a spreadsheet, which outputs a residential care band and the contracted rates for the client. These are DSD contracted rates and so are not negotiable. • If the results indicate that the support level of the client is Band 5, it will be necessary to further identify the total number of support hours required each week for the client. This will determine an individualised contract rate.	• IHC • Hohepa Hawkes Bay	• Whole of New Zealand for IHC • Hohepa Hawkes Bay area only

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Model	Background and Details	Areas/Providers Currently Using This Model	Coverage
ID Transparent Pricing Model	• Developed by Deloitte Touche Tohmatsu in collaboration with the then Midland Regional Health Authority, NASCs and providers of Intellectual Disability Residential Services in the Midland region in 1998. It was developed to price services for clients leaving Tokanui Hospital in Waikato region. • The model is predominantly based on the assessed required support need level in hours per week for clients in a residential setting. The level of support should enable them to live in their community and achieve agreed outcomes. • This model is ideally suited for use in houses of four to six clients.	• All providers in Midland region • Providers for people leaving Kimberley • Brackenridge Estate Ltd (Christchurch)	• Midland region and other parts of the country as applicable
High and Complex Transparent Pricing Model	• Developed by Deloitte Touche Tohmatsu in collaboration with the then Health Funding Authority, NASCs and a small number of providers of Intellectual Disability Residential Services in the Midland region in 2001. It was developed to price services for high and complex clients referred by Regional Intellectual Disability Care Agencies. • This is essentially based on the ID Transparent Pricing Model in operation but tailored for specific needs and outcomes for high and complex clients. • This model is suited for residential settings of one to a maximum of six clients.	• All providers in Midland region	• Midland region

Notes: Each of these models was developed by the Health Funding Agency or the Ministry of Health for use by NASCs. Each has accompanying documents to detail the operation and assumptions behind cost components in the model.

The Ministry of Health is aware of some of the issues, both positive and negative, raised by both NASCs and providers in relation to the pricing models. There has been work on a further enhanced pricing model. At this stage no implementation date has been determined.

Where providers are not covered by these pricing models, contract rates have been largely based on negotiated amounts between the providers and the Ministry of Health. It is the Ministry's intention to move to national consistency in both service specifications and pricing model. Some national rates are already in use. Additional information and specific rates can be confirmed with the DSD Service Manager.

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OTHER COMPONENTS OF THE NASC PROCESS

Review Protocol

In this context 'review' is used to describe the planned response to a request for review made by a disabled person regarding any part of their facilitated needs assessment or service co-ordination support plan.

Key elements of the review process must include:

- an ability to screen out, or resolve through discussion, complaints arising through misunderstandings
- a commitment to undertake further assessment or service co-ordination.

The NASC will have a review process that:

- is developed in partnership with disabled people, to include cultural input, clarifying the use of advocates, process timelines and training of NASC staff in the process
- meets the requirements of the Ministry/NASC contract
- is available in written format, and is available in other mediums
- is automatically provided to all recipients of the service
- records and analyses requests for review and the subsequent outcome. NASC practice may be adapted if indicated.

Some NASCs actively involve disabled people who are their advisor or their Disability Advisory Group at various levels of resolution of reviews.

Key questions covered by review include the following.

- Is the outcome consistent with the assessed need?
- Have mandatory processes been used?
- Has the SPA been used?
- Can consistency of resource allocation be demonstrated?

It is anticipated that the majority of reviews will be resolved at an early level, probably at Level 1 (see below). The NASC manager may choose to work towards early resolution of reviews as one of the annual Key Performance Indicators in the NASC Continuous Quality Plan.

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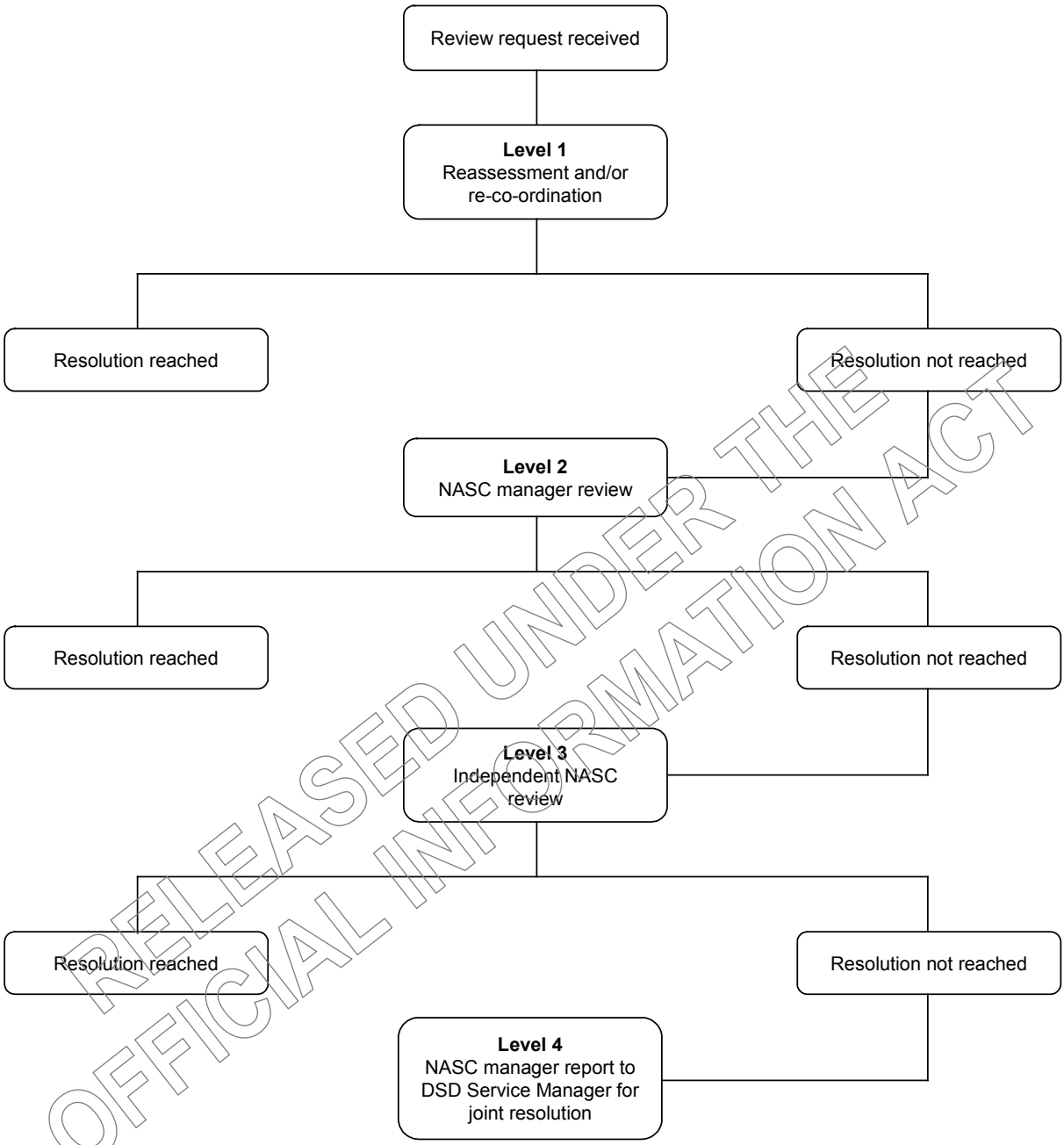
Overview of the Review Process



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Review Levels

The four levels of review shown in the preceding diagram are detailed here.

- **Level 1: Internal Review**

  The request for review is received by the NASC.

  - **Step 1:** The request for Review is received and acknowledged, within 24 hours, by the NASC.
  - **Step 2:** There is dialogue between the two parties to determine the reason for Review and to work towards resolution. Should this dialogue not resolve the issue then a number of options should be offered.

- **Step 3:** The disabled person is offered reassessment and/or a review of the support plan by the NASC staff involved and/or the disabled person is offered alternative NASC staff to peer review the work to date. Agreement is reached and documented as to the method of review, that is, team/peer review, paper based review, visit, or a combination.
- **Step 4:** The review will be undertaken following a documented and transparent process and reflecting use of relevant documents including Guidelines, Standards, SPA and so on.
- **Step 5:** In the event of a satisfactory outcome for the disabled person this is confirmed by letter from the NASC to the disabled person.

- **Level 2: Management Review**

  The outcome proposed in Level 1 does not satisfy the disabled person.

  - **Step 1:** The disabled person's file is handed to the NASC manager. The request for review and the subsequent actions are reviewed by the manager who will seek whatever additional information is required to aid resolution in a manner that best supports the process. This may include meeting with the disabled person.
  - **Step 2:** A full review is undertaken by the NASC manager. This is a documented process reflecting use of relevant documents including Guidelines, Standards, SPA, and so on. The manager will work with the disabled person to reach resolution. The NASC staff will be kept informed.
  - **Step 3:** The outcome of the NASC manager's review is communicated to the disabled person. The outcome is confirmed by letter from the NASC to the disabled person.

- **Level 3: Independent NASC Review**

  The outcome proposed in Level 2 does not satisfy the disabled person.

  - **Step 1:** The process for review by an independent NASC is conveyed to the disabled person. Timeframes are agreed between all parties.
  - **Step 2:** The request for Independent Review and the disabled person's file will be handed to the independent NASC. This NASC must have experience and competence in the particular aspect of NASC practice being examined. The request for review and the subsequent actions are reviewed by the manager of the independent NASC. The manager of the independent NASC will determine and facilitate the review process.
  - **Step 3:** The two NASC managers reach agreement on the review outcome. The disabled person is contacted by the primary NASC to confirm completion of the review process and informed of the outcome. The outcome is confirmed by letter from the primary NASC to the disabled person. **Note:** This third step acknowledges the consequence of resource allocation decisions on each NASC's budget management responsibilities.

- **Level 4: Review by DSD**

  The outcome proposed in Level 3 does not satisfy the disabled person or the primary NASC does not concur with proposed outcome. The review and

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subsequent outcomes are reported to the DSD Service Manager. DSD will utilise internal mechanisms to support the NASC to reach resolution.

Planned Review

Planned review of the disabled person's support plan is a contractual responsibility. Its purpose is to determine how well the plan is supporting the disabled person's prioritised needs and goals.

Any changes that require further attention – such as readjustment of the support plan, service delivery issues, rehabilitation issues, referral for reassessment – will be acted on. The NASC will determine with the person an appropriate timeframe for review. This will reflect the complexity or significance of need as well as of anticipated change such as rehabilitation outcomes, the passing of a crisis. If there is significant change in need or circumstance and the support plan no longer meets needs, reassessment will be required.

The disabled person may call for a review in the instance of a change in need or circumstance.

Reassessment

Reassessment will be required if there is a significant change in need or circumstance of the disabled person, and the support plan no longer meets their needs. This requirement will usually result from the service co-ordination review process. It may be agreed at the time of assessment if a change in need is anticipated. Reassessment may also be sought by the disabled person or significant others with the permission of the disabled person.

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Resource

Volume 2 Appendices; Appendix 9: DSD Mandatory Communication Tools
Mandatory letters

- 9.5: The disabled person has been reassessed and their package has changed.
- 9.6: The disabled person has been reassessed and is no longer eligible for DSD-funded services but may be eligible for funding through other agencies.

Inter-NASC Transfers

The requirements on the NASC in relation to movement of people between NASCs are outlined in the DSD NASC Service Specification (Volume 2, Appendix 1). Key to smooth transfers are:

- an agreed protocol which is observed between NASCs
- an agreed transfer information template
- a transition plan developed by both NASCs with the person and their family/ whānau prior to the transfer.

The receiving NASC assumes responsibility for the commencement of support services and the budget management aspects of the support package of a transferring person from the point of arrival. This should be according to the transition plan already agreed by all the parties.

It is important that whenever possible all aspects of the transfer are agreed by all parties beforehand and recorded in the transition plan. This is particularly important in situations where new supports/services currently in place are not available in the new area.

The timing of reassessment or review will be based on the needs of the individual's situation. This aspect should be included in the transition plan. Individual circumstances may indicate a need for this to be varied subsequently.

Any consequences of the support package of transferring person(s) on the NASCs' budget management responsibilities should be reported to respective DSD Service Managers but should not influence the process of transfer.

Note: Additional work will be undertaken jointly by the Ministry and NASCA to update a flow chart and procedures currently used by NASCs.

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Exits

There will be instances where a disabled person will exit the NASC. These instances include:

- a person is not eligible for the NASC service. They may be the responsibility of another funder such as ACC or a DHB. The NASC needs to be aware of the potential for joint funding and service provision
- a person transfers to another NASC.

Note: In both of the above situations the NASC must ensure that full information is given, referral made or assisted and/or prior planning completed before the actual exit, with continuity of supports where these are being received.

Other instances of exit include:

- review or reassessment identifies that supports/services are no longer required
- a person chooses to exit themselves from the NASC process
- a person dies.

The NASC manager is encouraged to develop clear protocols to meet these situations and to discuss with their Service Manager any unclear situations.

Advocacy

While NASCs are expected to provide a person-centred service, they are specifically not contracted to advocate for individuals. It is important that NASCs are widely seen as impartial, allocating resources for all disabled people on the basis of need.

Therefore, it is inappropriate for a NASC worker to advocate for an individual client. Individual advocacy should be sought external to the NASC.

Everyone using a disability service has the protection of the *Code of Health and Disability Services Consumers' Rights*. The NASC should have an established procedure that enables the person, their family/whānau and carers to have access to an advocate, if desired, who is independent of the service, culturally safe and flexible and responsive to the needs of the person, family/whānau and carers. This advocate may be a member of the person's family/whānau, carers or friends, or a member of a professional or religious group nominated by the person.

> If the disabled person is unable to represent their interests, the NASC organisation must identify the appropriate procedures to ensure the rights of the disabled person are preserved.

A form of advocacy exists in an organisational context where it is the responsibility of the NASC manager to report to the Ministry trends in relation to unmet needs of disabled people to assist in future planning.

Resources

Health and Disability Commissioner. URL: www.hdc.org.nz

Ministry of Health. 1994b. *Standards for Needs Assessment for People with Disabilities*.

Health and Disability Consumer Advocacy Service pamphlet

Local advocacy services pamphlets.

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Crisis Response

The NASC manager must anticipate and incorporate the need for a crisis response service and have available a 24-hour emergency call system so that those experiencing genuine emergency can access services. While there are various ways of responding to this contractual requirement, the service must be reliable and appropriate. In the instances of a NASC located in a DHB, conversation with both the DHB and DSD Service Managers would be helpful to determine how best to meet this requirement. To fulfil this requirement, the NASC must be able to source crisis response options, such as emergency respite care. The role of the NASC manager is to develop these agreements in anticipation of need.

The crisis response system should be monitored, reviewed and adjusted accordingly.

SPECIFIC POPULATIONS

DSD NASC's Responsibilities for Disabled People as They Become Older

People aged 65 and over who have a 'lifelong disability' remain the responsibility of the DSD-funded NASC. However, should an age-related event occur or age-related condition develop to the extent that the need for residential care must be considered, transfer to the DHB-funded NASC is then mandatory.

This information must be provided to the older disabled person so they are fully informed of the assessment and service co-ordination processes, can participate in informed decision-making and know the process that will be followed should there be a significant change in their age-related need.

Transition to the DHB

It is vital that the NASC manager appreciates the importance of a collegial relationship with DHB-funded NASCs to promote the development of referral and transition protocols to these services. Such protocols would include processes and timeframes for:

- referral
- notification of acceptance of transfer
- transfer of file information
- receiving NASC initial contact with transferring client
- period of maintenance of existing DSD services
- dispute resolution.

A process chart outlining these steps is included on the next page.

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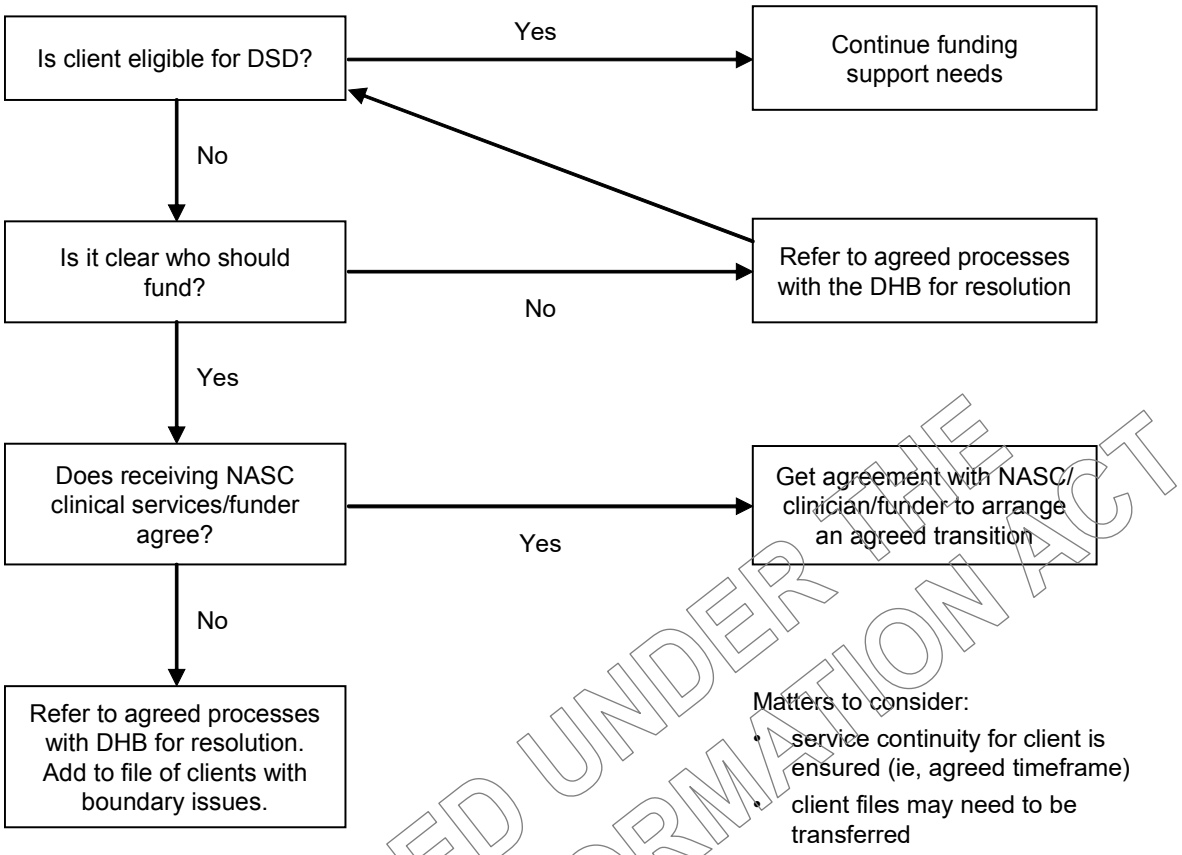
Flow Chart for Possible Transition Between DSD-funded and DHB-funded NASCs



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Facilitated Needs Assessment and Service Co-ordination for Children with Special Needs

The information below has been provided by Parent to Parent New Zealand Inc and provides the NASC manager with useful insight as to a parent's need for information and support during the NASC process.

NASC managers and assessors and service co-ordinators need to respect the fact that the family of a child with a disability knows best what the needs of that child, and the family itself, are.

The whole process of assessment should be about assessing the family as a whole, not just the child with a disability. This is fundamental to the well-being of the child because it is the family unit that supports the child on a day to day basis. If the family's needs are not being met then they cannot support the child as he/she needs to be supported.

NASC managers, assessors and service co-ordinators must work in partnership with families, and must treat families with respect, dignity and in a culturally sensitive way. Effort must be put into establishing a good rapport with families, as without this, a true picture of the needs of all those involved will not be obtained. Good reflective listening skills are a vital part of this process.

Assessors need to be able to facilitate a discussion about what is going on within the family, and must have the skills necessary to pick up on what the needs might really be.

Needs assessors and service co-ordinators must work closely with families to determine what their specific needs are and to find solutions together. These solutions must be individually tailored for each particular family. Each situation is unique and that must be understood. The service co-ordinators must be flexible in his/her approach and the solutions must also be flexible and open to change.

There must also be absolute flexibility around the review and reassessment of a client and his/her needs. Assessors need to ensure that the family is aware of how the process works. It is extremely important that a family knows that they can ask for a review at any time if their needs change.

Staff training should include an understanding of the grief process. Staff training must also involve input from families to highlight the stress involved in telling, re-telling and re-living their stories each time an assessment is required. Assessors need to be sensitive to even minute cues as sometimes a family may be reluctant to be completely open about their situation, or may not fully realise themselves how bad things really are.

A useful way of soliciting the input of parents and carers is to include them in their local NASC reference groups. This is an ideal way for parents to help shape policy, practice and training.

Essential resources for a NASC manager to be aware of are the *New Zealand Disability Strategy* (Minister for Disability Issues 2002), and its objectives and the Ministry of Health report *To Have an Ordinary Life* (NHC 2003).

Resource

Parent to Parent New Zealand. URL: www.parent2parent.org.nz

Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003 and Children

At the point of writing, there are continuing discussions between CYFS and DSD on the place of children with regard to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) and the jurisdiction of the Youth Court. NASC managers will be advised of the outcome and consequential policy and procedural requirements that affect Regional Intellectual Disability Care Agencies (RIDCAs) and NASCs.

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Regional Intellectual Disability Care Agency

A Regional Intellectual Disability Care Agency is a specialist service for people with an intellectual disability whose behaviour poses serious risk of harm to themselves or others. These behaviours may also result in a breach of the law or in the person being unable to access mainstream service provision.

Those eligible for RIDCA services include people who:

- are a 'proposed care recipient' or a 'care recipient' or a 'special care recipient' as defined in the IDCCR Act
- have an intellectual disability and whose behaviour may pose serious risk of physical harm to self/others and for whom at least one of the following conditions applies: access of mainstream community options is limited or prevented; or the person manifests a psychiatric disorder, or substance use disorder or behaviour results in a breach of the law.

In consultation with the proposed care recipient, their family/whānau and the health specialists involved in their care, the needs assessment is completed and a care and rehabilitation plan devised.

A compulsory care order is then made to detain the person as a care recipient. This can be made for up to three years duration and may be extended by the Family Court following a review if it considers that to be appropriate.

Regular reviews and reports to the Family Court will reflect the continued appropriateness of the care and rehabilitation plan.

Referrals to RIDCA can be made from NASC organisations, Corrections Services, courts and other mental health and disability support services. Referrals should be made on the RIDCA referral form with information/documentation demonstrating that the individual meets the RIDCA eligibility criteria. This involves consultation with the person, family/whānau, present and past service providers, and clinicians involved in supporting the person.

Acceptance of the referral lies within the RIDCA's jurisdiction, exercised on the basis of the eligibility criteria (refer Volume 2, Appendix 8). The NASC's responsibility is to make comprehensive and appropriate referrals by familiarising itself with the eligibility criteria and assisting the RIDCA in gathering all relevant material.

Once the needs assessment has been completed a request for services is developed in consultation with the person, their family/whānau and the service provider of choice.

Resource

Ministry of Health. Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. URL: www.moh.govt.nz/idccr

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Transition from RIDCA to the NASC

Note: National protocols to guide the transfer of people from NASC to RIDCA and transition from RIDCA to NASC are being developed by DSD. This information is provided to guide the NASC manager.

There are instances when the need to transition the disabled person from the RIDCA to NASC may be identified. While the co-ordination of the transition is the responsibility of the RIDCA team, a transition protocol should be jointly established by the RIDCA and NASC.

The protocol would:

- include the means of identifying instances where there may be review leading to possible transition
- specify the referral process for review for transition, including who can initiate this request
- specify the actions to be taken at each point of the process
- identify which parties should be included at each point of the process
- identify which actions they are responsible for
- identify the person responsible for the facilitation and completion of each action
- identify documentation requirements
- identify timelines
- plan for ongoing transition support for the NASC, personnel and timeframes.

The transition plan would form part of the protocol. Included in the plan would be:

- the disabled person's goals and actions
- transitional support requirements
- agreed initial support package
- behaviour support requirements
- mental health input
- training arrangements for the provider
- handover requirements
- further resources to support successful transition.

The establishment of an effective relationship with the RIDCA provider will assist the NASC to effectively support disabled people with intellectual disabilities. This relationship will be reflected in an understanding of the RIDCA service and subsequent appropriate referral to and the transition from RIDCA services. Also, opportunities for collegial planning, learning and development, and support of the NASC staff by RIDCA expertise may be identified.

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Resources

Volume 2 Appendices

- Appendix 6: Regional Intellectual Disability Care Agency
- Appendix 7: Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Autism Spectrum Disorder Guidelines

The Ministry of Health is leading an intersectoral group to develop Autism Spectrum Disorder (ASD) best practice guidelines. These will provide evidence-based information for health, disability and education professionals and service agencies for the treatment and management of people with ASD. There are three work streams covering different stages of life. The guidelines will be completed in June 2005 and are expected to be useful to, and provide best practice guidelines for, needs assessment and service co-ordination.

Existing ASD/NASC guidelines developed by the Health Funding Authority in 2000 will be reviewed within this process.

High and Complex Needs Strategy (HCN)

The High and Complex Needs (HCN) Strategy is an intersectoral strategy, jointly funded through Votes Child Youth and Family Services, Education and Health. It is designed to address serious service gaps and shortfalls for children and young people with high and complex needs. It seeks to enhance collaboration in service development and funding across sectors for individual children and young people with the highest and most complex needs by:

- encouraging case collaboration
- facilitating the development of innovative joint service responses
- developing intensive and case managed services for those with the highest and most complex needs (exception funding).

NASC managers need to ensure their staff are clear about and work to the process for out of home placements, particularly in regard to the need to exhaust all other disability support options before referral to the High and Complex Needs Unit.

Resources

The Intersectoral Strategy for Children and Young People with High and Complex Needs, Te Kahu Tauahi Whānau. A joint strategy of the Ministries of Health and Education and the Department of Child, Youth and Family Services. April 2005.

HCN Guidelines for the Application and Plan Processes are available by email hcn@cyf.govt.nz

High and Complex Needs Unit. URL: www.hcn.govt.nz

Volume 2 Appendices

- Appendix 8: High and Complex Needs Unit

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4 Information Management and Professional Business Processes

Access to information is a vital component of effective service to support the independence of disabled people and is an integral component of the NASC business.

Within the NASC business there are two quite different aspects of information management. One reflects the contractual requirements of DSD, including how information should be communicated, what information should be gathered at what point, how the information must be reported to the funder and how the information is used to support the disabled person. These requirements are clearly laid out in the DSD NASC Service Specification (Volume 2, Appendix 1).

The other aspect reflects the management of information that belongs to the disabled person, particularly the release of information.

MANDATORY COMMUNICATION TOOLS

Mandatory letters and communication tools have been developed by the Ministry for use by the NASC to ensure that consistent messages are communicated to disabled people in particular scenarios.

They have been provided by the Ministry with the intent of promoting the sharing of accurate information in an appropriate and sensitive manner.

The NASC manager must ensure that these tools are readily accessible and that staff appreciate their intent and use. The six letters cover the following situations.

1. The disabled person has been newly assessed and is eligible for DSD-funded DSS.
2. The disabled person has been assessed as eligible for services but may experience a delay in the commencement of those disability support services.
3. The disabled person has been newly assessed and is not eligible for DSD-funded support but may be eligible through other agencies.
4. The disabled person has been newly assessed and is not eligible for DSD-funded DSS and not eligible through other agencies.
5. The disabled person has been reassessed and their package has changed.
6. The disabled person has been reassessed and is no longer eligible for DSD-funded services but may be eligible for funding through other agencies.

Resources

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- Appendix 9: DSD Mandatory Communication Tools
- Appendix 10: DSD NASC Fact Sheet
- Appendix 11: DSD Service Users' Frequently Asked Questions

PRIVACY ACT 1993

The Privacy Act 1993 affects all NASCs in that they collect, store, use and disclose information about disabled people. The purpose of the Act is to promote and protect individual privacy.

> The Privacy Act sets out 12 principles which must be upheld. All NASC activity should be considered in light of these principles. A disabled person may complain to the Privacy Commissioner should they consider there has been a breach of their privacy.

The 12 privacy principles cover:

- the purpose of the collection of personal information
- the source of personal information
- the collection of personal information
- the manner of collection of personal information
- the storage and security of personal information
- access to personal information
- the correction of personal information
- the confirmation of accuracy of personal information before use
- the limits on retention of personal information
- the limits on the use of personal information
- the limits on disclosure of personal information
- unique identifiers.

Access to personal information should be easy for disabled people. Upon receiving a request for personal information, made either orally or in writing, the NASC is obliged to make a decision and notify the disabled person of this decision within 20 working days. A written protocol determining how the NASC will respond to these requests should form part of the NASC's Quality Plan.

Resource

Office of the Privacy Commissioner. URL: www.privacy.org.nz

OFFICIAL INFORMATION ACT 1982

New Zealand citizens or permanent residents or people who are in New Zealand can request personal information under the Privacy Act 1993. It is anticipated this would be the usual manner in which disabled people seek personal information from the NASC.

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The Official Information Act 1982 (OIA) exists to provide an avenue for people to access official information as described under the Act. This would usually be a request of the Ministry of Health. However, the information sought might include information relating to decisions made about the person, NASC policies and procedures, and meeting agendas and minutes.

The objectives of the OIA are to:

- increase public access to official information to
  - enable more effective participation in the making of laws and policies
  - promote the accountability of Ministers and officials
- give persons access to official information about them
- protect the public interest and safeguard personal privacy.

Requests for official information may be made only by:

- a New Zealand citizen
- a permanent resident of New Zealand
- a person who is currently in New Zealand
- a body corporate incorporated in New Zealand
- a body corporate incorporated outside New Zealand that has a place of business in New Zealand.

A principle of availability underpins the OIA. This means that all information must be made available unless there is good reason under the Act to withhold it.

Each request for official information needs to be considered on its own merits. A request for information does not have to be in writing nor to state that it is being made under the OIA.

A reasonable charge for the provision of information can be made but the information as to cost should be made available to the requester at the beginning of the process.

A response to a request for information must be made as soon as reasonably practicable but no later than 20 working days after having received the request. If a NASC is asked for information by the Ministry so that the Ministry can fulfil its obligations, in relation to a request, the NASC must provide information as soon as is practicable.

Official Information requests may be refused if there is 'good reason' to withhold information. The Ombudsman has jurisdiction under the OIA Act to investigate and review a decision to withhold information.

The NASC manager should possess a good working knowledge of the OIA Act so as to respond with knowledge and confidence to any requests for information from the Ministry.

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Resources

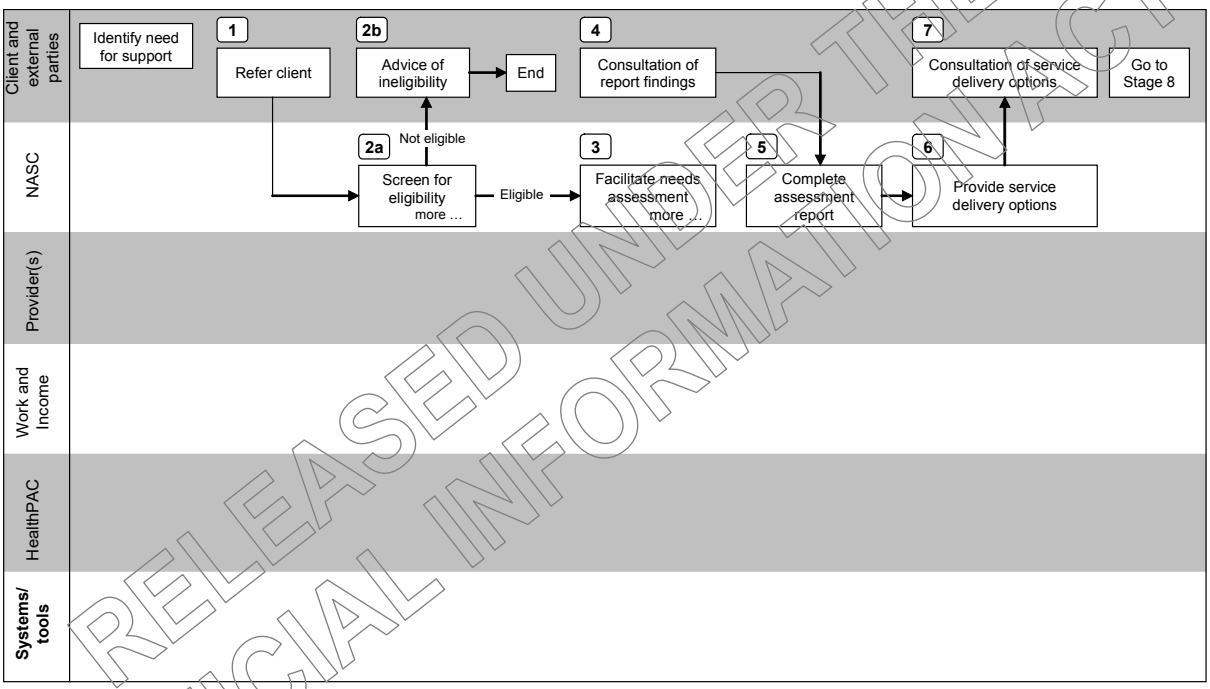
Ministry of Justice. 2001. Official Information: Your right to know. URL: www.justice.govt.nz/pubs/other/pamphlets/2001/info-act.html

www.dol.govt.nz

THE NASC BUSINESS PROCESS

The NASC process is shown in the flow charts below. These flow charts show the progression of the process, at what point each aspect of the business is involved, what information is to be managed and what the tasks are at that point.

Disability Service Provision via NASC



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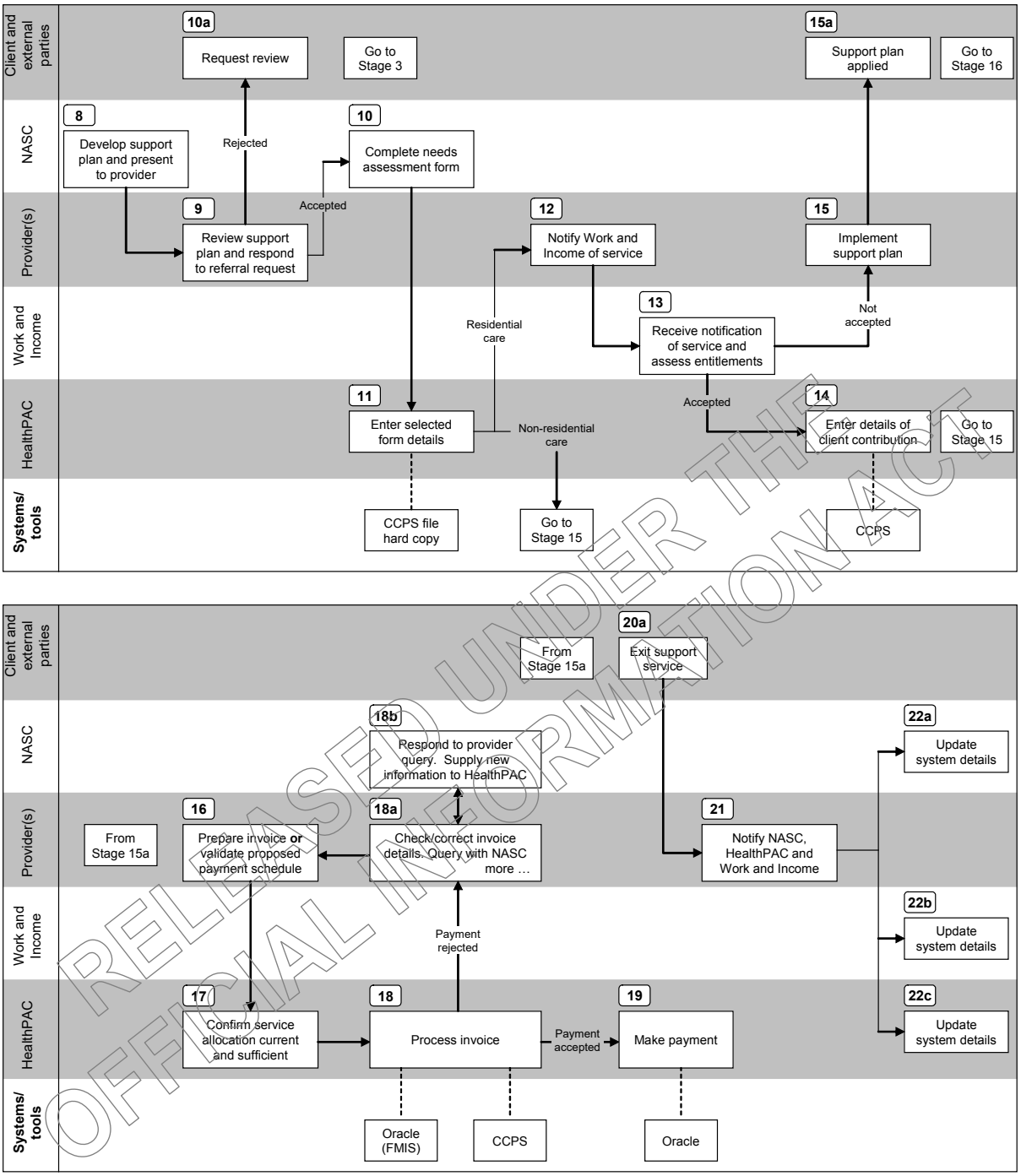

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HEALTHPAC

Health Payments, Administration and Compliance (HealthPAC) is a business unit of the Ministry of Health. It exists to provide services to health and disability funders such as the Ministry and DHBs. These services include:

- payment and administration of agreements
- payment to health and disability providers for contracted services
- data collection and provision of information
- audit and counter-fraud functions.

HealthPAC has offices in Wanganui, Wellington, Christchurch and Dunedin. Wanganui and Wellington branches make payments for primary care such pharmacy or general practitioner (GP) claims. Christchurch heads the Audit and Compliance section. Dunedin is the main centre for agreement administration, monitoring of those agreements, all other provider payments, client based payments and client claims.

Client Claims Processing System

Loading Client Allocations

Information has to be supplied to HealthPAC before payment of claims can be made. Provider claims in relation to each client have to be paid against the information entered into the Client Claims Processing System (CCPS) in HealthPAC. This includes client/service user and carer individual demographic information and information on service allocations authorised by NASC staff.

There are two ways of providing information to HealthPAC:

1. NASC notification forms (hard copy)
2. NASC electronic loads.

NASC Notification Forms

NASC notification forms contain client information that the electronic loads do not capture and allocations that cannot be sent down via electronic loads.

Care must be taken that the NASC is using the most up-to-date forms. The use of an incorrect form will result in the information being loaded incorrectly or the form being sent back to the NASC so that it can be replaced with the correct form and information needed.

The information contained in these forms is manually entered into the Ministry of Health systems.

NASC Electronic Loads

The NASC Electronic Load is created from the NASC client management system and is primarily used for home based support allocations and some carer relief.

The load consists of a number of files that are electronically loaded into CCPS. These files need to be created and sent to HealthPAC regularly, usually weekly.

The files contain:

- some client information
- assessment and service co-ordination information
- service allocation
- carer information.

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Rejections – in Electronic Loads

When the files are loaded into CCPS a number of rejection reports are created. It is important that rejections from these files are corrected and resubmitted with the next electronic NASC load the following week. If rejections are not corrected, the risk of large provider invoice rejections increases (see below).

Managers and staff in the various NASC roles all need to work to a process of continuous quality improvement to minimise the number of NASC rejections by ensuring high standards of data entry into NASC systems. This process needs to be supported by ongoing monitoring and training.

Accuracy and **timeliness** are of **key importance**.

Invoice Rejections

Information Flow

When electronic invoicing files are processed, CCPS sends providers a selection of reports to inform them which lines are accepted and which lines are rejected. These reports are sent before the invoice is paid and are in two formats:

- .csv file (can be viewed and edited in Excel)
- .rtf file (can be viewed in Word).

Errors are caused for a number of reasons. These can be broken down into two sources with three main causes and many sub-causes.

Errors can be either:

1. provider error, or
2. NASC error.

The three main causes for invoice rejection are:

1. invoice exceeds eligibility
2. client not eligible for service
3. client not found.

All of the above causes could be related to:

- provider invoicing incorrectly
- NASC not sending the data through to HealthPAC
- NASC being late in sending the data
- data sent by the NASC being rejected by HealthPAC.

Process for Fixing Invoice Rejections

1. Provider checks that it is claiming correctly. This includes checking whether it is claiming for the correct service and correct service period.
2. If the provider is claiming correctly then the provider sends an Excel file or email to relevant NASC with the errors for the service claimed in the service period.

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3. The provider should ensure that all the clients included in the claim are part of the particular NASC prior to sending any information to avoid additional work for the NASCs and time delays.
4. The NASC is to either resubmit or send corrections to update CCPS and allow the provider to re-invoice for the rejection.
5. If the provider is in error, the NASC needs to communicate this to the provider.
6. If the provider is claiming incorrectly, the provider will need to correct the rejection and submit this line with the next invoice.

Timeframes for Fixing Invoice Rejections

As a guideline:

- 95 percent of provider rejections should be fixed within two weeks
- 100 percent of provider rejections should be fixed within four weeks.

This guideline allows for lines to be rejected once or twice before being fixed finally.

A current guide to invoice rejections and what error messages mean is available from the Ministry of Health through the DSD Service Manager.

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Working Relationships/Processes

It is imperative that NASC staff maintain a good relationship with the providers so rejections can be fixed as easily and quickly as possible. The NASC manager needs to ensure good working relationships are established and maintained to support best outcomes for all involved in these processes.

It is recommended that there is a central contact for fixing provider rejections within each NASC so providers have only one known person to speak to when they have rejections.

DSD Provider Agreements

HealthPAC Dunedin – Agreement Administration generates provider agreements, on the request of a DSD Service Manager. This enables the Directorate to issue standard documentation, and to hold detailed information about the agreements in the Contract Management System (CMS).

There are two main types of agreements: one for Residential Services, which includes specific residential clauses, and another for Non-residential Services. Both have the following two parts to the agreement.

Part One: The Head Agreement contains non-negotiable 'boilerplate' clauses that are standard for every contract. It is made up of:

A: General Terms and Conditions
B: Provider Quality Specifications
C: Information and Reporting Standards

Part Two: Service Schedules contains all service and provider specific information. This part includes:

A: DSS Type Terms and Conditions (generally only used for residential services)

B: Provider Specific Terms and Conditions – which contains the service, term and the price, and any other provider-specific information

C: Service Specification

Performance Monitoring

The responsibility for monitoring a provider lies with the DSD Service Manager, but in most cases Agreement Administration set up reporting requirements, from the service specifications in CMS. Templates reflecting these requirements are sent to the provider with their executed copy of the agreement. The providers then complete the templates with the data required and return to HealthPAC. This data is recorded in CMS against the reporting units. The templates are forwarded to the DSD Service Managers to follow up any issues.

Payment Processes

All payments are made by direct credit. Apart from Client Claims, there must always be a formal agreement document in CMS (and CCPS, if applicable).

CMS Payments

CMS payments apply to those services that generally do not require independent information from an assessment for payment of the service.

Payment Type in DSD Service Agreement is 'CMS'.

The provider must invoice the Ministry for service supplied. The information that the provider must supply is outlined in the agreement. Providers will receive invoice headers to attach to the front of their invoice.

CCPS Payments

The CCPS payments team processes all payment for providers claiming funding for individual clients with assessed needs and eligibility for services confirmed by a NASC. Payments can only be made when there is a formal agreement with a provider in place, and client eligibility details have been received correctly and in full from the NASC.

Payment Type in DSD Service Agreement is 'CCPS'.

There are three main ways payments are processed.

1. **Provider Generated (Proposed) Invoices** are when the provider sends in a provider-generated invoice. If HealthPAC agrees with the invoice details, it is

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accepted and items are paid. Rejection items are sent back to the provider. In some cases such as home based support services, these transactions are made by electronic file.

2. **HealthPAC Generated Invoices** are invoices (proposed payment schedules or PPS) issued by HealthPAC on behalf of the funder to the provider of services. The invoice lists each of the clients for whom services are supplied. These client details are based on the details received by HealthPAC from the NASC. The provider checks, amends if required, and returns the PPS to HealthPAC via post or fax. After payment is made, a Buyer Created Tax Invoice (BCTI) is returned to the provider for their records.

3. **Client Claimed Payments** cover two services paid by clients using a specified claim form to claim payment: Carer Support and Expenses to Attend Treatment. NASC staff need to be aware of this process so they can assist clients who ask for advice on how to submit claims. Both services have specific policy and guidelines around them, which are monitored by HealthPAC to ensure payment is made correctly.

HealthPAC Dunedin Assistance

HealthPAC Dunedin operates a number of Help Desk services including:

- Carer Support
- Expenses to Attend Treatment and associated payments
- Provider and Residential Payments
- GP, Pharmacy and DHB enquiries
- DHB Support

The HealthPAC Dunedin Help Desk number is 020 281 222. The Help Desk is available 9 am–4 pm on week days.

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Components of Agreements

The following components feature in agreements.

- **Provider Name** identifies the legal entity with which the funder has a contract. Trading names and facilities can and should also be listed in the agreements.
- **Agreement Number** is the number allocated to the agreement in CMS, with the format of xxxxxx-xx. This number is also loaded into CCPS as a reference. CCPS allocates its own agreement numbers also.
- **Purchase Unit Code** is a code that relates to the service and the service specification. Codes are noted on service specification. This Purchase Unit code is mapped to a Service ID for CCPS, which may be broken down by area, level of service etc.
- **Facility Details** are the name and address of the facility where the service will be provided. This is also entered into CCPS, so that PPSs can be produced for each facility.

- **GST Percentage** varies. Whilst the standard GST rate of 12.5 percent applies for all non-residential services, long-term hospital level residential services attract 10.75 percent GST. Community residential and rest homes attract a GST rate of 10.25 percent.
- **Payment Type** is noted above under 'CCPS Payments'.
- **Purchase Method** is the way payments are made and calculated for each service. CCPS payment types are demand driven, and are therefore Price Volume Uncapped. The table below provides more information.

Options for Purchase Method

Options	Definitions
Block	We pay a fixed price per payment period for a specified service, or group of service.
Budget Holding – Capped Budget Holding – Uncapped	This refers to a third party or other organisation that holds the budget and is responsible for making payments on behalf of the Ministry. Budget is capped or uncapped.
Capacity	We pay a fixed price per contracted service (or contract) but the price per payment period may alter.
Price Volume Capped	Services are based on a unit price and volume. Invoices are paid up to the maximum volume for that period.
Price Volume Uncapped	Services are based on a unit price and volume. Invoices are paid up to the unlimited volume.
Price Volume Wash-up	Fixed price per payment period with the ability to claim a wash-up.

- **Price** is always GST exclusive.

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A NASC Experience of File Rejection by CCPS

The following information has been provided by a NASC. It is included here to support the NASC manager in reducing the risk of rejection and meeting the requirements of HealthPAC.

This has been a trial and error process especially with the address lines. For example if in address line one was written the name of the rest home instead of the actual physical location of the rest home then this would cause a rejection. Also if a place name was spelt incorrectly, or a 'Street' typed in instead of 'Avenue' this also would be enough to reject the client file.

HealthPAC provided the following link to support the entry of correct data: www.linz.govt.nz

This link can be used thus:

Go to Place names – Search Streets and Places.

Enter:

Street Name: A (which listed all the roads alphabetically with the 'a' section)
Territorial Authority: Area in which you want to search – eg, Whakatane

General Electorate: ANY
Māori Electorate: ANY

This allowed for the printing of booklets for each area A–Z for our administrative team to have at their fingertips for the purpose of accurately entering the addresses. Using this has certainly reduced the number of rejections being received.

IBA (NHI system) needs to be updated by the NASC organisation to reflect the same data as on the NASC databases and posted to the local system. This ensures all information matches.

We have found that when client information is incorrect all other information rejects (ie, the needs assessment and service co-ordination screens). In this instance it may mean that once the corrections to the client screen are made, an adjustment must also be made on the referral screen, needs assessment screen and service co-ordination screen. We manage this by putting all dates forward by one day. By doing this it then captures all information when running the report ready for exporting to the Ministry of Health.

Funding warnings are becoming more frequent. Our practice is to only notify by email when a person has changed from DHB funded to Ministry funding and request that HealthPAC then make the adjustment at their end.

INFORMATION AND BUDGET MANAGEMENT

Indicative budgets

Consistency of access to and allocation of disability support services is a key expectation of the Ministry of Health in its contracting with NASCs. This ensures support to disabled people is as equitable as possible within available budget.

Approximately two-thirds of the budget of the Ministry and DHBs for DSS is for services that are demand driven. Access to these services is managed by NASCs.

Budget management is therefore an important function of the NASC and an important responsibility of the NASC manager.

Budget Setting

There are a number of factors that the Ministry considers in setting the NASC budget. They include:

- previous expenditure in a region
- commitments made for the future year such as price increases
- national consistency and equity
- major projects like de-institutionalisation.

Information Tool Kit

The Health Funding Authority developed the Support Package Allocation tool in 1998 to ensure national consistency of support packages. SPA remains the required tool

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for service co-ordinators and NASC managers continue to be responsible for ensuring the tool is understood and consistently used.

To support core competencies for all DSD-funded NASCs, the Ministry has developed a tool kit for NASCs. The tool kit includes:

- the client portfolio
- a budget for each NASC
- population service indicators
- standard letters and other communication tools
- reports on utilisation and support allocations
- expenditure reporting against the budget
- a review panel which is still being developed.

Notes:

1. The DSD believes the best way to achieve accurate and meaningful budget setting and reporting is by reporting by NASC region against the NASC identifier (ID) held against each client in CCPS.
2. The Ministry's focus is on ensuring that allocations of support services are consistent and equitable across the country. To achieve this, the Ministry has developed Population Service Indicators (PSI). The PSIs are the average levels of support allocated for types of government-funded support or service across the NASC's population or client portfolio. They are not applied to individual allocations.

The DSD will advise the NASCs of current PSIs. Any queries should be addressed to the DSD Service Manager by the NASC manager.

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Budget Management Reports

The Ministry provides access to a number of reports to assist NASCs with budget management.

The reports are to be provided via a secure Web-based application. The reports that are currently available and a description of the contents of the reports are listed below.

1. Service Allocation Trending Report

The service allocation trending report shows the average allocations for each NASC for:

- household management
- personal care
- IHC home support
- carer support
- residential services.

The intent of this report is to give information to NASCs so that they can manage allocations for their population consistent with the Population Service Indicators.

The report is written to calculate the average allocations for active clients. An active client is a disabled person for whom service has been paid through CCPS in the last 60 days.

The format of the report shows the average allocations as at:

- 1 July of the current year
- the end of the previous month
- the reporting date, that is the month in which the report was run.

The report also shows the change in allocations since July of the current year.

2. Client Portfolio

The client portfolio report shows for each NASC the clients identified as 'belonging' to a NASC. It is a weekly or monthly report.

It is the Ministry's expectation that NASCs actively monitor this report to make sure that the list of their clients is accurate.

3. Financial Management Information System

Derived from the Ministry's Financial Management Information System (FMIS), these reports show the expenditure by NASCs for:

- carer support
- day programmes
- discretionary expenditure
- home support
- residential care
- respite care
- supported living.

The reports show monthly year to date expenditure, the monthly, year to date and full year budget; and the variation between the expenditure and budget. The FMIS report is different to other financial reports provided because it includes accruals – that is, an estimate of costs incurred but not yet charged. Consequently the FMIS report and the CCPS report may not correspond.

4. Weekly Allocation Report

The weekly allocation report is similar to the service allocation trending report. This report shows the change in allocation for existing clients such as people previously receiving a particular service.

The report shows the average allocations for people being reassessed and for people who have exited the service.

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The information provided in this report is:

- new eligibilities for this week – total units of all new eligibilities, clients with new eligibilities, average eligibility per client
- reassessed eligibilities for this week – total units of all reassessed eligibilities, clients with reassessed eligibilities, average eligibility per client
- eligibilities no longer current starting this week – total units of all finished eligibilities, clients with finished eligibilities, average eligibility per client
- total eligibilities for this week – total units of all eligibilities, total eligible clients, average eligibility.

5. Service Utilisation Reports

The service utilisation reports are monthly reports. There are four reports for the four services types: home support, carer support, residential care, and other. The information provided in these reports is covered in Volume 2 Appendices.

Process for Modification of Reports

Reports can be modified, and new reports written, on the request of a NASC manager to the DSD Service Manager.

Other Reporting Requirements

Further to the requirements of the budget management reports, there are additional reporting requirements. Details of these reports are included in the DSD NASC Service Specification (Volume 2, Appendix 1). These contractual obligations include:

- monthly reporting (as per template provided by the Ministry of Health)
- quarterly reporting, which includes a gap analysis trending report. Information reporting both unmet need and gaps in support service provision has the potential to inform both current work and future Ministry of Health planning.

Resource

Volume 2 Appendices

- Appendix 12: DSD Service Utilisation Reports

Transfer of Funder Status

It is important for NASCs to manage the transfer of clients to other funders so that clients are not adversely affected. A flow chart that the Ministry expects NASCs to follow in relation to transfers to DHBs is given in Section 3 under 'Specific Populations'.

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5 Disability and Intersectoral Support Options

INTERSECTORAL COHESION

Disabled people are often frustrated by the need to repeat similar information to a range of service providers that enter their lives. When people repeatedly share personal information with different professionals, it takes away their sense of worth or mana and can sometimes be considered disrespectful.

In many instances a variety of professionals know certain aspects of that person's life but there may be no holistic approach. Each professional may only be interested in one aspect of a person's wellbeing.

It is therefore preferred that disabled people who access a range of services enjoy the benefit of an integrated approach. People who access services from many different points need to be assured of continuity, quality of services and a co-operative approach to achieving identified outcomes. People accessing NASC services need to know that there is a commitment to the development of nationally consistent NASC policies and practices.

> The NASC provider must establish and sustain effective relationships with other organisations providing services to disabled people. These relationships must reflect the profile of the population served and the communities within it, and must include community organisations, voluntary groups, support service providers, and other public sector agencies.

In order to support a holistic and co-ordinated approach to service delivery, the NASC manager should develop a strategic relationship with key government departments, community providers and disability support organisations. Involvement of team members, particularly service co-ordinators, and nurturing this interface will strengthen relationships, aid communications and promote joint planning and initiatives.

A few examples of community organisations are Parent to Parent, Multiple Sclerosis Society, Alzheimers New Zealand, People First and Disability Resource Centres.

Each NASC community differs in its access to certain services. On an individual basis there are key government departments and community services where service co-ordinator knowledge about services, access, eligibility, role and function is imperative.

This knowledge and the connection with those services support the work of referral co-ordinators as they screen referrals and identify a more appropriate resource for people who are not eligible for NASC services.

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Although opportunities for service development may be identified by the NASC staff, the NASC manager has a lead role in these instances. The DSD Service Manager must be informed, with conversations occurring prior to any proposed strategic development.

DSD-FUNDED DISABILITY SUPPORT SERVICES

New Zealand will become a 'fully inclusive society' when people with impairments can say they live in 'a society that values our lives and continually enhances our full participation' (Minister for Disability Issues 2001)

Guided by this vision, support services for disabled people aim to promote a person's quality of life and to enable community participation and maximum independence. Services must create linkages that allow a person's needs to be addressed holistically, in an environment most appropriate to the disabled or older person.

> The importance of a respectful collegial working relationship between the NASC and providers cannot be overstated. This approach will support providers to respond positively to innovative and creative service requests and to enhance their services to disabled people.

The NASC must establish and sustain effective relationships with other organisations that are providing services to disabled people. The identification of key stakeholders and the establishment of a professional relationship by the NASC manager is therefore essential. It is a requirement of the DSD NASC Service Specification (Volume 2, Appendix 1) that Memorandums of Understanding, protocols and other liaison mechanisms will be in place with key agencies and providers. These are agreements on how the relationship will be conducted.

A comprehensive knowledge of DSD and DHB contracts with providers of relevant disability support services will support the achievement of desired outcomes for the disabled person. A clear understanding of a provider's roles and responsibilities will lessen the risk of compromised service delivery due to unrealistic expectations.

The NASC manager must share information with the service co-ordinators and include them in meetings with providers. Regular meetings should be established and minutes kept. Collegial relationships between the service co-ordinators and the providers is also the concern of the NASC manager. Opportunities to further develop support services need to be identified and discussed with the Ministry of Health, DHB and providers.

Work is under way within DSD to ensure there are no outstanding historical variations in DSS service specifications and thereby to support equity and national consistency.

Where regional variations are known to exist, it will be important to clarify the current practice with the DSD Service Manager.

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The table below lists support services contracted and funded by the DSD/DHB which are accessible via the needs assessment/service co-ordination process, on which more detail is given in the subsections that follow. These services are not necessarily contracted in all local areas. There may be individual local differences in service specifications and extent of services contracted. The manager should hold current local information on all DSD contracted services, including their service specifications.

These can be supplied and updated by the DSD Service Manager.

Summary of Disability Services Provided by Disability Services Directorate

Service	Description
Assessment, Treatment and Rehabilitation (AT&R)	Assessment (including clinical assessment), treatment and rehabilitation services in both inpatient and domiciliary settings.
Carer Support	Support to provide relief to primary informal caregivers.
Child Development	Non-medical multidisciplinary allied health and community-based services for children and young people.
Community Health Services and Support	Community health services and support, the specific nature of which varies nationally.
Day Programmes	Services that are reintegrating people into the community from institutional care.
Disability Information	Provision of information and advisory services generally provided by voluntary organisations such as Epilepsy Society.
Discretionary Funding	The specified amount within the indicative budget of each NASC that can be used, according to contractual requirements, to provide more flexible supports for a small number of people whose disability support needs cannot be met through contracted services.
Environmental Support Services	Assistance with daily living – eg, with personal care, mobility, communication, housing modifications, vehicle grants and modifications.
Expenditure to Attend Treatment (ETAT)	Targeted travel and accommodation assistance (according to need) for those eligible persons according to current policy and protocols.
Head Injury Rehabilitation	Services for rehabilitation after head injury.
High and Complex/ Compulsory Care	A range of specialist services for people with an intellectual disability who also have high and complex behavioural needs (applies only to High and Complex services).
Home Support	Personal care, sleepover and household management services that enable a person to continue living within their own environment. This service is specifically for clients who meet the Ministry definition of disability. It excludes personal and mental health.
ID Care Manager	A person working with the client, their network and providers to develop a Care Plan that reflects the needs and goals of the client and to ensure that they are met (applies only to High and Complex services).
Interpreting	Disability-specific interpreting, including New Zealand Sign Language.

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Service	Description
Needs Assessment	Facilitated needs assessment that excludes clinical assessment and excludes mental health NASC services but may refer for specialised assessments.
Regional ID Care Agency	Specialist needs assessment (excluding clinical assessment) and service co-ordination for people with an intellectual disability who have high and complex support needs (applies only to High and Complex services).
Rehabilitation/Habilitation	Rehabilitation and habilitation services.
Residential Care: Community	Residential care services that provide short- and long-term care in the community setting for non-aged clients.
Residential Care: Hospitals	Provision of short- and long-term care in a privately owned or public hospital facility.
Residential Care: Rest Homes	Residential care services that provide short- and long-term care in rest homes.
Respite Care	Services provided out of the home environment. Carer relief services in formal settings to provide respite for carers of people with significant disability.
Service Co-ordination	Information, planning and co-ordination of access to disability support services. Excludes mental health NASC services.
Specialist Support	Specialist support services including behaviour support.
Supported Living	Services for disabled people who wish to live independently in the community but who require a level of support to do this successfully.

Other services, which may not be nationally available, include:

- Contract Board
- Dual Diagnosis (Mental Health funded)
- Foster Care
- Shared Care.

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Carer Support

Carer Support is a subsidy funded by the Ministry of Health. It is designed to assist the unpaid primary or full-time carer of a disabled person (as defined by the Ministry of Health) to take a break from caring for that person. The purpose of offering the carer a break is to enable them to continue to provide the required care to the disabled person as well as to maintain that person in the community for as long as practicable. The full-time carer is the person who provides more than four hours per day unpaid care to the disabled person such as the parent of a child with a disability.

Carer Support is designed to be flexible and can be paid to neighbours, friends, some family members or formal care agencies, for instance rest homes. There are two rates of reimbursement: informal/individual and formal/organisation. In some areas, these rates are described as domiciliary and non-domiciliary.

Unused days in one year can not be transferred to the following year. Difficulty experienced in using Carer Support may indicate another form of support may be more useful to the carer.

Carer Support is not intended to be used primarily for one-off crisis management.

While the intent of Carer Support is identical throughout the country, there are some regional policies and procedures. The NASC manager needs to obtain relevant guidelines from the DSD/DHB Service Manager. DSD is working on a consistent Carer Support policy which is to be distributed separately according to that implementation plan.

Access

A facilitated needs assessment will identify the needs of the disabled person and their carer/family/whānau. Service co-ordination will work with the disabled person and their carer/family/whānau to develop a package of support that will best meet the identified needs.

Carer Support may be one component of a planned package of support. There is no set entitlement for Carer Support. The days allocated must reflect the extent and complexity of need.

The Ministry of Health provides a brochure 'How to Claim Carer Support' which is to be given to disabled people and their carers. Service co-ordinators need knowledge of the brochure as they are often approached for assistance in completing these claims.

Resources

Complexcarers@xtra.co.nz
Eldernet. Contact: team@eldernet.co.nz; URL: www.eldernet.co.nz

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Child Development Services

Child Development services are non-medical, multidisciplinary allied health and community-based services, including an early intervention for preschool children. These specialist assessment, intervention and management services aim to promote rehabilitation/habilitation outcomes for children who have an intellectual, sensory or physical disability.

Child Development services are intended to promote and facilitate each child's progress towards developmental milestones so that the child's potential is attained. Some may operate from a centre of excellence to meet the needs of children who have disabilities. In some areas the service will be up to school leaving age. The service is expected to be delivered in such a way that the resulting support is appropriately linked with, and integrated into all other services that the child may be accessing.

Appropriate supports and information are to be made available to the child's family/ whānau/hapū/iwi and other support networks. They are also to be delivered in the most suitable setting for the child and the family/whānau in the most cost-effective manner possible.

Inclusions

Child Development services are for children and young people who have been identified as having a physical, sensory or intellectual disability, or a combination of these, or who are at risk of developing such a disability, or have developmental delay, or have an Autism Spectrum Disorder. It also includes whānau, families, caregivers and advocates associated with children who meet the criteria stated above.

Note that different DHBs have different criteria for access to this service dependent on the age of the child. The exact criteria should be clarified with the DHB concerned as detailed in the Provider Specific Terms and Conditions of their contract with the Ministry of Health.

Access

A child and their family/whānau may be referred to the service via a number of routes. The primary source of referrals will be from the relevant NASC provider. Referrals will also be accepted from the following medical practitioners and allied health professionals.

- general practitioners
- neonatal services and paediatric medical and surgical services
- community health services
- other Ministry-contracted health and disability services
- education-funded allied health services
- Child, Youth and Family Services.

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Day Programmes and Vocational Services

Currently the Ministry of Social Development's Work and Income has primary responsibility for funding vocational services. In instances where people with an intellectual disability have been resettled following deinstitutionalisation, DSD funds day programmes.

Work being undertaken by DSD regarding boundaries will help inform any change in responsibilities.

Funding for a disabled adult to attend such programmes may be obtained by the person applying for a Disability Allowance. This pays for, or contributes to, the cost of a recognised programme. There are specific criteria with which vocational programmes must comply, including increasing the skills, participation and employment of participants. Activities that may meet these criteria include individual day activities, supported employment and vocational training programmes.

Resources

Ministry of Social Development. URL: www.msd.govt.nz

Work and Income. Disability and Child Care Allowance.
URL: www.workandincome.govt.nz/get-financial-assistance/extra-help/disability-child-allowance.html

Disability Information and Advisory Service

A Disability Information and Advisory Service (DIAS) provides independent and objective information and/or advice to disabled people, their families, whānau, caregivers, providers and the general public. Information and/or advice is provided about the nature of a specific disability, or disability in more general terms, and its impacts on the everyday life of the person with a disability and their family/whānau.

Additionally, information and/or advice will be provided about disability support services that are available and how a person with a disability would access them. The objective of the DIAS service is to contribute to the improvement of the health and wellbeing of disabled people, be responsive to their needs, and provide access to:

- accurate, independent and objective information and/or advice about a specific disability or disability, in general terms
- accurate, independent and objective information about disability support services.

The DIAS service will assist people with a disability to make informed decisions around issues such as:

- equipment and environmental support
- culturally appropriate services
- self management of a specific disability and of disability in general terms
- maximising function and independence related to disability
- reducing risk factors and preventing further disability.

Access

The service must be accessible to all people. This need for accessibility applies to the national office and all regional societies/branches if the provider holds a national organisation.

- There are no exclusions or barriers to this service.
- People can enter or exit this service whenever they choose.

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Environmental Support Services

A range of services are provided under the category of environmental support services. ESS are considered essential to meet the person's long-term disability need and/or to overcome barriers to participation in their community. Eligibility is defined in the Ministry of Health policies on ESS. An accredited specialised assessor must identify the need for all support services. Service is available to eligible clients for initial assessment and for re-assessment if needs have changed and/or where equipment has become obsolete or inadequate.

Equipment provided directly from the contracted service includes wheelchairs, aids to communicate the expression of core needs and feelings, individualised walking sticks and frames, individualised/customised seating, and shower commodes. Contracted providers will determine the eligibility of applications, process applications, purchase new or refurbished equipment, co-ordinate the replacement and/or repair of worn equipment (including replacement of batteries for hoists and wheelchairs at the frequency expected) and co-ordinate support services (which may include various types of equipment, vehicle and/or vehicle and housing modifications). In addition, the provider will notify assessors of policy and procedural changes and updates.

Assessors are required to adhere to agreed levels of service for the following categories: communication, household management, hearing, personal care, personal care pain relief, standing frames, seating (levels 1–3), information and communication processing, vision, walking, wheelchairs (standard, specialised, powered), housing modifications, housing advisor, and vehicle purchase and/or adaptation.

Exclusions under this specification are extensive and should be referred to directly. Some commonly excluded equipment and services are equipment required for periods of less than six months, equipment at discharge from hospital unless the person is eligible for long-term provision, retrospective funding for any ESS, contact lens benefits, hearing aid subsidies, equipment for therapy, replacement of equipment following careless use, assessment costs for any ESS including any related travel and accommodation, and hire of equipment.

Prioritisation guidelines are applied by the ESS provider to ensure that support is delivered to clients within the timeframes specified by the Ministry of Health. Asset testing is required for housing modifications over a threshold as referenced in the DSD ESS Service Specification (ask DSD Service Manager).

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Home based Support

Home based support comprises personal care, sleepover and household management services that enable a person to continue living in their own environment.

- **Personal care** is defined as assistance with activities of daily living that enables a disabled person to maintain their functional ability at an optimal level. These activities include but are not limited to: showering, bathing, grooming, toileting, dressing, transfers, mobility and feeding. All personal care is fully funded.
- **Household management** is defined as services that assist a person with a disability to maintain, organise and control their household/home environment, enabling them to continue living within their own environment. These services include but are not limited to: cleaning, meal preparation and laundry.
- **Sleepover** is defined as assistance with personal care and household tasks for an overnight period of stay where there is facility for the caregiver to sleep. Sleepover is contracted for up to 12 hours. This service is not currently included in all Home based Support Contracts. Its status in regard to a specific contract should be verified with the DSD Service Manager.

Access

After a facilitated needs assessment and the identification of need, the service co-ordinator will work with the person to reach the preferred solution for their needs. Home based support may be one solution. If selected, disabled people must be given a choice as to their home based support service provider.

Once identified, the service co-ordinator sends a Support Plan to the provider specifying the hour(s) of support and type of support required. The plan should detail the amount of assistance the disabled person can provide with the activity so as to foster the retention of skill. The minimum requirement for this transfer of information can be found in the Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines (Ministry of Health 2002b).

Personal care and household management are contracted at hourly rates.

Community Services Card

Household management is fully funded to people who have a Community Services Card. A person who does not have a Community Services Card and requires household management support should apply to the Ministry of Social Development's Work and Income to be income and asset tested under section 69F(A) of the Social Security Act 1964. The test is used to decide whether a person will get the service(s) free or should pay. If they have to pay, the test determines what amount should be paid and what part of the cost will be subsidised. This information should be provided to the disabled person.

Please note: In practice the Community Services Card has been taken as the default income and asset test. It has been assumed that if the person does not have a Community Services Card then that the person will have to pay for household management services.

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Resource

Service Specification DSS Home Based Support (available from DSD Service Manager).

Rehabilitation Services

Within DSD there are contracted providers of rehabilitation services. Development work will be under way during 2005/06 for national specifications for rehabilitation. Details of a particular provider's service specification should be obtained from the DSD Service Manager.

Rehabilitation services support disabled people to adapt, develop or maintain life skills.

Rehabilitation services are generally characterised by:

- a focus on restoration and goal achievement
- a timeframe with an end point
- delivery largely by health professionals
- a process of intervention with the aim of increasing independence.

Rehabilitation can occur in a number of locations, including:

- inpatient rehabilitation provided by DHBs but funded by the DHB or DSD through the Crown Funding Agreement, DSS schedule
- residential rehabilitation where a disabled person receives rehabilitation in a community residential setting which may be funded by DSD contracts
- community rehabilitation which may be funded by DSD or DHB
- residential rehabilitation for disabled people with high needs funded by DSD contracts.

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Access

Access to residential and community-based rehabilitation is through the process of facilitated needs assessment and service co-ordination. In some parts of the country, inpatient rehabilitation services funded by DSD may also require the involvement of the NASC. It is useful for the NASC to have access to specialised input in order to determine rehabilitation needs as appropriate. When the need to utilise rehabilitation services is identified, the NASC must determine the appropriate funding mechanism. It is helpful to agree to a process with the provider that identifies an agreed reporting structure. This structure would include timeframes for completion of rehabilitation, specific rehabilitation goals, and feedback on the progress and achievement of rehabilitation goals.

Residential Care Costs for Older People in Residential Services for Older People

The NASC manager should have a clear understanding of how residential services for disabled and older people are funded. They should ensure that the service co-ordinators are knowledgeable and able to respond to queries from the disabled or older person and their carer regarding their financial obligations.

It is recommended that referral to a skilled social worker is considered to support the disabled or older person through the emotional and financial complexities of entering a facility.

The Social Security (Long-Term Residential Care) Amendment Act 2004 has been enacted. This makes a number of significant changes to income and asset testing for older people who require long-term residential care. These changes come into effect on 1 July 2005 and will progressively reduce asset testing.

Resource

Volume 2 Appendices

- Appendix 14: Residential Care – Progressive Removal of Asset Testing

Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities

The DSD Service Specification, Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities, sets clear expectations for NASCs in:

- managing young disabled people's access to and exit from aged care facilities
- communicating with the Ministry of Health.

Communication with the Ministry is required to support the Ministry's aim 'to accommodate younger people with lifelong disabilities in home like settings tailored to meet their specific needs'. The Ministry will fund community residential services within aged care facilities for younger people with lifelong disabilities only when necessary.

The service users supported by these services (DSS1034 – Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities) are people with an intellectual, physical and/or sensory disability, aged 16 years and over who have been referred to the provider for service by a contracted NASC. If the person with an intellectual, physical and/or sensory disability receiving a service under this contract turns 65 years, it is expected that they will continue to reside there as it is their home. They will continue to receive a Residential Support Subsidy until their needs are assessed as relating primarily to age-related conditions.

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Access

Access to residential services is by an authorised referral from the NASC service that **has been approved by the Ministry of Health in writing** following an individual needs assessment process. This is emphasised in DSS 1034: 'The Ministry of Health must have approved the placement prior to the service user entering the service' (page 3).

The NASC service must receive this approval from the Ministry of Health. This is then forwarded to the provider as part of the admissions process. A copy of the written approval from the Ministry of Health for entry to services must be retained by the provider on the service user's on-site file.

Admission to a Specialist Service

Where a service user requires admission to a specialist provider such as a mental health setting, this change will involve input from a relevant 'specialist' such as a psychiatrist. The relevant NASC may be involved to assess change in the service user's needs.

Please note this applies particularly where the service user is over 65 years of age and develops needs assessed as relating primarily to age-related conditions.

Resources

DSS 1034 Service Specification Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities.

Volume 2 Appendices

- Appendix 13: Accessing Long-term Residential Care and the Residential Support Subsidy

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Community Residential Support Services for People with Physical Disability

The Ministry of Health purchases community residential services for people with a physical disability aged 16 years and over. This service provides 24-hour support at the level necessary for people to have a safe and satisfying home life. This includes having 24-hour duty of care if a service user has to remain home from day services or work for any reason. The level of support will meet holistic needs including social, spiritual, emotional and recreational needs. It can be provided through a combination of services determined at the time of needs assessment for each person.

Access

Access to these residential services is by authorised referral from the NASC organisation following an individual needs assessment.

The needs assessment and service co-ordination processes followed by the NASC organisation will ensure that the following criteria have been met for clients referred to the provider.

- The individual is eligible – that is, the person has a physical disability as assessed by an appropriate specialised needs assessor or professional recognised by the NASC not the provider.
- Needs assessment and service co-ordination indicate the individual requires the level of care and support available from the provider.
- The individual and their family/whānau/advocate have been involved in the selection of the provider.
- A Māori service user/whānau/family/guardian/advocate accepts the provider's cultural competence.

If a person with a physical disability living in a community residential home turns 65 years, it is expected that they will continue to reside there and continue to receive the Residential Support Subsidy. If however their need for disability supports changes and is assessed as relating primarily to age-related condition, it is expected that person will be referred to NASC for a reassessment of their support requirements.

Resources

DSS 1030 Service Specification Community Residential Support Services

Volume 2 Appendices

- Appendix 13: Accessing Long-term Residential Care and the Residential Support Subsidy

Community Residential Support Services for People with Intellectual Disability

The Ministry of Health purchases community residential services for people with an intellectual disability. This service provides support at the level necessary for people to have a safe and satisfying life. The level of support will meet holistic needs including social, spiritual, emotional and recreational needs. These needs can be provided for through a combination of services.

Access

Access to residential services by a person with an intellectual disability is by authorised referral from the NASC organisation following an individual needs assessment and service co-ordination.

The following criteria must be met for people to be referred to the provider:

- The individual is eligible – that is, has an intellectual disability as assessed by an appropriate specialised needs assessor/professional recognised by the NASC not the provider.
- Needs assessment and service co-ordination indicate the individual requires the level of care and support available from the provider.
- The individual and their family/whānau/guardian/advocate have been involved in the selection of the provider.

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- A Māori service user/whānau/family/guardian/advocate accepts the provider's cultural competence.
- The appropriate funding tool has been applied by the service co-ordinator, involving the Transparent Pricing Model, Allocation Resource Tool or existing contract rates.

It is expected the disabled person will make part payment from their Invalids Benefit.

If a person with an intellectual disability living in a community residential home turns 65 years, it is expected that they will continue to reside there as it is their home and continue to receive a residential support subsidy. If, however, their need for disability support changes, and is assessed as relating primarily to an age-related condition, it is expected that person will be referred to the NASC for a reassessment of their support requirements.

Resource

Volume 2 Appendices

- Appendix 13: Accessing Long-term Residential Care and the Residential Support Subsidy

Respite Care

Currently within DSD the regional respite care service specifications are being reviewed with the goal of developing a consistent specification.

Respite care is usually part of a package supporting a disabled person with a higher level of need who requires a proactive and planned approach to support options. It may be used in the instance of a significantly disabled person who has elected to remain at home but accesses regular planned breaks within a residential facility to provide their regular unpaid carer with a break.

Access

Facilitated needs assessment identifies the need for support for the disabled person's carer to enable them to continue in that role. In consultation with the affected parties and the service co-ordinator, respite care may form part of a support package.

It is the responsibility of the NASC service co-ordinator to first provide information about contracted services that the disabled or older person may access for these periods of respite care. If there is no suitable facility that the person can access and no contract exists already, the NASC will negotiate a rate for service with a facility. This practice needs to be within existing guidelines and delegated authorities.

Respite care may be provided in the disabled person's home or the respite carer's home. It is also possible for the disabled person to access respite care in another region.

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Specialist Services: Behaviour Support Services

Behaviour Support Services are provided through specialist providers to improve the quality of life for those people whose behaviour challenges their support networks, and/or places themselves or others at risk of harm. Provision of support for the person's skill development is included to ensure effective community participation. The focus of assessment and intervention is communication, social interactions and adaptive functioning with the aim of supporting appropriate behaviour responses.

A Behaviour Support Service aims to develop and implement a plan that minimises the impact of challenging behaviours exhibited by a person, enabling them to develop maximum levels of independence and participation in the community. The provider will achieve this by working with the person and their support networks including residential and vocational staff, welfare guardians, family/whānau and friends.

Assessment includes input from appropriate therapeutic disciplines to develop a comprehensive understanding of the person's situation. Planning follows assessment and includes goal setting, identifying proactive interventions, planning for the management of crises, risk assessment and preparation/planning for the person's departure from the Behaviour Support Service. Risk assessment informs the planning process.

A behaviour support plan will help the support people to understand the person's behaviour and responses and the needs of carers. After the plan has been agreed, education is provided to the person and to the person's support network so that the plan can be implemented. The focus should be on supporting the person in the environments where they live, work and socialise.

Access

Behaviour Support Services operate on a regional basis. They do not have staff permanently located in all centres across each region. Occasionally the scope of this service extends to people who do not have an intellectual disability. In some regions this service is provided through community support teams of the District Health Board, while in other regions it is provided by community-based service providers.

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Supported Independent Living

Key outcomes of Supported Independent Living (SIL) are to maximise the person's choice about where and how they live, develop the skills needed to access the community, and prevent or delay the need for admission into residential care service. SIL aims to provide as much support as the NASC process determines to be necessary for the person to achieve these outcomes.

People who can access this service are:

- disabled people who are currently living with their parents but who are at an age when it would be appropriate for them to transition to an independent living environment (which may be a flat or a house; living alone or with others; in rental accommodation, or in their own home)

- people who acquire a disability later in life and require an increased level of support if they are to continue living independently
- disabled people who are currently placed within residential services but who wish to transition into a living environment more appropriate for their age.

Choices that relate to lifestyle rather than support need are not funded as part of the SIL package. The choices will still form part of the person's lifestyle plan. Moreover, Supported Independent Living is not the same as residential care in the community. Nor is SIL the same as residential care in the community.

Access

After the facilitated needs assessment and identification of need, all support options, including SIL options, will be explored with the person.

The NASC provider will make referral to the provider for a person requiring SIL services. The purpose of the referral could be to:

- assist the person to find and establish an appropriate living arrangement
- assist the person to develop skills with which they can cope with day to day situations at home and in the community
- provide personal contacts on an individual basis to assist and support the person to maintain independence and a lifestyle of their choice
- meet support needs identified through the NASC process.

It is the responsibility of the provider to develop a support package based on the identified goals of that person. In addition, it is the provider's responsibility to monitor and review the support package. Any changes in support need are reported and responded to by the NASC.

Resources

Volume 2 Appendices

- Appendix 15: Supported Independent Living Guidelines for NASCs and Providers

Contract Board

National service specifications for contract board are still being determined. If a contract is established for contract board, however, then it can be expected that existing specifications are likely to be used.

Contract board is a service option for people with an intellectual disability who have indicated, or through their family/advocate have advised that they want to live in a contract board arrangement.

The objectives of contract board are to:

- provide a family-type setting for adults with intellectual disability

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- support contract board families to provide for the physical and emotional needs of the disabled person
- implement programmes designed by health and disability professionals
- maintain current skills and enhance independence through new skill development.

Access

After a facilitated needs assessment and the identification of need, the service co-ordinator will work with the person to agree on the preferred solution for their needs. Contract board is available to people with a range of needs; the primary requirement is their desire to remain in a family-like setting.

Families who provide a contract board opportunity are contracted to do so through a provider.

There are a number of service components within the provider's service specification. It is part of the requirements that each person must have an individual plan. The plan will be reviewed on an ongoing formal and informal basis.

Dual Diagnosis with Intellectual Disability

The dual diagnosis service is a specialised service that provides interventions to assist (directly or indirectly) people with a diagnosis of both mental illness and intellectual disability. The service is not purchased directly by DSD (with the exception of a new service for former residents of Kimberley Centre) but rather within the Nationwide Service Specification for Mental Health Services.

DHBs are responsible for purchasing services that are delivered regionally to eligible people. A number of the regional providers will also be involved in the delivery of services accessed through the Regional Intellectual Disability Care Agency. Considerable regional variation exists among services. Detailed local knowledge will need to be sought from the DHB or RIDCA with responsibility for regional coverage.

A range of components are provided. These include:

- assessment and treatment of mental illness in people with intellectual disabilities, where such specialist service is required
- co-ordination of treatment to ensure joint care management between mental health and intellectual disability services
- family/whānau support
- self help or mutual support opportunities for the service user
- education, consultation and advice to other mental health services and intellectual disability services to assist those services in the ongoing care of people under their care.

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Access

Access to the dual diagnosis service is by referral from community or inpatient mental health services, key workers or intellectual disability service providers.

Resource

Nationwide Mental Health Service Framework – General Requirements 2001 (MHCS31)

Foster Care

National service specifications for foster care service are still being determined. If a contract is established for foster care, then it can be expected that existing specifications are likely to be used.

Service options for children and young people with intellectual disabilities are explored to support them to live in their own family or whānau wherever possible. Where this not possible due to the impact of significant disability, the most appropriate placement may be with another family in foster care.

The objectives of foster care are to:

- provide nurture, care and development for children and young people with disabilities
- develop the child or young person in the context of an inclusive society
- support the foster carers to provide for the physical and emotional needs of the disabled person
- support the family of origin to strengthen relationships and work towards reunification except where there is considerable unmanageable risk
- implement programmes designed by health and disability professionals
- maintain current skills and enhance independence through new skill development.

Access

The provider will arrange service following the endorsement of a Family Group Conference. The Family Group Conference is convened under the provisions of section 22 or 23 of the Children, Young Persons and their Families Act 1989.

Under these provisions, the NASC covering the region must be involved to negotiate a suitable funding arrangement.

Each person will have an individual support plan that will be consistent with the goals set by the Family Group Conference. This plan may include a risk management plan. The plan will be reviewed on an ongoing formal and informal basis.

Funding

Funding is at the occupied bed rate.

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Resource

Ministry of Health DSS 1036 Service Specification Foster Care June 2004

Shared Care

The shared care service provides for the care of a child or young person with an intellectual disability to be shared between the family/whānau and a paid caregiver from a support service. The duration that the person is cared for away from their family/whānau does not usually exceed four days per week.

There may be variations in service specifications and the availability of this type of support nationally.

The rate of funding per day may be determined by the level of support the person needs or at the service provider's contracted rate with the Ministry of Health.

INTERSECTORAL COLLABORATION WITH GOVERNMENT AGENCIES

'Review of the Centre'

In 2003 the State Services Commission led a number of government agencies to provide a comprehensive analysis of the strengths and weaknesses of the public sector. This project was entitled **Review of the Centre**. The Review of the Centre recommended better integrated service delivery to address complex social problems and focus on the results that citizens want from governments. (More information on the Review can be found at www.ssc.govt.nz.)

The Review of the Centre concluded that greater collaboration among government agencies, and better integrated service delivery, are essential to address complex social problems and achieve better outcomes for citizens. The literature review and fieldwork showed there is a strong feeling within government and among stakeholders that a more inclusive and better co-ordinated public sector will lead to more efficient and effective services and improve outcomes for people and communities. Collaboration can benefit participating organisations through the development of better processes, enhanced relationships, a greater capacity to respond to local need and a more efficient use of resource.

Despite these benefits it is important to note that collaboration is not a panacea for underlying problems. Collaboration cannot in itself solve funding problems, legislative limitations or a lack of skilled practitioners. Collaboration can pave the way for creativity in balancing needs and funding resource.

The Mosaics document (Ministry of Social Development 2003), which is based on information from a number of sources including Review of the Centre, argues that collaboration is time and resource intensive. A balance therefore needs to be struck between devoting time to collaborating with others and meeting obligations in

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delivering the organisation's own core business. The important factor is that the disabled person retains control and direction to the extent that they wish.

Trials to Improve Intrasectoral and Intersectoral Collaboration and Co-operation

The Ministry of Health is currently contracting with three NASC organisations across New Zealand to establish trials of innovative needs assessment and service co-ordination arrangements, processes and services.

The main driver of the project is the *New Zealand Disability Strategy*, which has considered long-standing concerns of consumers and the disability sector. There are concerns about unnecessary duplication, fragmentation and often poor co-ordination of services, both within and across government agencies.

The trials are expected to align closely with the principles of the NZDS.

Project objectives taken from its summary are to improve:

- outcomes for people with all disabilities across all aspects of life
- collaborative arrangements within and between organisations with an interest in needs assessment and service co-ordination
- effectiveness of needs assessment and service co-ordination for different groups including Māori and Pacific peoples
- transitioning between services including for young school leavers.

An important component of the collaborative process is the development of partnerships with disabled people, different disability groups and Māori and Pacific peoples. There is particular emphasis on:

- reducing the number of transactions and duplication among organisations undertaking needs assessment and service co-ordination, and repeated assessments faced by disabled people
- improving the transitions from one organisation's services to another's, especially at critical times such as when young people move from school to employment and adult services.

The trials will be concluded in September 2005. Independent evaluation will inform recommendations to the Government on how to improve collaborative and co-ordinated arrangements for intersectoral and intrasectoral needs assessment and service co-ordination for disabled people aged under 65 years.

Key Government Intersectoral Links

Each NASC will need to establish the key stakeholders in its area. There are certain government organisations with whom a formal relationship should be established in the interests of developing a seamless service for disabled people. The following list is a preliminary rather than definitive guide to those organisations:

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- District Health Boards
- Primary Health Organisations
- Accident Compensation Corporation
- Ministry of Social Development
- Ministry of Education
- Child, Youth and Family Services.

District Health Boards

It is essential that the NASC manager develops and maintains a purposeful relationship with members of DHB teams relevant to NASCs, such as community services. This interface can result in opportunities including managing issues of eligibility, collaborative service delivery, identifying opportunities to work together in programmes such as an injury or falls prevention programme, and information sharing.

Establishing contacts within the DHB will promote the NASC manager's understanding of:

- the role, function and location of the DHB
- the key personnel (eg, portfolio managers, contracts managers, service provider managers) and their role and function
- the services provided by the DHB such as rehabilitation services and child development services, including their access criteria, referral method, feedback loop, discharge planning process and so on
- the mechanisms the DHB employs for consultation such as community forums
- the relevant mailing lists so as to be informed of DHB activities
- the role and function of accredited equipment assessors through the professional advisor and how to interface with them.

This knowledge and the related connections should be shared with relevant NASC team members to support them in their jobs.

The interface between the NASC manager and the DHB portfolio (contract) manager is important. It is recommended that the NASC manager develop a link with the portfolio manager of disability support (and older people's) services as well as both personal health and mental health. Meetings with Planning and Funding will provide opportunities such as making a collaborative response to identifying gaps in support services.

While DHBs have their own health needs analysis tools, the NASC can provide qualitative information that will address gaps in services. Equally, each DHB will have information available that may assist the NASC to configure its service to the demographics of its population.

Each DHB has a Disability Advisory Support Committee. This may provide another venue for the NASC to share information, network, explore service development options and support DHB initiatives.

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Regular meetings with the provider arm of the District Health Board will be useful in developing joint protocols, which will result in a better service for disabled people. In addition, an understanding of the pressures that both parties may be experiencing will foster a co-operative approach to the process of eligibility, needs assessment and service co-ordination.

Primary Health Organisations

Primary Health Organisations (PHOs) were set up in response to the Government's Primary Health Strategy. This Strategy called for an increase in access to primary health care and services, particularly in areas of deprivation. There are approximately 70 PHOs in New Zealand. They share a common purpose; however, the structure and approach of each organisation may vary. A primary focus is health promotion and a key requirement of a PHO is to be responsive to the community in which it dwells. PHOs have contact with high needs groups within the community.

Relationships with the local PHOs are opportunities for joint strategic planning and initiatives. For example a PHO has funded a falls prevention programme and an upright and active programme for rural areas. PHOs have access to robust data that may support the NASC manager in service planning and development.

Accident Compensation Corporation (ACC)

ACC administers New Zealand's accident compensation service which provides personal cover for all New Zealand citizens, residents and temporary visitors to New Zealand. In return, people do not have the right to sue for personal injury other than for exemplary damages.

ACC's pledge 'is to prevent injury, to provide the best treatment and care if injury occurs, and to quickly rehabilitate people back to work or independence at a price that offers high value to all levy payers and all New Zealanders.'

ACC is a Crown entity responsible for:

- preventing injury
- collecting personal injury cover levies
- determining whether claims for injury are covered by the scheme and providing entitlements to those who are eligible
- paying compensation
- buying health and disability support services to treat, care for and rehabilitate injured people
- advising the Government.

ACC provides accident insurance cover, injury prevention services, case management, medical and other care and rehabilitation services.

A link with ACC is important. The transfer of disabled people between the two agencies is not always seamless. This is especially so when ACC resource is at

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variance with what is provided by the NASC. A strategy to manage this situation should be agreed and implemented by the two parties. In some instances there may be opportunities for joint funding to meet certain support needs arising from both disability and accident-related disability.

The DSS Service Specifications explicitly exclude people who are covered by the Injury Prevention Rehabilitation and Compensation Act 2001. This exclusion needs to be understood and applied by the referral co-ordinator to avoid inconvenience to the disabled person.

Resource

Accident Compensation Corporation. URL: www.acc.co.nz

Ministry of Social Development's Work and Income

The Ministry of Health and Ministry of Social Development have worked together to develop this section.

Background

The Ministry of Social Development's Work and Income carries out income and asset testing of clients as part of its work and pursuant to its statutory role under the Social Security Act 1964. This income and asset testing includes cases where it is required to access the following DSS:

- Where applicants have been assessed as requiring DSD-funded financial assistance for **vehicle purchase and/or vehicle modification** for full-time work, vocational training or tertiary education, they are income and asset tested to establish whether they are eligible for financial assistance. Income and asset testing takes into account if the applicant including their spouse/partner has an income over $40,000 per year.
- Where applicants have been assessed as requiring **home modifications** valued at over $7900 including GST, income and asset testing of the applicant (and their spouse/partner, or house owners where they occupy the same property as the person with a disability/applicant, or parents where the applicant is a child) establishes what proportion of costs over that amount (if any) the applicant will have to pay before uplifting the rest of the grant.

Enable New Zealand (for Waikato and all areas further south) and *acces*sable (for Auckland and Northland) are contracted by DSD to manage equipment and other ESS, and can provide further information on:

- access and eligibility criteria for these two services – there are some differences between Ministry of Health policy in the Auckland/ Northland region and the rest of New Zealand
- how to contact Work and Income for income and asset testing required for vehicle purchase and home modification assistance
- people assessed as requiring home help, who are funded by DHBs if they are aged over 65, and by DSD generally if they have life-long impairments, are under

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65 years of age and do not have a Community Services Card. They can ask to be income and asset tested in regard to their eligibility for funded service. These income and asset testing requirements are outlined in section 69FA of the Social Security Act 1964.

Many disabled people receiving DSS have a long-term relationship with Work and Income because they are on a benefit such as the Invalids Benefit. Their benefit arrangements will be affected if they receive a specific DSS that involves an interface with Work and Income such as:

- long-term residential services for people generally under 65 years of age who are assessed as in need of these services, and access the Residential Support Subsidy (RSS) (see Volume 2, Appendix 13)
- long-term rest home and continuing care services for people over 65 years of age, and single people who have no dependent children and are 50–64 years of age, assessed as needing these services, and access the Residential Care Subsidy (RCS). In addition to determining whether any benefit or New Zealand Superannuation is affected, Work and Income is also responsible for separately income and asset testing clients who apply for RCS and assessing whether the client can pay or contribute to their care.

A pamphlet, *Long-term Residential Care in a Rest Home or Hospital: What you need to know* (Ministry of Health 2004b, on the Ministry of Health's website: www.moh.govt.nz) has recently been produced on the RCS.

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Resources

Volume 2, Appendices

- Appendix 13: Accessing Long-term Residential Care and the Residential Support Subsidy

Enable New Zealand. URL: www.enable.co.nz

Accessable. URL: www.accessable.co.nz

Ministry of Education

Special Education 2000 (SE 2000) is a government policy framework aimed at providing educational opportunities for students with special education needs within the early childhood and compulsory school sectors.

SE2000 was designed to take account of students' needs more effectively by creating a variety of delivery systems which, depending on the type and level of need, could be met in the school or in special settings.

SE2000 consists of several components that are targeted at the student's level of educational need. There are three major components.

1. **The Special Education Grant (SEG)** is a grant provided to all schools to assist students with moderate special education needs. The amount is based on the school's decile ranking and roll size.

2. **The Ongoing and Reviewable Resourcing Schemes (ORRS)** provides funding for individual students with high and very high special education needs.
3. **The Resource Teacher: Learning and Behaviour (RTLB) Service** comprises specially trained teachers who support and work within schools to assist staff, parents and community members to meet the needs of students with moderate learning and/or behaviour difficulties.

Each child with special needs has an Individual Education Plan (IEP), which outlines the student's educational goals and the time in which goals should be achieved. Development of the IEP may involve the student's teachers and teacher aides, parents or caregivers, and specialists such as RTLBs, therapists, psychologists and some co-ordinators. Ideally the plan is reviewed at least twice a year, but this may vary depending on changes in the needs and circumstances of the student. This comprehensive plan provides opportunity for the NASC manager to have their staff work co-operatively to support all the child's needs.

Child, Youth and Family Services

CYFS is the government agency that has legal powers to intervene to protect and help children who are being abused or have problem behaviour. CYFS staff manage a range of services to carry out statutory and preventative social work practice. These services include working with families and whānau, community agencies and other professionals to:

- protect children
- manage young offenders
- ensure that children in need are secure and cared for
- help families to maintain and strengthen their child-rearing role
- facilitate the adoption process.

There are two pathways by which children and young people with disabilities come under the umbrella of the Children, Young Persons and Their Families Act 1989. Specifically, they may be:

1. in need of care and protection
2. assessed as being 'so severely disabled' that they require out of home placement (section 141).

CYFS funds and supports a wide range of community-based social services with a focus on children, young people and families/whānau in need of support.

Family Group Conferences are formal meetings that are designed to ensure that families and whānau are supported to develop their own solutions to their problems.

In care and protection cases, CYFS social workers and families/whānau work together to reach agreement on how to keep a child safely within the family. Service co-ordinators may be invited to attend Family Group Conferences usually in relation to the NASC role and funding.

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Resource

Department of Child, Youth and Family Services. URL: www.cyf.govt.nz/

Memorandum of Understanding between CYFS and the Health Funding Authority, July 1999

This provisional MoU was developed to assist in managing services to children and young people with intellectual and physical disabilities. Both organisations wished to ensure that these children and their families/whānau receive a comprehensive service that is responsive to their needs. In cases where there are both care and protection issues and disability support needs, staff roles and responsibilities can often be confused.

The MoU is designed to provide ways to address these matters and clarity for those involved with a family/whānau as to what they are doing.

It is planned that this MoU will be reviewed over 2004/05. NASC managers will have an opportunity to identify issues and operation policy required in the revised MoU.

Note: In relation to work with children and young people in conjunction with CYFS, NASCs need to work to the DSD Out of Home Placement for Children and Young People Policy.

Resource

Memorandum of Understanding between CYFS and the Health Funding Authority, July 1999

Out of Home Placement for Children and Young People Policy, DSD, 2004, Appendix 5.

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NON-GOVERNMENTAL ORGANISATIONS

Traditionally, families/whānau and service providers have represented the interests of disabled people. This is changing as disabled people choose to represent themselves. Disabled people have established consultancy services which provide a useful resource for the NASC manager.

Community support organisations provide services to disabled people in a number of ways, such as:

- the provision of information including on disability, resources and services
- DSD-contracted services such as respite care
- disability support services contracted by other funders
- support networks and groups for disabled people, parents and carers
- advice and practical support
- advocacy services including participation in the NASC process
- contact with support services and health professionals.

Organisations and individuals welcome contact with the NASC manager and the team. The development and maintenance of this professional relationship enhance integrated service delivery opportunities. An understanding of the role and function of each organisation and its referral protocols enables the NASC to make useful referrals to the service. Equally, an understanding of the NASC role and function by support organisations will help them to make referrals in a timely manner.

Community disability support organisations are an invaluable resource for the NASC as they can provide clear guidance as to the type of service their client group wishes the NASC to provide. The NASC manager should seek ways to include and value this input. Input into NASC service development, training, information development, NASC interviews and consumer reference groups are some examples of how this relationship can be mutually beneficial.

When seeking assistance from organisations and individuals, the NASC manager must be mindful of the mana of the individual. The manager should not assume that there is no need for recompense for services provided.

A list of non-governmental organisations (NGOs) can be obtained from a variety of sources including the WEKA website and DSD.

Resource

WEKA: What everybody keeps asking about disability information. URL: www.weka.net.nz

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THE PROVIDER INTERFACE

The importance of the NASC manager's relationship with managers of provider organisations is referred to in the DSD Service Specification (Volume 2, Appendix 1). The NASC must establish and sustain effective relationships with other organisations providing services to disabled people.

> The NASC is required to give providers sufficient information for them to do their job and so support the disabled person to work towards their goals.
>
> This information includes client information and service information that may be used by support services providers as they plan their services. The *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002a) sets out a minimum requirement of the information that is to be shared in making service requests to service providers.
>
> The NASC must always be mindful of the safety of not only the disabled person but also the provider's employees. Joint protocols should be developed agreeing to any additional information that will be routinely shared, how sensitive information is shared, the identification of 'red flag' issues and a communication strategy.

While developing protocols, issues of confidentiality of information and the disabled person's privacy should receive priority. There is real advantage in the NASC manager having a sound understanding of the legislative requirements.

The way of balancing information and privacy needs is to gain the consent of the disabled person, or their representative, to share this information.

To maintain effective networks, the NASC will provide information to other DSS providers on trends, unmet needs and so on for the purpose of fostering creative, innovative and flexible services.

The NASC is required to monitor support services. This includes the actual delivery of the support plan as negotiated between the NASC and the provider, gaps in services and any unresolved issue or risks. A good relationship with the providers will facilitate these processes with mechanisms in place and agreed strategies to address any issues that may arise.

The NASC manager needs to:

- know their local providers
- know the services they offer and to which client group these services are available
- have a knowledge of disability and the ageing process, and the impact of these on lifestyles, to support appropriate referrals
- know which providers offer culturally competent services, what these services are and to which groups they are available
- have the service specifications for all services from DSD and/or DHB so as to ensure service requests are within the contracted requirements of the provider
- meet regularly with the provider to build a sustainable relationship, share information, develop a communication plan, resolve concerns, and explore new ways of working together.
- maintain contact with the provider's service managers
- ensure NASC staff know about all available services including any entry criteria or special features of a provider
- facilitate collegial, co-operative relationships between NASC staff and the provider's key staff
- encourage and support a collaborative approach to service delivery
- establish protocols with providers for service requests, acceptance of service requests, management of waiting lists, withdrawal of services to clients etc
- ensure staff provide necessary information in requesting services
- maintain contracted timeframes
- report unmet needs to DSD and/or DHB
- report any service quality issues to DSD/DHB according to the NASC Service Specification
- review service plans with disabled and older people as contracted
- establish a mechanism for responding to complaints made about providers by service users.

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Service providers need to:

- know NASC managers and team leaders
- identify key personnel and roles of the provider organisation
- have a knowledge of disability and the ageing process, and the impact of these on lifestyles
- have information pertaining to the contracted roles and responsibilities of the NASC
- provide information about services in a variety of formats for NASCs and disabled and older people
- advise NASCs of services contracted by DSD/DHB, the intent of the service and how this may be accessed
- advise on any service variations such as delivery delays
- develop processes with the NASC including notifying the NASC of deceased, exited or transferred service users, declined service requests and so on
- advise on gaps in services
- maintain timeframes such as acknowledgement of receipt of referral, commencement of service
- meet regularly with the NASC to build a sustainable relationship, share information, develop a communication plan, resolve concerns, and explore new ways of working together
- commit with the NASC to work towards supporting the individual's chosen outcomes
- be committed to a collaborative approach to service delivery
- request review or reassessment when a significant change of need or circumstance is identified, and identify risk if critical or if service user is in immediate danger.

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6 Developing Quality NASC for Māori

This section is a compilation of contributions from various individuals and organisations who have experience and interest in improving NASC services for Māori.

It is intended as a resource and guideline for the NASC manager to meet their obligations and expectations for Māori with a disability. While not exhaustive or definitive, this information is provided as a starting point for the NASC manager to find practical solutions to achieve sustainable outcomes.

The basis of recognition for Māori lies within the Treaty of Waitangi, the New Zealand Disability Strategy (Minister for Disability Issues 2001) and *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002).

The NASC Service Specifications relating specifically to Māori are systematically analysed, with some practical ideas and examples offered to show how the NASC manager may fulfil those requirements. There is reference to actual examples provided by three NASCs on how they have met these obligations, with further detail in Appendix 16 of Volume 2.

The final part of this section poses, and answers, some Frequently Asked Questions, ending with some suggestions for resources that the NASC manager may wish to access for future use.

A list of all Māori disability providers and contact details within each DHB region can be sourced directly from the District Health Board and DSD Service Manager.

At any time, the NASC manager is encouraged to contact the Māori Project Manager and Māori Development Manager within DSD for any advice and support that may be required.

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MĀORI SERVICE PLANS

The DSD NASC Service Specification includes expectations that the NASC organisation will:

- have the capacity to include a cultural component in the facilitated needs assessment
- facilitate improved access for Māori to disability support services by ensuring equitable distribution of resources
- provide the NASC service in te reo Māori where necessary or appropriate or specifically requested by the client.

The following sections offer suggestions for how a NASC organisation can meet its cultural service requirements to Māori. While they provide a certain level of detail, they are not an attempt at a 'one size fits all' solution. Each NASC (organisation) will need to consider these aspects with direct reference to its own staff, service user, iwi and hapū relationships.

NASC PROVIDER QUALITY SPECIFICATIONS

The following 11 requirements are the main sections from the NASC Provider Quality Specifications that relate specifically to Māori. Here, each requirement is stated in full, followed by one or more suggestions of practical ways of addressing it. The suggestions are a combination of comments from the Ministry of Health, NASC Māori managers, and a forum of Māori NASCs. As stated above, these suggestions are only provided as a starting point for the NASC manager.

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Cultural Values

You will deliver NASC services in a culturally appropriate and competent manner, ensuring that the integrity of each consumer's culture is acknowledged and respected. You will take account of the particular needs within the community served in order that there are no barriers to access or communication, and that your services are safe for all people. You will include significant local or service specific ethnic and other cultural groups in assessing satisfaction with services. You will incorporate Māori principles/tikanga into your organisation.

Suggestions for Addressing This Requirement

It is essential that the NASC start from the perspective of the disabled or older person to build a service that will promote achievement of the above strategies. This local perspective will reflect the realities of disabled and older people within that iwi. Familiarity with the tikanga and kawa (protocols) of the local iwi will help the manager to gain credibility, as will actively participating where appropriate. It would be appropriate to take advice from a Kaumātua/Kuia Advisory Board or similar body if the NASC has one. Encouraging staff at all levels to be involved with cultural competency will establish a solid foundation for a culturally competent NASC.

The establishment of a Māori Advisory Board in NASC areas would provide the NASC manager with support.

- It would provide them with local knowledge.
- It would give an idea of service gaps within the rohe (area).
- It may have suggestions of appropriate cultural trainers in the rohe.
- Tautoko from the mana whenua – if effectively supported by the Māori Advisory Board.
- It would build relationships with appropriate iwi groups. However, the NASC within urban areas may need to be guided by the advisors as to what the appropriate representation from iwi groups, mana whenua, taura here, or other Māori groupings should be.

If a Māori Advisory Board has not been set up in the NASC area, the NASC manager may need to contact the following organisations for assistance in identifying key Māori in the rohe to ensure that the cultural support is appropriate and accurate:

- local runanga or iwi authority
- local DHB
- Ministry of Health
- consumer groups
- key disability agencies in the rohe.

In addition, a NASC manager can access resources that will explain Māori principles and tikanga.

Consistency

All services provided by NASCs should be consistent with the Ministry of Health's Māori health policy and strategies.

Suggestion for Addressing This Requirement

The relevant documents that all NASC managers should have and be guided by are:

- *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002)
- *Whakatataka: Māori Health Action Plan 2002–2005* (Ministry of Health 2002c).

Copies of both documents may be obtained from the Ministry of Health website – www.moh.govt.nz

The NASC manager should identify with the Māori Advisory Board the issues specific to the iwi/rohe and their impacts against national policy and strategies.

Written Policy, Procedures or Plan

Where you are required to develop a written policy, procedure, programme, protocol, guideline, information, system or plan in order to meet any specification under the Ministry of Health Agreement, you should demonstrate implementation, through documentation supported as requested through interviews with staff, consumers and Māori.

Suggestions for Addressing This Requirement

- Highlight current and ongoing culturally effective developments within your NASC – these should be reported through the quarterly reports to the Ministry of Health.
- Link to Māori Health Publications from www.moh.govt.nz.
- Consider obtaining external advice on the development of appropriate policy and procedures and on methods of implementation.

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Quality Requirements for Māori – Māori Participation

For NASC services to meet the diverse needs of Māori, you must ensure that Māori participate in decision-making concerning governance, management and service delivery and that such participation is integrated at all levels of strategic and service planning, development and implementation within your organisation.

Actions to achieve these objectives will include:

- consultation with and involvement of Māori in your strategic, operational and service processes
- development of a monitoring strategy in partnership with Māori that reviews and evaluates whether Māori needs are being met by your organisation, including through:
  - removal of barriers to accessing your services
  - facilitation of the involvement of whānau and others
  - integration of Māori values, beliefs, and cultural practices
  - availability of Māori staff to reflect the consumer population
  - existence, knowledge and use of referral protocols with Māori service providers in your locality
  - education and training of staff in the requirements of the Ministry of Health's Māori health policy and strategies. Implementation of these expectations could be stated in employment contracts or personal performance indicators
  - education and training of staff in Māori values and beliefs and cultural practices
  - support and development of a Māori workforce.

Suggestions for Achieving This Requirement

- The NASC manager should utilise all cultural resources available to them to enhance services for Māori clients.
- Dedicate a specific role to developing the competency and capacity of the NASC.
- Undertake Māori consumer and community consultation to establish a framework for service development.
- Set up or maintain Māori Advisory Group involving kaumātua, clients, iwi, providers and other Māori.
- See www.hauora.com for information on Māori workforce issues and development.
- Include personal performance indicators to monitor and plan for progress.
- Maintain and update a database of resources for Māori.
- Use local resources and expertise to practise local customs and protocols.

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Quality Plan

You will have a written, implemented and at least annually reviewed Quality Plan designed to improve outcomes for consumers. This plan may be integrated into your business plan. 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 your organisation and services, and will cover how you will address Māori issues including recognition at least of:

- Māori participation in strategic, governance, management and service delivery planning, implementation and review functions
- Māori as a Government Health Gain priority area
- Māori health priority areas
- the Ministry of Health Māori health policy and strategies and the Māori health clause in the Standard Terms and Conditions
- Māori-specific quality specifications, monitoring requirements and service-specific requirements.

Suggestions for Achieving This Requirement

- Organisational values must reflect the commitment to providing a service that truly meets the needs of Māori.
- Enable Māori (consumers, whānau, staff, advisors) to be involved in design and review of the NASC strategic plan and annual business plans to ensure Māori issues are addressed within key operational documents.
- Assess all levels of the organisation for commitment to Māori strategy and development.

Employees' Competency (Education and Training)

Where you are required to develop a written policy, procedure, programme, protocol, guideline, information, system or plan in order to meet any specification under the Ministry of Health Agreement, you should ensure:

- your employment policies and practices will support professional career pathway development for Māori health workers
- Māori service advisory positions
- Māori change management positions
- the recruitment and retention of Māori employees at all levels of the organisation to reflect the consumer population

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Suggestions for Addressing This Requirement

- See 'Developing NASC Bicultural Competencies' below.
- Include Treaty of Waitangi training for all staff to improve competency, and be responsive to appropriate cultural training and support.
- Make a commitment to all staff to ensure that they establish culturally safe practices with regards to Māori and that team members at all levels will be involved in appropriate training.
- Make cultural resources available to staff – such as cultural supervision, external mentoring, Māori staff forum, supporting external Māori initiatives – to enhance cultural competency at all levels of the organisation .
- Include Key Performance Indicators in the NASC manager job description that cover meeting agreed performance targets for Māori.
- Take specific initiatives that address priorities in service development (assessment tool based on Tapa Wha, Treaty of Waitangi, staff training, access to Māori workforce). The Tapa Wha model originates within Māori Hauora development and its principles are applicable to many other areas, including disability services.
- Use culturally competent staff effectively but be mindful of their existing workloads.

Supporting Māori

You will facilitate support from whānau/hapū/iwi; kuia/kaumātua; rongoa practitioners; spiritual advisors; Māori staff and others as appropriate for Māori accessing your service.

Suggestions for Addressing This Requirement

- Move into the community to establish linkages. Face to face hui are the most valid form of communication for Māori. There needs to be an ongoing commitment to these relationships and the work that will eventuate.
- Your attitude will influence behaviour of other team members. Self reflection may be a useful means of recognising strengths and weakness.
- In the event that kaumātua and kuia support is required by the NASC, they will be offered a koha to recognise the taonga (gift) this service has been to the organisation. Ensure koha/payments comply with Inland Revenue requirements, to protect kuia and kaumātua.
- Effectively involve kaumātua/kuia with development of services and acknowledge their contribution to this. Get away from the 'dial a kaumātua' practice. It is important to include kaumātua/kuia in a meaningful way within the NASC. Bringing them in only when you want them does not build lasting relationships. The relationship must be respectful and genuine.

Complaints Procedure

You will enable consumers/families/whānau and other people to make complaints through a procedure for the identification and management of complaints. This

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procedure will meet the requirements of the Code of Health and Disability Services Consumers' Rights. It will ensure that:

- complaints are handled sensitively with due consideration of cultural or other values
- Māori consumers and their whānau will have access to a Māori advocate supporting them during the complaints process

Suggestion for Addressing this Requirement

- Ensure complaints information, including information provided in te reo Māori, is readily available to Māori at all times of service delivery.

Ethical Review

You will consult with and receive approval from Māori for any research or innovative procedures or treatments that will impact on Māori.

Suggestion for Addressing This Requirement

- Work in conjunction with the Māori Advisory Board and Consumer Advisory Board (if established) before approaching the Ethics Committee.
- Contact the Māori Advisory Committee or Māori Manager of the Health Research Council. The Council's guidelines for research involving Māori are available at www.hrc.govt.nz

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Consumer Advocates

You will inform consumers, in a manner appropriate to their communication needs, of their right to have an advocate, including supporting the resolution of any complaint. You will allow advocates reasonable access to facilities, consumers, employees and information to enable them to carry out their role as an advocate. You will know of, and be able to facilitate access to, a Māori advocate for consumers who require this service.

Suggestions for Addressing This Requirement

- Work in conjunction with the Māori Advisory Board and Consumer Advisory Board to identify appropriate representation/advocates.
- Contact the Health Advocates Trust.

Consumer/Family/Whānau and Referrer Input

Consumer input will be reflected in the maintenance and improvement of quality of service, both for the individual consumer and across the service as a whole. You will actively seek feedback from Māori by appropriate methods to improve the NASC organisation's responsiveness to Māori.

Suggestions for Addressing This Requirement

- Offer Māori service users a choice of Māori or non-Māori assessment facilitators. Do not assume that Māori necessarily want a Māori facilitator.
- NASC processes need to be flexible to respond to the needs of Māori. Assessment processes may differ but the contracted requirement to identify the disability support needs will be met.
- An understanding and agreement as to how these processes are to be implemented should be the result of a collaborative approach by the NASC manager and Māori staff. The identification of gaps in services for Māori may lead to service development that meets the need of Māori.

NASC EXPERIENCES

NASC organisations have responded to the 11 requirements outlined in the previous section in varying ways, reflecting the community in which they work. Appendix 16 in Volume 2 contains examples of how three NASC organisations responded to the various requirements as appropriate and specific to their organisation and area.

It is emphasised that these are provided as examples only. Each NASC throughout the country will need to develop its own services to meet these requirements in its own way as appropriate and specific to its organisation and area.

Resource

Volume 2 Appendices

- Appendix 16: Quality NASCs for Māori – Three Examples of NASC Experiences

DEVELOPING NASC BICULTURAL COMPETENCIES

The Ministry of Health is in the process of designing a competency planner to assist staff in the Ministry to assess, plan and meet requirements to work biculturally. The competency planner will be a reference point and toolkit. The draft document defines a competency as:

> *... a person's ability to consistently achieve defined outcomes in a defined context.*

The draft document is based on four facets of bicultural awareness:

1. relationship management
2. te reo Māori
3. awareness of context/impacts
4. partnership/quality alignment.

It also covers three levels of development:

- Level 1 is concerned with providing a solid foundation for all staff.
- Levels 2 and 3 are specifically for those staff whose work impacts on Māori or who have significant interaction with Māori.

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Each competency is defined, with its context explained and expectations for each level identified. To support the process, the draft document details development options including experiences, websites, books, coaching, mentoring and learning groups and courses.

It is hoped copies of the competency planner will be provided to NASCs once completed. Each NASC can then edit and adapt the competencies to suit its own organisation. Additionally DSD is developing best practice guidelines in relation to Māori, and cultural competency guidelines in relation to Pacific peoples.

FREQUENTLY ASKED QUESTIONS

Question

Which parts of the key strategies directly relate to Māori?

Answer

- *New Zealand Disability Strategy* Objective 11 – 'Promote participation of disabled Māori'
- *Health of Older People Strategy* Objective 4 – 'The health and disability support needs of older Māori and their whānau will be met by appropriate, integrated health care and disability support services'.

Question

How do I set up a Māori Advisory Group?

Answer

1. Develop a relationship with Māori health and disability providers in your area.

- Contact the Māori manager in your local DHB for advice on Māori providers in the area and ways of developing relationships with them.
- Contact the Māori Health Directorate for assistance in developing relationships. Note that many urban areas will have a variety of Māori groups – including mana whenua, iwi, hapū, Taurahere, urban services and so on. The Ministry of Health and local DHB may be able to offer guidance in this area.

2. Develop a relationship with iwi organisations in your area.

- Contact the Māori manager in your local DHB for advice on iwi organisations in the area and ways of developing relationships with them.
- Contact the Māori Health Directorate for assistance in developing relationships.
- See *TAKOA: Te Aka Kumara o Aotearoa* (2004) (available in book or website) for listings of contact organisations and people within each area.

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Question

How do I get Māori consumer input to my service?

Answer:

See answer to the previous question on Māori Advisory Groups. In addition, try the following steps.

- Contact national Māori organisations that may be of assistance – eg, Ngati Kapo (Māori Blind Collective); or Māori within the National Deaf Association may be able to provide advice and guidance on engaging disabled Māori.
- Contact People First New Zealand or DPA for assistance with advice on different meetings/forums occurring throughout the country.
- Invite all Māori receiving services from NASC to a Māori consumer forum. Ensure that the forum has kuia and kaumātua involvement and protocols are observed. Seek membership of Māori Consumer Advisory Group from the meeting.
- When establishing the advisory group, consider the following:
  - mutual expectations between disabled Māori and the NASC
  - Terms of Reference
  - appropriate meeting venues with necessary resources
  - payments/koha/gifts or other methods of recognising consumer contribution
  - appropriate preparation for meetings such as facilities, meeting materials, interpreters, and whānau support.

Question

How can I access cultural advice on my practice and how do I know that it's the 'right' advice?

Answer

Here are some possible actions.

1. Options for relationship building and maintenance

- Hold regular meetings.
- Develop Memorandum of Understanding.
- Establish Māori Advisory Group to the NASC with clear understanding of mutual expectations including in regard to advice on protocol, referral guidelines, improving staff capacity and competence on Māori issues.
- Hold joint training with Māori organisations.

2. Internal planning and development of NASC commitment to Mäori

- Determine what level of commitment NASC is prepared to make to addressing Māori issues.

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- Plan levels of engagement and appropriate involvement with Māori – that is governance, management, operations.

3. Seek guidance from Ministry of Health and District Health Board

Contact:

- DSD Māori Development Manager and Māori Project Manager
- Ministry of Health – Māori Health Directorate
- District Health Board – Māori Managers.

CULTURAL ASSESSMENT

The NASC manager is reminded of the material on cultural assessment, including principles and process, in the *Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines* (Ministry of Health 2002a). In situations where a NASC does not have the resource to provide cultural assessment, the Guidelines are to be followed as closely as possible.

Resources

Translations to Māori words and terms can be found in the Reed Māori- English dictionary. A hard copy or electronic version can be purchased through www.Māori.org or bookshops, or it can be viewed at libraries.

Volume 2 Appendices

- Appendix 16: Quality NASCs for Māori – Three Examples of NASC Experiences
- Appendix 17: Excerpt from 'Guidelines for Cultural Assessment – Māori', Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

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7 Improving Quality for Disabled People

INCREASING RESPONSIVENESS TO DISABLED PEOPLE

Disabled people and those who support them have an important role to play in the development of a NASC culture that removes barriers, demonstrates true inclusion and provides opportunities for disabled people.

> *'Nothing about us without us'*
> James I Charlton, 1998

Crucial NASC stakeholders include disabled people and those who support them, the funder, providers and community organisations. The NASC must be responsive to its key stakeholders. It is the responsibility of the NASC manager to ensure this happens well.

In 2003 DSD established the Consumer Participation Project. Its aim was to find the best way to increase and better support consumer involvement in its activities. DSD facilitated a separate consultation process with Māori and Pacific peoples to identify their views. The key findings of this consultation provide insight for the NASC manager into disabled people's views on how they believe their input can best be used to contribute to the development of services that affect them.

A summary of the key findings is that:

- disabled people are willing to be involved in activities as they hope this will improve the services they receive
- they will give their time only if their input is heard and acted on
- they want to be involved at the planning stage
- it is important that all disabled people and their families and whānau have equal opportunity of participation regardless of where they live
- information should be accessible for all consumers; plain English is called for in all communications as well as specific communication processes
- any mechanism must have a feedback loop
- costs will be incurred in achieving meaningful dialogue
- ongoing communication in a variety of formats is wanted
- participation is wanted both locally and nationally.

The challenge for the NASC manager and the service is to increase genuine participation of disabled people to better determine their future as advocated by the *New Zealand Disability Strategy* (Minister for Disability Issues 2001).

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COMMENTS AND COMPLAINTS

Effective managers are always interested to learn from past successes or failures. For the NASC manager, possibly the most important source of this learning is the feedback received from disabled people. They are the stakeholders most affected by the service provided by the NASC. They must be provided with opportunities to provide frank feedback. The manager is key to ensuring the NASC is known as an organisation that has a culture and practice of inviting feedback, both positive and negative. This feedback may be regarding the NASC's performance or the delivery of disability support services from providers.

The NASC is contracted to provide the Ministry of Health with quarterly reports on the delivery of services by contracted support service providers. There is also the requirement to advise the Ministry urgently of situations of potential high risk. While it is expected that the NASC will work with the disabled person and the provider to resolve any complaints about the provider's service, any unresolved issues, problems or complaints identified by disabled people should form part of the quarterly report. It is useful for the NASC and the providers to agree to a protocol for the sharing and resolution of complaints.

Responding in a positive manner to comments and complaints that disabled and other people may make about the quality of the NASC service creates an opportunity to improve existing systems and processes.

The NASC manager may ask disabled people who provide input to the NASC and/or the Health Advocacy Trust to review the NASC complaints process to validate content and language.

- Every NASC must have a complaints policy, consistent with the requirements of the Ministry/NASC contract, including Head Agreement and Service Specifications, and in anticipation of the relevant requirements of the Health and Disability Sector Standards (HDSS).
- Information will be made available to disabled people by the NASC early in the engagement, and prior to the facilitation of a needs assessment. It will outline the process by which they may make comment or complain about the service they receive.
- Service users should be involved in the development of process and resource material.
- The NASC procedure should also meet the Health and Disability Services Consumers' Rights Code requirements.

The NASC organisation must establish a process to ensure that:

- any complaint is handled impartially and fairly
- the person is kept informed
- the person's services are not compromised.

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The NASC manager must ensure that NASC staff are trained in the complaints procedure and can speak competently to the process. Staff need to have and exercise the ability to support a disabled person or family/whānau to:

- have full information
- distinguish between a misunderstanding and resolvable situation
- make a complaint about the NASC organisation.

It is important for the NASC manager to maintain a complaints log book to monitor the timeliness and effectiveness of the NASC response. A log book also provides an accurate reference for any follow-up action(s) including staff training and, if necessary, performance management.

Resources

www.hdc.govt.nz

Volume 2 Appendices

- Appendix 1: DSD NASC Service Specification

CONTINUOUS QUALITY IMPROVEMENT

The NASC will have some key purpose and goal statements about making a difference in people's lives or a similar constant reminder to the organisation of what it is trying to do and of the need to achieve this with a person-centred perspective. This focus will facilitate opportunities for further participation of disabled people and a responsive, innovative and sustainable service.

> At the forefront of the drive to improve quality are processes called Continuous Quality Implementation (CQI) or Total Quality Management (TQM). These focus on the goal of constantly improving the quality of the organisation's services and products. A quality plan should be developed each year with close involvement of service users and other key stakeholders. It may form part of, or be separate from, the organisation's annual plan.

To provide high-quality services, the NASC manager must develop an organisational commitment to quality which may require a change in the organisation's culture. The philosophy of CQI should be repeatedly emphasised and applied. It must be constant and permeate all activities of the NASC organisation.

Disabled people must be the starting point, and the focus, of all quality activity. It is they who ultimately determine quality.

Good internal systems to monitor service delivery and measure quality are needed. Incentives should be in place to lift the NASC to the next level of performance. The NASC team should be involved in this and all CQI activity.

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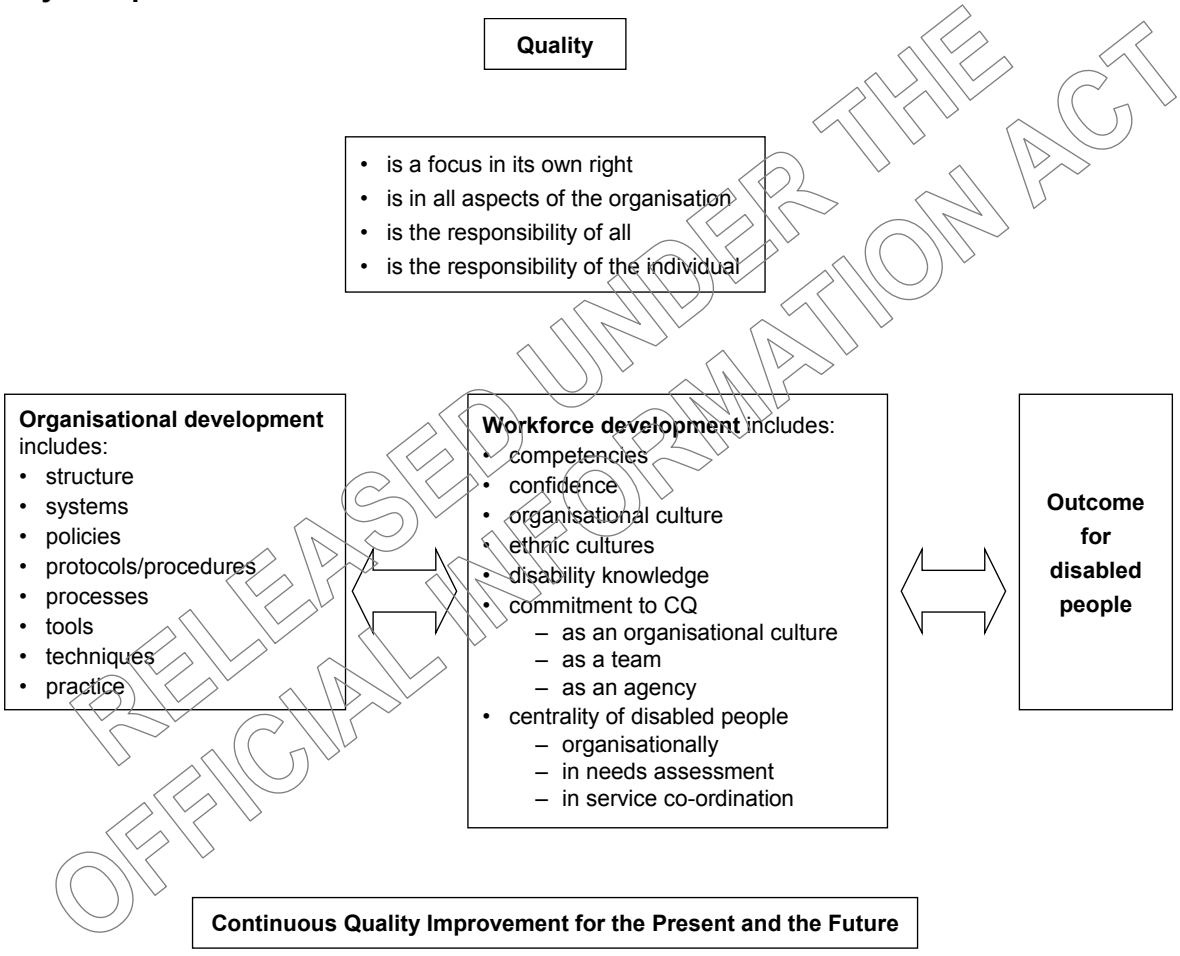
The NASC manager's commitment to the principles of CQI is essential. Role modelling of this commitment, the active and purposeful involvement of disabled people, and the inclusion and support of the NASC workforce will all contribute to a realistic, well-tested and attained CQI plan.

Components of a Continuous Quality Improvement Plan

A CQI system focuses on the present and the future. Its key components are outlined in the following diagram.

Key Components of CQI Plan



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Actions for improvement include:

- analysing and evaluating the existing situation to identify areas for improvement
- establishing the objectives for improvement
- searching for possible solutions to achieve the objectives
- evaluating these solutions and making a selection
- implementing the selected solution
- measuring, verifying, analysing and evaluating results of the implementation to determine that the objectives have been met
- formalising changes.

The NASC manager enhances quality by creating an environment where people are fully involved and in which a quality management system can operate effectively.

The NASC manager's role includes:

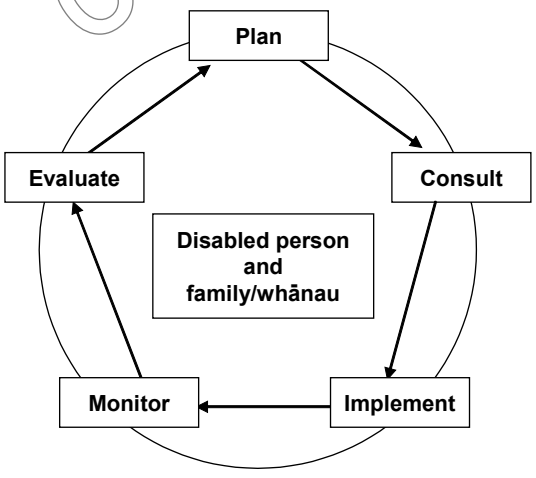
- establishing and maintaining the quality policy and quality objectives
- promoting the quality policy and quality objectives, developing increased awareness, and motivating involvement
- ensuring focus is on all stakeholders including disabled people, cultural communities, Ministry and NASC organisational requirements
- ensuring an effective and efficient quality management system is established, implemented and maintained
- ensuring that appropriate processes are implemented to enable requirements to be fulfilled and quality objectives achieved
- ensuring the availability of necessary resources
- reviewing the quality management system periodically.

Documentation required to support the CQI plan includes documents that:

- provide consistent information about the quality management system (quality manuals)
- describe how the quality management system is applied (quality plan with Key Performance Indicators)
- state requirements (specifications)
- state recommendations or suggestions (guidelines)
- provide information about how to perform activities and processes consistently (protocols, procedures, processes, tools, techniques, practice)
- provide objective evidence of activities performed or results achieved (records).

The process is a continuous cycle, as the following diagram reflects.

The CQI Cycle



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Ministry of Health Contractual Requirements

The Ministry of Health Head Agreement, Part 1, Section B: Provider Quality Specifications B5 states that NASCs are expected to have a written, implemented and at least annually reviewed CQI plan. This may be integrated into the business plan. The plan should outline a clear quality strategy and identify the organisational arrangements to implement it. The plan should include at least:

- an explicit quality philosophy
- clear quality objectives
- quality improvement and risk management systems
- quality management – systems for monitoring and quality audit compliance
- designated organisational and staff responsibilities
- consumer input into services and into development of the CQI plan
- how Māori issues will be addressed including recognition of Māori participation within governance structures, management and service delivery planning, implementation and review functions
- acceptability: cultural values, services to Pacific peoples, consumer advocates, consumer/family/whānau and referrer input, consumer rights, complaints procedure, personnel identification, ethical review
- development of an informed staff – employee CQI plan knowledge, education and training.

The plan should also cover the following areas:

- written policy, protocol, programme, procedures, guidelines, templates.
- effectiveness – service information, eligibility, entry to service, service provision, planning discharge from the service or transfer between services
- facilities – accessible, facilities maintained
- mechanisms for monitoring contract requirements, budget expenditure, service improvement, response times.

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Meeting Service Requirements

The CQI plan should support the NASC to work towards compliance with the Health and Disability Sector Standards (HDSS) standards and criteria identified by DSD as applicable to NASC. Until compliance with the HDSS is required, the CQI plan should support the NASC's compliance with the provider contract quality specifications including:

- General Provider Quality Specifications, Section B
- Service Specification DSS 1004 and DSS 1005 and DSS 1004D, Needs Assessment and Service Co-ordination
- *Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines*, Ministry of Health, February 2002a
- *Standards for Needs Assessment for People with Disabilities*, Ministry of Health, June 1994b

- *Service Co-ordination for Disabled People*, Ministry of Health, February 1995
- *Principles for NASC Agencies*, Health Funding Authority, 1999
- *Standards and Competencies for Needs Assessment*, Health Funding Authority, 1999b
- *Standards and Competencies for Service Co-ordination*, Health Funding Authority, 1999c

Self Audits

Self audits can be a valuable part of the formal and informal process of CQI. The NASC manager could develop and implement self auditing mechanisms to provide ongoing measurable reflection of the organisation's performance. If an issue arises, the manager can then initiate a self audit of current practice.

Some benefits of self audits are that they:

- are a catalyst for continuous improvement
- provide information for decision-making
- improve efficiency and effectiveness – contributing to lower cost and better service
- improve evaluative information about performance
- enable systematic consideration of long-term problems.

Self audit activities include:

- review of actions as documented in the CQI plan
- peer reviews
- individual and specific audits of the composition and working of the organisation: structure, systems, policies, protocols, procedures, tools, techniques, practice
- individual and specific audits of the organisation's ethics, disability knowledge, team work, agency culture
- individual and specific audits of the organisation's ability to promote and maintain centrality of disabled people.

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Resource

Ministry of Health. 2003. Improving Quality: A systems approach for the New Zealand health and disability sector. URL: www.moh.govt.nz

Acceptability of Service

The NASC is required to monitor the acceptability of the service it is providing on a regular basis. The NASC can choose how to facilitate this. The means should be developed in conjunction with disabled people so that the mechanism is acceptable and effective.

Support family and whānau, service providers and advocates should also be included in this monitoring activity.

Areas of service to monitor could include staff, cultural sensitivity, levels of choice, informed consent, staff communication skills and the ease of use of the NASC's services.

This monitoring will provide the NASC with feedback on how the service is viewed by people who are in some way affected by the service. It can provide useful information affirming what works well and in what areas there are opportunities for improvement. Documentation of the processes used, conclusions reached and subsequent actions will all contribute to a CQI plan.

DEVELOPING A QUALITY NASC FOR OTHER CULTURES

Responsiveness and quality both require the NASC manager to have the competence to welcome and respond to the needs, aspirations and contributions of people of other cultures. This section provides the NASC manager with a starting point from which to better understand and respond to disabled people from other cultures.

Pacific Peoples

> *Promote participation of disabled Pacific peoples*
> New Zealand Disability Strategy Objective 12

There are a number of different ethnic groups within the broad category of Pacific peoples. Each is unique and diverse in the expression of their cultural identity. In total there are eight main island groups living in New Zealand: Samoa, Tonga, Cook Islands, Fiji, Niue, Tokelau, Tuvalu and Kiribati. While there are natural connections, each has their own identity, culture, spirituality, language and customs. It is important to value the uniqueness and cultural differences of each of these groups. There are also important differences in the cultural expressions of Pacific peoples born in the islands and those who are New Zealand born.

The belief system that unites Pacific peoples is that family is the centre of the community and way of life. Keeping the community and families together as a united entity is an important duty for Pacific peoples. Furthermore, respect for one another, having humility and maintaining dignity of others as well as their own, are fundamental values upheld by Pacific peoples.

A fundamental principle when working with Pacific peoples is 'People First'. This means that when NASC staff are working with any people, they should remember that each person should be valued for their uniqueness as well as their cultural or other differences. The NASC service should be person driven. This implies that every person is significant enough to be valued.

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Good advice when working with Pacific peoples is: 'Don't assume, always ask.' No one can presume to know everything of their own culture, let alone another culture. Every person is unique and different. If you are unsure of an aspect of a person's culture, disability or other aspect, it is respectful to ask about it and acknowledge your own limitations in this area.

Delivering a Culturally Responsive Service to Pacific Peoples

It is the manager's responsibility to *'Promote the participation of disabled Pacific peoples'* (*New Zealand Disability Strategy,* Minister for Disability Issues 2001). Thus the development and maintenance of strong links and good relationships between the NASC and the Pacific community are crucial. The following are competencies/tasks for the NASC manager to acquire or perform in fulfilling this responsibility.

- **Acquiring a general knowledge of Pacific peoples**. This includes acquiring an understanding of each island group's uniqueness; and a knowledge of their New Zealand Pacific community such as the leaders of that community. This involvement in the community, for example through reference groups, can enhance understanding of Pacific peoples. Demonstrating genuine respect for and developing an understanding of customs and cultures of the individual and their community will support the idea of a culturally responsive service.
- **Advocating for and supporting the establishment of a Pacific Reference Group and Pacific Advocacy Group**. Any advocacy/reference groups should be selected by Pacific peoples to ensure that the diversity of the Pacific peoples is acknowledged. Regularly liaising with these groups can support the development of strong relationships as well as provide feedback about any concerns, changing community needs and trends for Pacific peoples. It could provide the NASC manager with insight as to how the NASC is regarded in the community. The relationship between the NASC and advocacy/reference group should be a two-way process. The manager, with the group, should learn about the community need. This will enable the NASC to respond in a more effective manner to the community the reference group represents.
- **Developing strategies to promote the NASC in the Pacific community**. The NASC manager needs to consider ways of engaging the Pacific community, and what and how the service will be promoted, as well as to develop ways of ensuring that older Pacific peoples and Pacific disabled peoples make use of and continue to participate in the NASC.
- **Developing a strong link with disability support providers in order to work in a collegial manner to assist in the development of services to meet the needs of Pacific peoples.** The NASC manager, needs assessment facilitators and service co-ordinators need to develop a broad knowledge of the Pacific network in the area where they are working. The manager should encourage service providers to have knowledge of the needs of Pacific peoples and ensure they are making a concerted effort to meet those needs. Some specific instances might be that older people will not easily complain if the service is not meeting their needs; transport can often be a problem in accessing services. Spending time in one another's organisations can support the process of forming strong links

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with one another. It would also be beneficial to invite service providers to attend the cultural components of training.

- **Developing a policy that a qualified interpreter is made available to all families accessing NASC services**. Needs assessment facilitators should make this option accessible for all families. English is a second language for many older Pacific peoples and they should have the opportunity for a preferred language to be used in their assessment. Whilst the use of a translator can be useful, NASC staff should be aware that many NASC concepts do not translate well into other languages. Literal translations can be misleading. The translator should have an understanding of the NASC framework so that they can best describe the intent and purpose of needs assessment and service co-ordination. This will support the process for the disabled or older person.
- **Developing a policy to ensure appropriate training and support of all staff, particularly needs assessment facilitators and service co-ordinators.** This training should be purchased from, and delivered by, the Pacific community. The following issues should be considered in relation to this training.
  - Cultural awareness and cultural competency should be given equal importance to training about disability or older people.
  - Working in cross-cultural ways – the need to respect difference and view each assessment situation within its own context –should be explored.
  - A broad knowledge of service providers for Pacific people should be developed.
  - Socioeconomic factors that have an impact on Pacific families as a whole include: older and disabled people from the Pacific community are sometimes transient, live in impoverished conditions and in situations of overcrowding; socioeconomic factors might be preventing some Pacific people from accessing a service as transport might not be affordable.
  - The environment in which NASC works is often unfamiliar to many people. It is important to learn about the needs of the community and some of the possible risk factors for older and disabled Pacific peoples.
  - Training might include the meaning of various customs such as: hospitality, eg, should the offer of food or a cup of tea be accepted?; greetings, eg, whilst it is not necessary to use these greetings, having a knowledge of them and the associated customs might enhance the building of relationships; respecting being a visitor to the home; gift giving, eg, does the NASC have a policy about receiving gifts?; differing family structures and ways in which families might share information; the role of spirituality in the family.
  - In working with people from any cultural group, training needs to include: dress codes, most appropriate ways of making initial contact, relationship building, fact finding in a respectful manner, homework on the types of disability or the specific needs of the person being assessed, ascertaining who is family and who are the 'genuine' support people, what family (if any) needs to be included in the assessment interview, respecting the knowledge of the person being assessed or their support person/people.

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- **Developing a means of ensuring that Pacific peoples who are using the NASC service have the option of culturally respectful and competent staff.** The NASC manager could support this by employing a diversity of staff to best reflect the population in which the NASC operates. This support could be provided by managing the workload of the needs assessment facilitators and service co-ordinators and allowing them quality time to give value to each client's needs; and by acknowledging the additional skill of staff who are fluent in a Pacific language.

Service Delivery: Needs Assessment and Service Co-ordination for Pacific Peoples

Acceptance of assistance lies in the relationship between the helper (needs assessment facilitators) and the helped (person being assessed). The role of needs assessment facilitator can be seen as gathering personal details and information from the person. The true worth of the needs assessment facilitator lies in their ability to hand the power of the needs assessment relationship to the person being assessed or the support person/people. This is done by genuinely believing that the person being assessed or their support person/people is the expert of the assessed person's own needs. For Pacific peoples, this should be a respectful reciprocal relationship. Reciprocity is a fundamental value in many Pacific cultures. It includes essential components of trust, acceptability and mutual respect. This type of reciprocity must be established if the needs assessment facilitator is to capture a person's felt need, unexpressed need and spiritual need. Building a relationship is essential and it should be remembered that personal contact is often preferred to telephone contact.

Physical needs are often of low priority for older Pacific peoples who may not want to express the way impairment is impacting on their daily life. In turn this reluctance to complain about impairment may mean they are not formally diagnosed nor is a disability identified. This may restrict their entry to a NASC service. It is therefore imperative that the NASC manager networks with Pacific advocacy/reference groups to ensure that disabled people and older people are encouraged to seek services, often through community education on the role of NASC.

Facilitated needs assessment covers not just the individual but the whole family system and how this system is coping with caring for the disabled or older person. A holistic perspective must always be maintained with referrals made to other organisations as necessary. The needs assessment facilitator should incorporate a 'holistic' approach by acknowledging the individual with a disability or the older person as well as the collective (family). The assessment facilitator should acknowledge the individual's needs within the context of their interdependence with the family. It is an acknowledgement that the support system is the family or other designated persons.

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It is important to consider the possibility that the primary caregiver may not be immediate family. It is not uncommon for Pacific families to nominate or delegate this role to some outside the family. For example, parents may attend all meetings concerning their child while the grandmother is the primary caregiver. Therefore it is important to involve the wider family network to ensure that all significant people are included in communication and decision-making for the disabled person. Parents have an important role in speaking on behalf of their children. While this role should be respected, the needs assessor should always ensure that the person being assessed is not lost in the process.

In the instance of older people, the spokesperson for the family may often be a son or daughter. This role is based on who the older person most trusts.

Complaining is often alien to Pacific peoples. They need to understand that they have a right to complain and have the necessary advocacy/support to go through the complaints procedure. This feedback will also ensure quality improvements for service delivery for Pacific peoples. Pacific peoples find it harder to complain if it is 'one of their own' who has done the assessment as they don't want to 'put down' someone in their ethnic group. Thus the assessment facilitator needs special skills to explain the complaints process in a manner that will be respectful of the person who is being assessed. The NASC manager is responsible for supporting this communication and managing complaints according to the organisation's policy and protocol which should reflect a respect for the values of Pacific peoples.

It is important always to acknowledge the uniqueness of each person. It cannot be assumed that because a person comes from a particular community, their needs or requirements will be the same as others from the same group.

It is important to consider that privacy may be an issue for some people who come from smaller communities and who may not want someone from their own community working with them and knowing about their family business.

The issue of the gender of the person working with the family needs to be considered. It is important to assign a staff member of the appropriate gender, as families may close the door on support otherwise.

The use of Pacific services – whether in the form of advocacy, health, disability support or care services – is to be encouraged. These services should be culturally appropriate and respectful of all the needs of the person being assessed.

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Building Human Resource Capacity of Pacific Peoples in NASCs

> The employment of staff in the NASC from within the Pacific community will facilitate the entry of Pacific peoples into the NASC.

The skills of people from the Pacific community can provide the best support for cultural perspectives to other staff as well as knowledge of who is available and appropriate to call on from the Pacific community when advice is needed. Cultural training needs to be made available to all the NASC staff including administration support and the telephonist/receptionist.

Flexible conditions should be available for staff if they need to work unusual hours to be accessible. Where Pacific staff are few in number it is important to consider the risk of burnout when staff have to be all things to all people. Therefore, external and/or cultural supervision should be a strong component of the working conditions and career path development for each individual.

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Resources

Department of Child, Youth and Family Services. 2000. *Towards Well Being: Responding to the Needs of Younger People.*

Minister of Health. 2002. *The Pacific Health and Disability Action Plan*.

Ne'emia S. 2002. *Capital Support in the Lives of Pacific Disabled People*.

Other Cultures

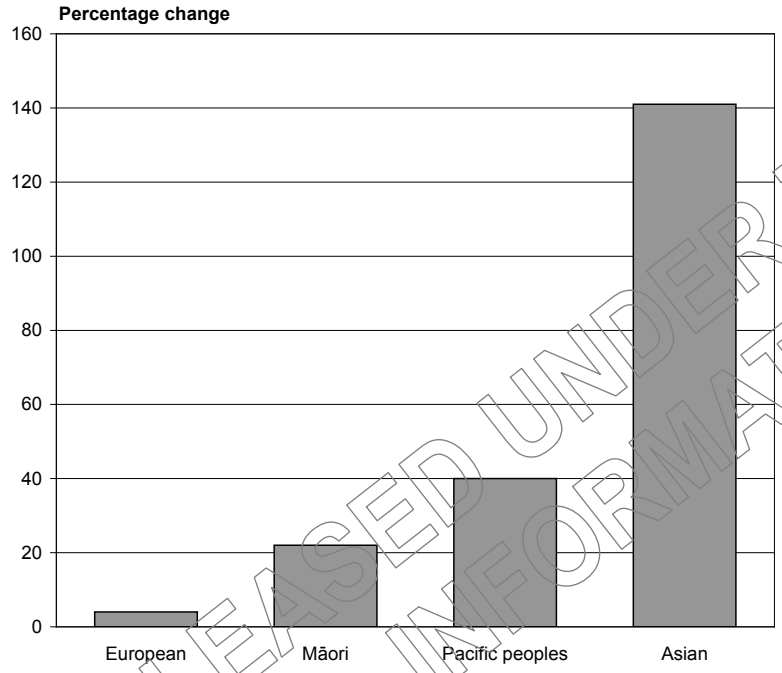
The current rapid changes in New Zealand are influenced to some degree by the diversity of cultures that now make up the New Zealand population. This demographic change presents a challenge to the NASC manager as they must consider how best to shape the NASC service so as to be responsive to the variety of disability experiences, attitudes and needs within their community.

The 31st New Zealand Census of Population and Dwellings was held on 6 March 2001. The following snapshot highlights some of the key findings from tables prepared for the National Summary topic-based report published in March 2002. This information particularly reflects New Zealand's increasing ethnic diversity.

- The census counted more people of Asian ethnicity than Pacific peoples.
- Almost 240,000 or 1 in 15 people were of Asian ethnicity.
- Counts of people of Asian ethnicity more than doubled between 1991 and 2001.
- There were 231,801 Pacific peoples.
- The count of people of European ethnicity declined from 83 percent of the total in the 1991 Census to 80 percent in 2001.
- 1 in 7 people (526,281) were of Māori ethnicity.

- Two-thirds of people of Asian ethnicity live in the Auckland region and 1 in 8 live in the Wellington region.
- Two-thirds of Pacific peoples live in the Auckland region.
- In the Auckland region, 1 in 8 people are of Asian ethnicity, 1 in 8 are Pacific peoples and 1 in 10 Māori.
- Nearly 9 out of 20 people in the Gisborne region are of Māori ethnicity.

Change in Ethnic Groups 1991–2001



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- The fastest growing of the top 50 ethnic groups in 2001 are listed in the table below.

Fastest-growing ethnic groups 1991–2001

Ethnic group	2001 count	Percentage increase from 1991
Korean	19,026	1,946
Arab	2,856	1,514
Croat	2,502	1,363
Iraqi	2,145	772
South African	14,889	642
Russian	3,084	543

As the following summary indicates, the population is also older.

- The median age of the population increased from 31 years at the 1991 Census to 35 years in 2001.
- In the 1901 Census the median age was 22 years.

- In 2001, 450,426 or nearly 1 in 8 people were aged 65 years and over, compared with 1 in 25 in 1901.
- The Marlborough region had the highest proportion, nearly 1 in 6, aged 65 years and over.
- The Auckland region had the lowest proportion, 1 in 10, aged 65 years and over.
- The Gisborne region had the highest proportion, more than 1 in 4, aged under 15 years.
- There was an increase of 26 percent in the number of people aged 85 years and over between 1996 and 2001.

The changing demographics present the NASC manager with both a challenge and an opportunity. They will need to take an open and practical approach to adapting components of the NASC practice to better meet the requirements of people whose perspectives of disability may differ, whose social structure may vary and for whom English may be a second language. It is at this time a truly representational disability advisory group coupled with extensive community linkages can support the NASC in reducing the barriers for disabled people from other cultures to access disability support services.

A number of strategies can be employed to improve the NASC staff's understanding of disabled people from other cultures. One strategy is to provide learning and development opportunities to enable the staff to conduct a culturally competent process. People who belong to different cultural groups have their history and story to share and so will provide useful insight for the NASC. The employment of culturally diverse staff reflecting the NASC's demographic environment in all aspects of the NASC work could be another goal of the NASC manager. Accessing opportunities to meet people within their culture also provides the NASC manager with unique experiences and understandings.

The identification and implementation of strategies and actions, such as the development of pamphlets in other languages to encourage the entry of people from other cultures, should form part of an ongoing quality plan.

Resources

Auckland Regional Migrant Resource Centre. URL: www.arms-mrc.org.nz

Cultural diversity tables. URL: www.stats.govt.nz

Ethnic Communities and Disability: How to communicate with a person from a certain culture with a particular disability. URL: www.mdaa.org.au/ethnic

Office for Disability Issues. URL: www.odi.govt.nz

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8 NASC Organisation and Culture

Disability supports are immersed in the philosophies that rationalise the respectful inclusion of disabled people into the community.

In this enormous task, NASCs play a pivotal role around entry to services. It is essential therefore that all NASC staff know and support these philosophies. NASC staff are drawn from a variety of backgrounds and some may be challenged in accepting the social model of disability and practising within that paradigm.

> The establishment of a philosophy and values, and entrenching these into the organisational vision, mission and ethical framework in conjunction with disabled people, will significantly determine the culture of the NASC.

Inconsistent personal perspectives and practices can compromise the culture of the NASC, the success of the service and the satisfaction of disabled people. Philosophy and values therefore take on a greater importance in a NASC than in many other organisations.

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PHILOSOPHY OF DISABILITY SUPPORT

People working within a NASC need to be particularly aware of the diversity within the disabled community that arises from variation in impairment, socioeconomic status and capacity/capability. Also needed is an awareness of the importance of family/whānau and/or carers in the lives of some disabled people.

It is expected that the NASC will have ways of ensuring that service users are involved in the organisation's work in relation to both the quality and their experience of the service.

The NASC organisation must ensure that disabled people have control over their own lives. Support options should be flexible, responsive and needs based. They must focus on the person and, where relevant, their family and whānau. They must enable people to make real decisions about their own lives.

NASCs are seen to be in a position of responsibility, enabling access to needed services. They have a duty to be aware of this responsibility and to exercise it carefully, avoiding negative outcomes for the disabled person.

Models of Disability

Presently, in New Zealand, the disability sector strongly endorses the social model of disability. It is beneficial to briefly outline the different models of disability to show how thinking about disabled people in society has evolved over the last century.

Charity or Tragedy Model

The charity/tragedy model views disabled people as needing help because of their impairment. It moves away from traditionally harsher responses in which disabled people were sometimes totally unsupported. This model appears to be based on a perception that disabled people need continuous support and cannot think for themselves or cope on their own.

The Medical Model

The medical model focuses on the clinical needs of disabled people and their impairment. It sees them as 'sick' and as passive receivers of service.

This model has encouraged society to 'treat' disabled people in specialised facilities away from community life. Disabled people have therefore been excluded from mainstream society.

The Social Model

The social model is seen as a vehicle for political change and social justice for disabled people. It maintains that impairments are a normal part of humanity and that disabled people are oppressed because of the limitations or barriers existing in society. It suggests that the needs of disabled people are not fully taken into account in our social structure.

This model suggests the impairment is not in itself a problem even though there might be a need for a different set of living requirements. It is characterised by a strongly rights-based approach that recognises disabled people make a valuable contribution to society and do or can actively participate in society.

This model is increasingly recognised through international human rights law and legislation. The social model has been adopted by the *New Zealand Disability Strategy*, *Positive Ageing Strategy* and *Health of Older People Strategy*. Consistent with this model, these strategies recognise and acknowledge that:

- society should be fully inclusive
- society should value people and continually enhance their full participation
- older people should participate to their fullest ability in decisions about their health and wellbeing
- society should encourage people to age positively and be recognised as an integral part of families and communities.

The social model encourages people to continuously question ways of acting and thinking, to dispel commonly held myths and beliefs about impairment and disability and to formulate new ideas that become part of an enabling society.

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The social model will guide the NASC manager in developing a NASC that reflects the rights of the disabled person, that considers the power issues involved in the relationship between NASC and the disabled person and their family/whānau, and that develops a partnership with the disabled person. It acknowledges the expertise of the disabled person in knowing what they need most.

VALUES

The NASC manager should develop a framework of values that not only reflect the organisation's culture but are consistent with the *New Zealand Disability Strategy*, *Positive Ageing Strategy*, *He Korowai Oranga* and *The Pacific Health and Disability Action Plan* (PHDAP). These values will guide people who are working in the NASC organisation and so they are critically important.

The following discussion of values may increase understanding of their importance. One way to define values is as a:

> *Set of beliefs or standards that the organisation (organisational values) and its stakeholders (personal values) believe in and operate from. Organisational values are utilised to guide the day-to-day operations, serving as a linkage between Mission (present operations) and Vision (intended direction). Personal values are utilised to allow organisational members to understand how their own beliefs fit into the organisational values and its intended operations and direction. www.eglin.af.mil/*

It is important for an organisation to have its own set of values as this links members of the organisation and offers them a stance from which to work. The following is an example of an organisation's set of values or credo:

We believe our first responsibility is to disabled people, to carers, to mothers and fathers and whānau, to health professionals, educators and all others who access our services.

In meeting their needs everything we do must be of high quality, and of a professional standard.

We must constantly strive to provide excellent services.

We must be impartial, providing the disabled person with choice.

We will strive to meet the cultural needs of disabled people, applying the principles of the Treaty of Waitangi.

We are responsible to our employees, and volunteers, the people who work with us throughout the region. Everyone must be considered as an individual.

We must respect their dignity and recognise their merit. They must have a sense of security in their jobs. Compensation must be fair and adequate, and working conditions clean, orderly and safe.

We must be mindful of ways to help our employees fulfil their family responsibilities.

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Employees must feel free to make suggestions and complaints.

There must be equal opportunity for employment, development and advancement. We must provide competent management, and their actions must be just and ethical.

We are responsible to the communities in which we live and work.

We must be good citizens. We must encourage access to improvements, better health and education. We must maintain in good order the property we are privileged to use, protecting the environment and natural resources.

We must experiment with new ideas.

Research must be carried out and innovative programmes developed.

Reserves must be created to provide for adverse times.

When we operate according to these principles, our clients should realise a quality service. (LIFE Unlimited 1997)

This value base incorporates the needs of all stakeholders in this organisation – disabled and older people, employees, their families and society as a whole. It enables a process of teamwork and working for common goals. It is a unifying principle for the organisation.

VISION

A vision statement should be a short, succinct statement of what the organisation intends to become and to achieve at some point in the future. It describes aspirations (or dreams) for the future, without specifying the means that will be used to achieve those desired ends. It provides direction and purpose to the organisation.

MISSION

A mission statement should be a short and concise statement of the NASC's goals and priorities. It clarifies what the NASC is or is striving to become. It does not state what the NASC should do in order to survive but rather what it chooses to do in order to thrive.

The value of a mission statement is that it:

- reminds staff of their basic overriding purpose, it should contain a formulation of the NASC's objectives that enables progress towards them to be measured.
- helps distinguish the NASC from others, it should be exciting and inspiring and differentiate it from other NASCs.

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ETHICS

Ethics are the moral principles or beliefs about what is right and wrong which guide our actions.

The purpose of a code of ethics is to establish and maintain standards of professional conduct for NASC staff. It is imperative to be guided by a core set of values and ethics when working with people and particularly when there are perceived power issues in that relationship. Many disabled people believe that a NASC employee has the power to grant or withdraw services that are needed. They might feel they do not have the 'power' to express their needs openly. It is therefore essential when working with people that the NASC manager and staff are alert to their style of interaction as well as their use of language. This could be an initial step in forming a more collaborative relationship with all people.

Ethics have been defined as:

'The practice of applying a code of conduct based on moral principles to day-to-day actions to balance what is fair to individuals or organisations and what is right for society.'

American Society for Quality. 2005. Glossary. URL: www.asq.org/info/glossary/e.html

The Ministry of Health has developed a set of principles to underpin the *Standards for Needs Assessment for People with Disabilities* (1994b).

1. Participation of community members and groups will support the development of NASC services that are flexible, easy to have access to, and responsive to the community they serve.
2. Disabled people will be assessed through a process that is co-co-ordinated, culturally safe, flexible and responsive to the specific needs of people and their caregivers.
3. The NASC will uphold the rights of people to informed decision-making and independent expression, and will treat them with dignity and consideration. The person, their family/whānau and caregivers will be respected for their knowledge and experience of disability.
4. People undertaking NASC activity will be competent, knowledgeable about the disabilities of people they assess, respectful of disabled people, their family/ whānau and caregivers, and acceptable to the person being assessed.
5. Communicating information regarding all aspects of the NASC process will promote self determination and choice for disabled people. This will include information about their individual rights and obligations throughout the assessment process, and the availability or choice of assessment services.
6. People will have access to information arising from their assessment. Their privacy and confidentiality will be safeguarded.

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7. The self-determination and choice of disabled people and their caregivers will be promoted by NASC processes that incorporates their views and goals, and that produces an accurate summary of their needs as the basis for informed service planning and choice of services.

These principles can help guide NASCs in formulating their own code of ethics and practice. In developing a code of ethics, the following would be considered a positive starting point.

Suggested Code of Ethics

Any code of ethics should be developed in conjunction with disabled people, considering the Treaty of Waitangi, the appropriate disability strategies and cultural influences. The Treaty of Waitangi sets out the basis for respect between the indigenous people (mana whenua or Māori) and others (Tauiwi).

The following might be considered as possible guidelines in developing a code of ethics.

Respect for the Worth and Dignity of All People

Each person should be positively valued in their own right; be shown respect, dignity and sensitivity; and have their rights and welfare guarded.

Respect includes being sensitive to cultural and social differences such as through the acknowledgement of difference in culture, nationality, ethnicity, colour, race, religion, gender, marital status, sexual orientation, physical or mental abilities, age, socioeconomic status and/or any other personal characteristics, conditions or status.

It implies that the NASC manager should learn about and take account of the diverse cultural and social contexts and practices of people with whom we work.

Right to Self-determination

Respect for every person's autonomy should be accorded by acknowledging the person's role and by sharing power and decision-making. This implies giving people the opportunity to make choices in defining their needs, in choosing their service providers and so on.

Accountability

Accountability should be shown to people who are being assessed, service users, employers, colleagues, funders and society. In addition NASC employees should be accountable for their own work. This implies that the NASC manager should promote and maintain high standards of practice at all times. This might be done through peer review, case management reviews, supervision and other supportive measures.

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Confidentiality

Every person has the right to privacy and confidentiality. People share privileged information with needs assessment facilitators and service co-ordinators, so need to be assured that they are safe when sharing information. Confidentiality should be respected at all times except when there is clear and imminent danger to the person or others at which time the person should be informed of those limits.

Commitment to People

People should not be abused in the professional relationship for personal, professional, political, financial or sexual gain. The NASC manager must set clear boundaries for the assessment/service co-ordination relationship as well as for any other relationship within the organisation.

Informed Consent

The person needs to be fully informed and understand what the needs assessment and service co-ordination involves. There should be no pressure for the person to give consent to disclose information. The person should be respected if they refuse to give consent or withdraw consent.

Competence

Every person should be assured of the competence of the needs assessment facilitator and service co-ordinator. The NASC manager must support staff to attain and maintain the highest level of knowledge and skills needed to practise as a needs assessment facilitator or service co-ordinator. Needs assessment facilitators and service co-ordinators should aspire to contribute to the knowledge base of the work. They should work and represent themselves as competent only within the boundaries of their education, training, supervised experience or other relevant professional experience. They should not provide a 'diagnosis' or attempt counselling. The NASC manager, needs assessment facilitators and service co-ordinators should be aware of their limitations and not attempt to work outside of these limitations.

The NASC manager should be responsible for continuing their own educational and professional development. This might include attending seminars and workshops, reading research articles, presenting training courses for others, contacting and visiting specialist organisations, and/or being involved in some cross-cultural programme or experience at least once a year. It is useful to keep a record of all educational activities undertaken each year by and for all staff.

Conflicts of Interest

The NASC manager should be aware of their personal values and the ways in which these might impact on their work. Dual (professional and social) relationships can either enhance professional relationships or present a conflict of interest. Such potential or actual relationships should be declared. An established process should be established to determine any conflict of interest.

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Conflict of interest may also be identified while performing one of the roles of the NASC such as selecting a provider. The NASC should have in place a process where such conflict can be identified or declared and recorded. This process might take the form of a Conflict of Interest Register. A process to manage this conflict of interest needs to be developed and implemented.

Dealing with an Ethical Dilemma

There may be instances where a NASC manager is faced with needing to make a decision for which the available alternatives challenge their ethical thinking. To assist in selecting the best alternative, the manager needs to consider the advantages and disadvantages of all alternatives. Such consideration would reflect a number of perspectives including contractual, practicality, financial and ethical.

The NASC manager must ensure the selected alternative is ethical and will not cause harm. To support this, it is essential that the manager has all the information that is available. Complete information is one of the keys to ethical decision-making. Additionally, the potential effects and consequences of each alternative must be considered.

Once the decision has been made and implemented, it is useful learning for the NASC manager to analyse the decision and any subsequent consequences so as to learn from the experience. The manager needs to ensure all staff have clarity, competence and supported processes for ethical decision-making. There should be regular opportunities for review of the effectiveness of the agreed processes and outcomes.

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A useful model of decision-making to authenticate a decision is outlined by Corey et al (1988).

This involves:

1. asking what the ethical dilemma is – is the dilemma legal, ethical and/or moral?
2. outlining the issues involved
3. referring to a code of ethics
4. seeking advice and/or supervision
5. outlining possible courses of action and their consequences
6. choosing the best course of action and being able to stand by it.

In addition, once the best course of action is chosen, the following should be considered:

- universality – the ability to recommend the chosen course of action in all situations
- publicity – the ability to explain the chosen course of action to others, such as colleagues, supervisor and the media
- justice – the ability to take the same course of action for all people in a similar situation and regardless of their influence in the community (Bond 1993).

Resource

Bond T. 1993. Ethical problem solving.

DEVELOPING NASC VALUES AND ETHICS

Disability strategies such as the *New Zealand Disability Strategy*, *Positive Ageing Strategy*, *He Korowai Oranga*, *Pacific Health and Disability Action Plan* reinforce the Government's drive to promote the value and participation of all people. These strategies should be the basis of a NASC's values and ethics.

In society, many groups face barriers in achieving the lifestyle that others take for granted. The Government, through these strategies, acknowledges the skills, knowledge and experience of people in such groups as a way of enhancing the individual concerned, the community and the country as a whole.

The *New Zealand Disability Strategy* (Minister for Disability Issues 2001), for example**,** fundamentally challenges the NASC to '*make a world of difference*'. The NASC manager has the ability to respond to this by developing a service that supports the implementation of the NZDS objectives. The focus should especially be on the objectives of ensuring the rights of disabled people, fostering leadership by disabled people, creating long-term support solutions centred on the individual, supporting quality living in the community, supporting lifestyle choices and promoting the participation of disabled Māori, Pacific peoples and disabled women, plus valuing families, whānau and people providing ongoing support.

The other key government strategies identified above are designed to promote the value and participation of all disabled and older people in our communities.

These strategies alert NASCs to the importance of being astute to the needs of the people with whom they are working as well as looking at ways in which NASCs can enable these people to be active members of and participants in society.

These strategies support the ideas of respecting difference in people and honouring the ways in which each member of the community can make a viable contribution to a better New Zealand. They have led society to question long-held ideas around disability which, although well-meaning, have not always allowed people the opportunity to be accepted and valued as part of society.

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Implementing Values Internally

Integration is as important inside the NASC as outside. Internally, the NASC manager must promote a team-based approach in which all members of the team receive core training that promotes learning about disability and the technical aspects of their job. There should also be opportunities for staff to reflect and learn about themselves, their attitudes and beliefs, the position of potential power they are in and the effect this may have on the disabled person. Staff should feel valued in their role as well as be able to value the disabled people with whom they work.

Processes within the NASC should be so smooth that the people with whom they work are not bothered by internal frictions and differences.

Embedding Values In Plans

The vision and mission or purpose statements of an organisation should provide direction and purpose to the organisation and clearly reflect the values of the organisation as well as the intent of the contract, key government strategies and the NASC's self determination. Ends or outcome statements should identify what difference the organisation should make in the lives of disabled people.

These overarching statements, normally included in strategic plans, should be clarifying and energising for all staff and stakeholders.

ESTABLISHING A CULTURE OF LEARNING

Staff contributions determine service quality. The professional development of staff towards best practice will be enhanced through ongoing training, supervision and teamwork. The NASC manager should undertake a training needs analysis to ascertain the training needs of the staff as well as their own training needs. An organisational training plan should be incorporated in the business plan and be linked to the individual's training plan through performance appraisals. The organisation can indicate its commitment to training in budget allocations.

Training should be appropriate. It should not be related only to non-performance, management problems or resource problems. In line with the organisation's values regarding disabled people, training should be linked to the knowledge, skills and values of the team. Outcomes of training should improve service standards, reduce errors and waste, increase teamwork, enhance productivity and build desirable attitudes. Training should help staff feel proud of the organisation for which they are working. It should be planned in such a way that it is enhancing skills or filling knowledge gaps for staff. This supports a value-based NASC.

The organisational training plan would include:

- **knowledge that all staff need** – an overall perspective of the organisation including the vision, mission, values and goals of the organisation, its processes and culture. Induction to an organisation is part of this training process
- **knowledge that needs assessment facilitators and service co-ordinators need** – this would include both knowledge- and skills-based training as the staff must deliver services to a uniformly high standard
- **knowledge that the NASC manager needs** – there will be specific areas where the manager can improve their performance. There are a variety of sources for management training and key NASC activities also need to be learned
- **knowledge that a specific individual needs** – during the course of employment with a NASC organisation a staff member might indicate that an individual training issue that needs attention.

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The manager should consider linking up with other NASC managers to share trainer costs and ideas. Alternatively, NASCA or the District Health Board might offer advice on accessing training.

Recommendations for Training for Needs Assessment Facilitators and Service Co-ordinators

People First New Zealand is a national organisation run for and by people with an intellectual or learning disability. The table below is included to inform the NASC manager of People First's training recommendations as well as provide an example of the value to be gained when disabled people have the opportunity to contribute their expertise to the NASC.

Plain English Ideas	**Detailed Ideas**
It is important that staff	**It is important and ideal that**
• Are polite • Show respect • Are positive	NASC staff are positive and polite at all times in their role when interacting with people with intellectual disability.
Communicate really well	NASC staff have exceptional communication skills.
Are well trained It is best if they are trained in intellectual disability	NASC staff have the appropriate background and training for the job, that is NZQA or tertiary qualifications and experience in the field of disability, preferably intellectual disability.
Have very good listening skills Don't interrupt – people need time to think and to work out their answers	NASC staff have very good listening skills and are patient, able to refrain from interrupting when a person is taking time to think or respond to ideas or thoughts.
Don't hurry people Know that people need time to do things at their own pace	NASC staff know that it is important never to rush a person through an assessment as people with intellectual disability need to feel that they are in charge of their own lives and not having them made to suit the professionals working with them.
Don't make quick decisions that people may not be able to do things People may be slower but they can learn new things	NASC staff need to try at all times to be non-judgmental or jump to conclusions about what people with intellectual disability are capable of. They need to be able to understand that although they are sometimes slower in achieving things, people with intellectual disability are able to progress and develop skills and achieve things.
Need to know about human rights	NASC staff need to know human rights legislation very well and remember it in meetings.
Need to be good at solving problems Need to help people work out what they need Do not persuade people to fit in with others' ideas to make things easier for staff	NASC staff need to have problem solving skills to help people define what they want and need. They need to be on the person's side and not try to change things to make them fit what is convenient for others.

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Plain English Ideas	Detailed Ideas
Need to take people seriously We are all individuals Know that we are adults not children	NASC staff need to take people with intellectual disability seriously. Each person is an individual; one size of anything fits nobody. They are adults, not children.
When needed use pictures and signs to communicate	NASC staff need to have a range of communication aids to express ideas. Pictures and signing are useful for many people with intellectual disability.
Are honest and straight up and have a sense of fun too	NASC staff need to have integrity, be honest and have a sense of humour as well.
Support people to make choices even if they don't work out well Everyone needs to make mistakes to learn	NASC staff need to be supportive when people make choices that do not work out well. Sometimes everyone needs to make mistakes to learn.
Be on the side of the person they are assessing	NASC staff need to work for the person whose needs are being assessed.

Resource

People First New Zealand, PO Box 9199, Marion Square, Wellington
victoriast@xtra.co.nz

DEVELOPMENT OF FORMAL TRAINING PATHWAYS AND QUALIFICATIONS FOR NASC STAFF

The need for a formal and recognised training programme and qualifications for needs assessment facilitators and service co-ordinators has been long identified. While this need also exists outside NASC services, the impetus to develop training programmes originated within NASCA supported by the Ministry of Health.

Currently two levels of training need have been identified:

1. An undergraduate qualification for people entering the work of needs assessment and service co-ordination
2. A postgraduate qualification for those people holding a relevant graduate qualification and possessing significant relevant experience in needs assessment and service co-ordination.

With this in mind, at the time of writing, two programmes are in the early stages of development. No completion date has yet been set. As a first step, in conjunction with NASCA, Community Support Services Industry Training Organisation (CSSITO) has received approval and funding to develop an undergraduate programme. This work is in its infancy and will look at other relevant training and Recognition of Prior Learning.

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CSSITO's next task is to establish a Standards Setting Team (SST) to design the unit standards and the qualification package. The SST will work with about 15 stakeholder representatives to complete this work.

The Clinical Training Agency (CTA), a division of the Ministry of Health, has responsibility for the development of postgraduate clinical training courses in health and disability. It has been agreed that training for needs assessment and service co-ordination roles, potentially across a number of settings, meets the CTA criteria. Development of service specifications is the next step. There will be input from key stakeholders. A tender process for teaching of the course to the specifications would follow.

While these two training programmes will be developed separately, CSSITO and CTA have agreed to work in close co-operation with each other. An intersectoral perspective will be explored through the Interagency Group who is responsible for the intersectoral needs assessment and service co-ordination pilot programmes.

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ONGOING SUPPORT

Supervision

Supervision, mentoring and training are key to developing and retaining effective staff. External supervision acknowledges the intense, complex, personal and professional challenges that NASC staff, including the manager, face.

> Supervision provides opportunities for the facilitation of competence. It is usually delivered through a one to one relationship.
>
> Supervision may come in various forms: management supervision, professional supervision, cultural supervision, group supervision and peer supervision.
>
> Clinical and professional supervision should not be provided without training.

An important criterion is that supervision takes place on a regular basis. It should be pre-planned with an agenda for the session. Areas covered in supervision will include both work and personal issues:

- discussion of workloads
- discussion of caseloads
- analysis of specific case problems and assistance with solutions
- ensuring that the staff member's work style is consistent with the values of the NASC
- discussion of staff member's wellbeing and early identification of signs of professional burnout

- discussion of signs of 'capture' of disabled people, role confusion and issues that compromise professional service delivery
- ensuring that the staff member has access to other appropriate supervision including culturally appropriate supervision.

Wherever external supervision is being provided, there should be some clear agreement regarding:

- purpose of supervision
- frequency and duration of supervision
- procedures for monitoring and reporting back to the NASC
- payment.

> Supervision provides opportunity for self regulation, reflection, learning and the acquisition of new skills. There may be agreement on tasks to achieve or goals to be set. Supervision is a place where staff will be supported.

Cultural Supervision

Cultural supervision is appropriate if the NASC manager and the staff member are of different cultures. The staff may wish to have a supervisor who is a specialist in one particular skill area or a supervisor from the same or a local iwi.

Walsh-Tapiate and Webster (2004) outline the purpose of their cultural supervision as to:

- build a worker's knowledge of Māori cultural values
- provide a supportive context for kaimahi (worker) to manage complex cultural issues
- ensure safe practice and culturally appropriate behaviour
- enable kaimahi to be clear about roles, responsibilities and accountabilities
- define the parameters for cultural supervision as distinct from training and development or professional supervision
- promote professional development by building skills, knowledge, confidence and competence in understanding Māori attitudes and behaviours in an area of practice
- provide opportunities for the worker to appraise their responsibilities to Māori within their practice
- support kaimahi learning by linking practice to cultural knowledge.

The authors adapted this work from the Department of Corrections (2001).

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Peer Review

Staff with specific areas of expertise can be very helpful for their colleagues. They can discuss issues, share learning and review case problems as a team. They can support one another when they are presented with difficult or challenging situations.

Peer review may be a formal arrangement or an informal relationship. Whatever format is adopted, it is important that there is an agreed way of working. Peer review may occur either one to one or in a team.

Mentoring

> A mentor is an experienced individual who provides advice and potential opportunities to a less experienced individual and helps that person to learn specific skills or approaches.

A mentor can provide the NASC manager or key staff with a 'sounding board' for ideas and suggestions on issues from handling a tricky task and dealing with conflict, to what training to access. A mentor is expected to be impartial and professional.

Mentoring provides a positive environment for personal growth and development, thus enhancing the individual and their capacity to do the job they are employed to do.

Mentoring by Disabled People

> Newer managers might be mentored by disabled mentors. This practice will promote the principles of the *New Zealand Disability Strategy*.

The benefit of this type of mentoring is that it sets up a personal and safe relationship with a person who has first-hand experience of the issues facing the client group(s). It gives the manager a chance to talk frankly with someone 'in the know' about:

- service development ideas
- staff–disabled people relations
- responsiveness to disabled people
- involvement of disabled people
- awareness and sensitivity
- NZDS implementation
- professional development
- staff training and development strategies
- best practice
- the bigger picture.

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If you are a disabled or more experienced NASC manager, this relationship can be used as peer supervision to allow you to discuss the above issues as well as:

- institutional ableism or ageism
- collegial relations
- self care
- confronting attitudes and behaviour
- power dynamics.

Whether you are disabled, older, non-disabled or younger, you should spend time choosing a mentor/supervisor who suits you. The person should be someone with a professional qualification and with whom you feel safe to share and be challenged.

COMMUNICATIONS

Communication protocols promote professional and appropriate communication. They should include clear direction regarding use of email and the Internet, communication with the funders, use of standardised communication templates, external communications and the like.

Team meetings are ideally held once a week to serve a range of practical purposes including developing team identity, sharing information and knowledge, planning and team cohesiveness. These meetings also provide opportunity for team members to develop skills of facilitation and leadership.

Meeting formats should be established with clear, agreed objectives and a regular reminder of the commitment to excellent service.

Experience and knowledge may also be exchanged through sharing of journal articles, feedback from conferences, or the development of a Journal Club.

Teleconferencing and videoconferencing provide opportunity for shared communications between offices of a particular NASC and between NASCs. They may facilitate peer support activity.

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9 Manager's Role and Responsibilities

The NASC manager holds an exciting and challenging position upon which the effectiveness and efficiency of a NASC depend.

This role requires the manager to effectively interact with a variety of people and undertake a wide range of tasks. It is for people who are prepared to be leaders, to inform, involve and consult, to establish a workplace culture, to build networks and respond to opportunities, to make decisions and to think creatively; in short, to actively and skilfully manage the NASC organisation. The work is complex because it is in a sector that is constantly changing and has finite resources available.

As well as general management skills, for any manager to be truly effective they must possess a good working knowledge of the components of the activities they are contracted to provide. With an understanding of and practical experience in facilitating a needs assessment or developing a package of services to meet identified need the manager can better respond to the challenges their staff may face, to legitimately question practice habits and to support innovative thinking.

One of the most important goals for the NASC manager and staff is to provide service that disabled people desire within budget. Organisational performance, efficiency and effectiveness measure how well resources are utilised to satisfy customers and achieve goals.

The NASC manager needs to be constantly updated on new trends, new policies and new contracts, as well as be innovative in the ways of leading their employees. It is important that the manager recognises their personal aspirations, work style and leadership skills as well as attends to their own health and wellbeing.

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GOVERNANCE

In April 2000, a briefing paper to the Minister for Disability Issues suggested that each NASC should have its own governing body or board and that the governing body should have representatives from the disability community and iwi.

> The board is generally responsible for shaping the strategic intent of the organisation on behalf of its key stakeholders and/or owners. The NASC manager is responsible for leading the operational and strategic planning and implementation based on this strategic intent.

In general terms, governance can be seen as the 'hands off' process whereby the governing body ensures that the workplace is well managed and led without doing the managing or leading within the workplace itself. Governance is primarily concerned with outcomes or ends. On the other hand, management is the 'hands on' day to day process of carrying out the policies and plans of the workplace in order to achieve the planned outcomes. Management, while concerned with the outcomes, is primarily concerned with the operational means.

BoardWorks International (1998) published the following comparison between strategic and operational thinking.

A Comparison of Strategic and Operational Thinking

Strategic Thinking	**Operational Thinking**
Longer term	Immediate term
Conceptual	Concrete
Reflective/Learning	Action/Doing
Identification of key issues and opportunities	Resolution of existing performance problems
Breaking new ground	Routine/ongoing
'Hands off' approach	'Hands on' approach
'Helicopter' perspective	'On the ground' perspective

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The BoardWorks website is listed in the resources at the end of this section. In addition, this organisation issues a journal six times a year with short readable articles on various aspects of governance.

The NASC manager would usually report to the governance body on a regular basis reflecting the current NASC environment and any possible threats to the organisation. The type of information needed for governance purposes tends to include:

- significant financial trends
- external environmental changes such as government policy changes
- compliance and non-compliance with governance policy
- serious legal conflict or dispute
- significant communication issues internally or externally
- new contract development
- staff appointments, staff leaving, staff training
- internal environmental change such as new programmes
- changes in the strategic plan.

This information ensures that the employer or governing body is fully informed in undertaking their role of holding the NASC manager accountable for achieving outcomes.

Ongoing monitoring and evaluation of the effectiveness of the NASC manager's practice should occur with at least an annual appraisal. Regular supervision in addition to board meetings that address progress of the organisation's plans and budgets are also recommended.

Retaining governance and operational management as separate functions is highly desirable. Whatever governance models are chosen by the organisation, it is vital that role definitions of the board and management are clear to avoid confusion and conflict.

Resources

BoardWorks International. URL: www.boardworksinternational.com

Carver J, Carver M. 2001. Carver's policy governance model in non-profit organizations. URL: www.carvergovernance.com/pg-np.htm

Gottlieb H. 2005. Board accountability: A model for community-driven governance. URL: www.help4nonprofits.com/NP_Bd_WhyBoardsExist_Art.htm

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KEY TASKS OF THE NASC MANAGER

Management and Leadership: An Overview

In regard to overall management and leadership, the NASC manager's key tasks are to:

- manage and lead the organisation to meet its contractual obligations
- lead the organisation with clarity based on an organisationally developed vision and mission, and goals
- maximise organisational efficiency and responsiveness
- manage the NASC in an ethical manner
- demonstrate a commitment to the implementation of the NZDS and other government strategies
- develop a culturally responsive and competent service especially with Māori, Pacific and other populations
- financially manage the budget and develop associated systems and information management
- identify or create, plan and strategically manage opportunities for the NASC
- analyse population trends and characteristics to increase NASC responsiveness
- manage and utilise information systems
- establish a quality system in the NASC
- actively involve disabled people in the organisation to help shape and develop the culture.

Management of NASC Staff

In managing NASC staff specifically, the NASC manager's key tasks are to:

- develop a clear organisational structure within the NASC
- recruit, supervise and support staff to maximise their diversity, skills and abilities
- develop a culture of shared enthusiasm for and commitment to the NASC's work
- identify and enable ongoing development of NASC specific core competencies
- identify and enable ongoing development of NASC specific cultural competencies
- have NASC practice and protocols implemented in the work practice
- maximise training opportunities for all NASC staff within a regularly reviewed training plan
- foster qualities of innovation and creativity
- develop a workforce that strives to reach the organisation's goals and vision
- have implemented a responsive health and safety policy.

Working Relationship with the Ministry of Health

In their working relationship with the Ministry, the NASC manager's key tasks are to:

- establish and foster a professional relationship with the DSD particularly the Service Manager
- meet all reporting requirements as per the Ministry/NASC contract.

Stakeholder Relationships

In their working relationships with stakeholders, the NASC manager's key tasks are to:

- identify, develop and foster professional and effective working relationships with key stakeholders
- establish clear communication systems with all stakeholders.

Self Care

In regard to self care, the NASC manager's key task is to:

- acknowledge this role can be challenging and so identify and adopt strategies to retain their physical, mental, emotional and spiritual wellbeing.

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Leadership

The NASC manager must provide an overall perspective and effective management and leadership of the NASC team. A manager's task is multi-layered and multi-skilled, providing strategic direction as well as expectations about how these directions can best be achieved. Leadership needs to be associated with the ability to motivate other people to be part of that direction, meeting the requirements of their parent body, the Ministry/NASC contract and disabled people as well as promote the values and principles of the *New Zealand Disability Strategy*, *He Korowai Oranga* and *Pacific Health and Disability Action Plan*.

> The NASC manager has to be both an innovator and an operational thinker, seeking innovative concepts to continually improve the NASC and the processes it uses. This role includes encouraging new ideas presented by recipients of the service, service providers, funders and staff. The NASC manager is the major link between these parties and needs to be innovative in identifying new ways of working.

Key responsibilities are as follows.

- Ensure that the functions of the service are managed effectively, efficiently, coherently, equitably and economically in line with the organisational strategic or business plan. This responsibility involves attending to a range of contracts/ agreements such as rental agreements, employment contracts, and contracts with funders, and Memorandums of Understanding.
- Provide active support and supervision of the work of administration support staff, needs assessment facilitators and service co-ordinators to ensure the efficient and effective provision of service. Services should demonstrate a person centred and innovative approach, and be of the highest standard.
- Initiate and respond to feedback from the recipients and funders of the service.
- Provide co-ordinated information and assistance to disabled people, staff, Ministry of Health, District Health Boards, stakeholders and providers. To fulfil this responsibility, the NASC manager must be sure that information is clear and that they know the expectations of all stakeholders. The manager needs to be familiar with the contracts between the NASC and the stakeholders. This knowledge can be shared with staff through team meetings, memos and so on.
- Ensure that, wherever possible, disabled or older Māori are offered a Māori needs assessment facilitator/service co-ordinator; and that disabled or older Pacific peoples are offered the opportunity to have a Pacific needs assessment facilitator/ service co-ordinator. If staff have to work cross-culturally, intensive training should be provided for those staff to develop a thorough understanding of structures, beliefs and values of the culture with which they are working.

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- Ensure that staff have a comprehensive understanding of the range of services in the area that can be used for the purposes of referral, consultation and service provision. This includes:
  - non-government funded services such as community services – budget support, service clubs, transport options etc;
  - government funded services such as specialist disability services, home support providers, residential care providers, and culturally based services.
- Adhere to the NASC systems, policies and resources in place and informing the governing body of NASC contractual agreements.
- Ensure that appropriate and effective administration and financial systems are in place.
- Ensure that all policies and procedures developed are in line with any legislation requirements such as the Human Rights Act 1993, the Privacy Act 1993, the Health and Safety in Employment Act 1992.

Organisational Planning

The NASC manager should develop and regularly review the following key documents of the NASC:

- strategic plan – identifying the NASC's purpose and vision, outcomes, service users or beneficiaries; analysing trends in the external environment and how well the organisation is equipped to achieve the outcomes desired. A number of responses to key future uncertainties will increase the NASC's resilience to risk
- operational plan – detailing how the organisation will achieve its outcomes; allocating financial and human resources and timeframes over a designated period with a comprehensive budget
- quality plan – identifying quality levels and the tools to measure achievement.

All these plans are useful to inspire, unite and guide the organisation on its path as well as to support the process of seeking financial and other assistance from other organisations.

Disabled people and staff should be closely involved in developing these plans. Key stakeholders might also appreciate the opportunity to provide input.

The active involvement of the NASC team in planning will reap dividends for the manager. When people are involved there is a greater sense of ownership and responsibility for actions. Additionally, as the staff are the people at the 'coalface', they have a realistic understanding of the environment in which the NASC services are delivered and so act as a reality check.

Fiscal Responsibilities

The NASC manager has two areas of fiscal responsibility:

- financial planning and management of the NASC organisation itself including its operational budget

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- budget management of the indicative budget for DSS on behalf of DSD.

Financial Management

Financial responsibilities will include:

- preparing budget forecasts prior to the start of the financial year
- budget management
- explaining variances on financial reports
- ensuring financial systems, budgeting and asset management are in place and operating efficiently.

Budget Management

> *The NASC is to ensure access to priority services for the population of disabled people within the contracted geographic area, and that commitments made to purchase service packages for people are such that they will not exceed the indicative budget for current and out years.* Ministry of Health (2005)

The aim of budget management is to effectively manage available resources in a way that balances value for disabled people with the Government's need to achieve value for money for the population. This involves managing cost-effective packages of services within an indicative budget, as determined by the funder, for the identified NASC population.

As from July 2004, indicative budgets and utilisation data have been provided by the Ministry of Health to DSD-funded NASCs.

Each NASC organisation may approach this requirement differently. The approach will reflect the size of the NASC, the NASC model and the organisational requirements.

Responsibilities include:

- overall management, planning and monitoring of the utilisation levels of a specific budget
- promoting and arranging innovative and flexible client-focused service packages
- promoting consistent and equitable outcomes for disabled people
- ensuring resources also foster interdependence within and between communities
- fairly prioritising and allocating resources to clients across client populations.

What does a NASC manager need to know?

A NASC manager should:

- have a historical overview and knowledge of what has gone before as this contributes to the understanding of what exists today

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- understand service provider contracts, which will result in realistic expectations, clearer lines of communication and an appreciation of the provider sector
- know about service specification development and contractual requirements and processes
- understand accounting basics and systems, including reading, understanding and creating financial reports, budgeting, cash flows, forecasted projections
- appreciate the usefulness of information regarding the location's demographics such as growth in child and youth populations, deprivation status of communities, and growth in the older population, as this will assist in informing and planning NASC services
- know budget levels for all services including home based support and Discretionary Funding
- know guidelines for funding levels such as Support Package Allocation and responsibilities regarding packages outside the levels
- be familiar with level of authority – that is, at what level of funding the Ministry of Health must be involved
- be familiar with Ministry of Health Guidelines including all those concerning NASC responsibilities such as definitions of carers; criteria for Individualised Funding and Discretionary Funding
- know responsibilities and protocols regarding service development to respond to identified gap in access, or services available to clients
- be familiar with any relevant legislation and how this may impact not only the client accessing services but also the NASC ability to respond to this need, for example:
  - benefits – what is available to whom and the implications of this
  - superannuation policies
  - Protection of Personal Property Rights
  - CYFS, Children, Young Persons and Their Families Act 1989
  - Health and Disability Services (Safety) Act 2001
  - Privacy Act 1993
  - legislative responsibilities in regard to holidays and other employment matters.
- know and apply the principles of risk management, including in regard to political and media interest, security of information technology
- be familiar with quality Improvement protocols
- manage access to facilitated needs assessment and/or service co-ordination.
- know how to develop and manage wait lists if the need arises
- know the reporting requirements of both the Ministry of Health and NASC, including identification of budget risk and both positive and negative trends
- know and apply the principles of budget development, reporting and maintenance
- develop a database to report budget projected and actual expenditure, ensuring databases capture all lines of information that may be required to be reported on to parent organisation or funder or be able to access information management support to do so.

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Additional responsibilities to the NASC Organisation's Owner

The NASC manager is also responsible for:

- knowing all organisational policies particularly in relation to delegation of authority
- strategically seeking new services and contracts to enhance outcomes for disabled people, to support the organisation's business and/or strategic plan, and to enhance the organisation's profile.

Resource

New Zealand Institute of Management. URL: www.nzim.co.nz

Staff Management

The NASC manager ensures that staff management and professional development needs are negotiated within budget and add value to the organisation's services. This area of management involves all the activities related to the recruitment, hiring, training, promotion, retention, support and dismissing of staff. The following list includes some of the tasks in this category.

- Manage and motivate staff so that they have a clear understanding of the expectations and goals of the organisation, gain knowledge of the service, provide the best service at all levels of the organisation and respect their own and their colleagues' contribution to the NASC.
- Ensure that services are provided in a culturally appropriate manner by providing staff training and development to meet requirements.
- Ensure staff receive appropriate training and support. This includes facilitating training needs analyses and ensuring the delivery of ongoing staff training. Staff could be allowed time to develop networks and to reciprocate by participating in the community. Staff might be encouraged to be accountable for this time through feedback at staff meetings as a form of information sharing.
- Ensure yearly appraisals of staff performance are carried out and analysed, and staff receive comprehensive feedback. The NASC manager should facilitate staff development plans and undertake ongoing performance management, which indicates staff training and development needs as well as areas where a staff member's specific skills or expertise could be used.
- Address non-performance issues and issues requiring disciplinary action. The manager should follow organisational requirements and be guided by internal processes and procedures.
- Ensure the organisation meets its statutory requirements and any internal policy requirements. These requirements include those set out under Employee Assistance Programmes, Employment Relations Act 2000, Occupational Safety and Health (OSH) and so on.

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Recruiting Staff

The Human Rights Act 1993 has a direct impact on the area of employing staff. The Act requires that the selection process does not unlawfully discriminate against applicants under any of the prohibited grounds of discrimination set out in the Act. The Fair Trading Act 1986 requires that the position being advertised should be accurately described. If either of these conditions are breached, the employer can be exposed to personal grievance claims.

In recruiting staff, the NASC manager considers the following issues.

- It is beneficial that the team represents the local community and the target population. When employing staff a major consideration is the ethnic and cultural composition of the team as a whole.
- It is essential that recruitment procedures are culturally unbiased and comply with legislation requirements.
- It is useful that a mix of appropriately skilled and experienced staff is recruited. This commitment may be reflected in the recruitment of needs assessment facilitators from complementary organisations, thus providing a specialised knowledge base for facilitated needs assessment. Such expertise may be provided on a fee for service basis.
- There should be acknowledgement that a second language is a competency.
- It is useful to seek staff who have skills to share information and provide the best support from the perspective of a disabled person and/or older person and/or a particular culture.
- It is beneficial to have representation of disabled people on the selection panel.

Knowledge Base of Needs Assessment Facilitators and Service Co-ordinators

Needs assessment facilitators and service co-ordinators should have:

- knowledge of the models of disability
- knowledge of disabilities and/or the ageing process
- knowledge of the needs of disabled and older people
- knowledge and understanding of the roles, responsibilities and importance of carers, family and whānau
- knowledge of the values underpinning the *New Zealand Disability Strategy*, *Health of Older People Strategy*, *He Korowai Oranga* and *Pacific Health and Disability Action Plan* (PHDAP)
- knowledge and understanding of Māori societal and familial structures, including whānau, hapū, iwi and the dynamics of whanaungatanga
- knowledge and understanding of the range of Pacific societal and familial structures
- knowledge of safety issues including safety of the disabled person and worker safety
- experience in working with people from a range of cultural backgrounds in the community

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- knowledge of the local community
- knowledge of the NASC philosophy and intent
- knowledge of NASC protocols and practice
- knowledge of contractual requirements eg, eligibility, timeframes, informed consent
- knowledge of disability support services.

Skills of Needs Assessment Facilitators

Needs assessment facilitators should have skills in:

- communication and interpersonal relations – building and establishing rapport, active listening skills, questioning skills that empower the disabled person to respond with confidence
- being adaptable and responsive to the needs of disabled people
- taking an approach that is person centred and directed
- facilitation
- maintaining a strengths-based focus
- working cross-culturally
- documentation – accuracy, specific and clear reporting
- initiating, co-ordinating and managing groups and intersectoral meetings.

Skills of Service Co-ordinators

Service co-ordinators should have skills in:

- taking an approach that is person centred and directed
- facilitation
- innovative and creative problem-solving
- negotiation
- communication and interpersonal relations
- community networking – this skill should be especially well developed
- managing resource allocation for the population
- working cross-culturally
- initiating, co-ordinating and managing intersectoral meetings.

Service co-ordinators also need knowledge of DHB resource including referral protocols.

Resource

Foster S. 2002. *An Analysis of the Skills and Knowledge Base for Needs Assessment and Service Co-ordination*. Unpublished Masters Thesis.

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Knowledge Base of Administration Support Staff

Frequently the first contact the disabled person has with a NASC is with a member of the administration support team. Consequently it is crucial that members of this team also receive excellent induction and training and have a fundamental understanding of issues relating to disability and older people.

An effective and through induction to the NASC for administration support staff will promote an understanding of the NASC process and the values underpinning the organisation. Key issues that require attention in the induction process include:

- knowledge of the role and functions of the NASC
- knowledge of key performance indicators for the NASC
- Ministry of Health eligibility criteria
- terminology associated with the sector
- DHB structure and terminology
- DSD-contracted services and what they offer
- knowledge of other disability support services in the area
- key staff in associated organisations
- computer system of the NASC
- NASC database
- working cross-culturally
- office systems
- health and safety requirements.

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Motivating and Retaining Staff

Staff work more effectively in an environment where they feel valued, respected and motivated. Their greater effectiveness will result in better outcomes for clients, higher productivity and a stronger capacity to retain staff. The manager can encourage team building by involving staff in planning, encouraging and acknowledging staff input, sharing the outcomes of service evaluations, encouraging staff to attend and speak at meetings and conferences, and promoting career development. It is more likely that staff will be retained if they are set realistic expectations in a dynamic work environment where they can feel safe to discuss their concerns. Staff should be encouraged to prioritise and set boundaries in their work. The manager should be alert to any signs of burnout and should address these immediately.

Health and Safety Obligations

Organisations are legally obliged to create and maintain a safe work environment for their workers. For DHBs, this work will be the responsibility of clearly defined individuals. The NASC manager is responsible for keeping up to date on organisational health and safety policies and processes and for ensuring they are implemented within the NASC organisation.

There are several significant risks to NASC workers. The safety of staff working in the community poses a challenge as they are often visiting people who are not

known to them or the NASC. Additionally the management of information, both handwritten and entered via a keyboard, brings the risk of occupational overuse.

The Occupational Safety and Health website offers much useful advice and guidance. The incorporation of strategies to promote and maintain a safe work environment must be emphasised in the initial induction of NASC staff and through ongoing development.

Resource

Occupational Safety and Health. URL: www.osh.dol.govt.nz

Strategic Communication

A successful NASC manager ensures that the value and importance of NASC services are clearly understood and effectively communicated within the disability sector, with key stakeholders, and with the media. The manager also keeps up to date with developments in the sector.

Public communications can be particularity sensitive and require robust peer review to ensure that the information is not open to misinterpretation, is positively presented and is pitched appropriately for the anticipated audience.

Communication strategies and protocols should be established, with key stakeholders and staff defining communication lines and limitations. This process involves establishing and encouraging effective internal and external communication systems. Examples include:

- establishment of a regular meeting schedule with the DSD Service Manager
- establishment of regular communication with the disability sector, the general public and the media, possibly through meetings, telephone calls, email, informal discussions or formal protocols
- development of information resources on NASC services. While these communications are usually written with the cognitively intact or intellectually able in mind, it is important to consider the wider audience and how NASC communications reflect the role and needs of others outside the usual target group.

Much of the documentation regarding disabled people is written specifically for those people who are not significantly cognitively impaired, and where it is totally appropriate and essential that they be in control of their own lives.

There appears to be a trend for standards and documentation designed for disabled people to be written exclusively for those people who are cognitively able. As my adult daughter's carer, I believe that I have an invaluable understanding and knowledge of her as a person that should be respected and utilised. This includes acknowledgement of the role I play in her life.

The critical role that carers play in the lives of those people who lack the necessary understanding and knowledge to make informed decisions is beginning to be

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appreciated. This increasing understanding now needs to be demonstrated in written communications from organisations including the NASC.

Parent and carer

DSD has provided resource that is designed to support the NASC in communicating clear and consistent information to disabled people. This information should be provided to all staff and the importance of nationally consistent communication to disabled people should be reinforced by the NASC manager.

Resources

Volume 2 Appendices

- Appendix 9: DSD Mandatory Communication Tools
- Appendix 10: DSD NASC Fact Sheet
- Appendix 11: DSD Service Users' Frequently Asked Questions

WriteGroup. Write training. URL: http://www.write.co.nz/training/index.htlm

'What did you Say?' Available from info@ccs.org.nz

Key Linkages

The NASC is reliant on constructive and trusting relationships with a range of agencies in order to do its job. Relationship building and networking are therefore critical and continuous processes. The NASC manager and staff need to communicate frequently with disabled people, service providers, funders, community support groups and so on. There are situations in which the external expertise is needed in order to provide the best service. If networking and relationship building have been taking place, the NASC can be assured that the necessary support will be available for disabled people in these situations.

Listening is as important as telling in these relationships. When people know that they are heard, they will more easily develop a rapport and relationship with the NASC. Following through on commitments, respecting confidentiality and demonstrating an interest in people's work-related issues also enhances relationship building and networking.

Strong linkages will support a mechanism to gain the input of disabled people and their communities. Input from all sectors can be gained, for example, in establishing service user groups, employing a disability advisor, and/or running community forums, focus groups and so on. Representation at governance level would reflect the NASC's responsiveness to its community.

Close linkages with Māori and Pacific communities will assist the NASC to configure the delivery of the service in a manner that best meets the needs of the community. Guidance may be provided by these communities with essential work such as the development of a culturally competent workforce. When networking with other cultures, remember to participate in that culture and ensure that there is reciprocity in the relationship. Many people feel that they are 'used' for their cultural knowledge

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and they need to be confident that the people and culture are respected and valued. The NASC manager and staff should be prepared to participate and share in the cultural events and community of Māori and Pacific peoples.

Migrant and refugee individuals and families have a network of support with which the NASC should link. Agencies such as Migrant Resource Centres provide many services that the NASC may find helpful in supporting disabled people. Such services include multilingual capacity, access to English courses, employment assistance and links to community groups and organisations.

It is important that the NASC manager considers and agrees how best to recompense disabled people who respond to a request to provide input to the NASC. Recompense may take the form of koha, taxi vouchers or may be subject to a formal contractual agreement. In addition, courtesies such as car parking and accessible facilities should be in place.

Memorandums of Understanding

For key agencies and providers, Memorandums of Understanding, agreed protocols and other mechanisms will guide how the relationship should be established and conducted.

A Memorandum of Understanding is a written agreement or document executed by two or more parties that establishes procedures of mutual interest.

It provides a general description of the responsibilities that are to be assumed by the parties in the pursuit of their goal(s).

It does not require either party to obligate funds and does not create a legally binding commitment.

For example:
http://fasteditapp.faa.gov/ams/do_action?do_action=ViewSection&sectionUID=FAA_1860&contentUID=3&contentVersion=3262&isDownload=NO&isFullDownload=NO&ShowRoots=YES

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Resource

Volume 2 Appendices

- Appendix 18: Memorandums of Understanding

Negotiation

The NASC manager will use negotiation skills in many areas of their work.

Negotiation is a process that should educate both parties about the other's needs and interests, resolve any potential conflict in these and reach an agreement that meets the needs of both parties without sacrificing either party's priorities.

Preparation for negotiation is essential. The NASC manager needs to have identified the objectives and the goals of the negotiation meeting and what outcome they wish to achieve. The collection and analysis of information relevant to the meeting will contribute to the identification of realistic and attainable outcomes.

Strong negotiators possess certain qualities including the ability to work effectively with others, patience, an open communication style and integrity.

Documentation of agreements and resolutions should form part of the process. This written record helps lessen the chance of outcomes being confused or misunderstood by meeting participants.

Taking Care of Yourself

The role of the NASC manager is not stress-free. However, the way in which a person relates to stress can make a significant difference to their health and wellbeing.

In November 2003, Janion Haywood, a New Zealand medical doctor, informally addressed a large group of employees. She defined physiological stress as anything to which you have to adapt. Adapting is not necessarily difficult; indeed, if we led a stress-free life, we would be dead. Janion Haywood suggested that people review the concept of 'healthy' stress. If stress can be viewed from a different perspective, it can be more easily managed. By seeing the word **healthy** as **heal – thy**, we move to healing our stress. When we view stress in this context it becomes more manageable and allows us to be in control of stress as opposed to stress being in control of us.

People sometimes find it difficult to recognise when they are stressed. Generally when people are stressed they find it difficult to cope or to sleep; they become irritable, tired, restless or withdrawn. They might not want to recognise that these symptoms can have an impact on their work.

While the management of a NASC is serious business, it is also important to have fun and make time for recreational activities outside of work. If the NASC manager is managing their self care well, it is much more likely that staff will too.

Moss (1996) suggests a number of work-based strategies for managing self care.

- Learn to say no when asked to take on additional duties – but do it tactfully.
- Delegate as many routine jobs as you can – try to find someone looking for extra work.
- Set realistic goals and objectives. Many people make the mistake of being too ambitious.
- Set priorities for the jobs you must do yourself. Write them down. Do the important ones first.
- Plan each day's work – either first thing each morning or just before you finish for the day. Allow time for interruptions and thinking.
- Try to complete what you have planned for each day. Don't take work home!

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- Make sure you allow time for coffee or tea breaks during the day. Don't work through your lunch time. Get away from your office – go for a brisk walk or a jog.

As stress and wellbeing can be caused by a number of factors, NASC managers should be applying a holistic approach not only towards disabled people but also towards themselves and their employees.

When the Executive of NASCA were asked what they would see as the most important aspects of a NASC manager's role, they identified the following points (which are not listed in any priority or any particular order). Specifically, a NASC manager needs to:

- have a commitment to disability and clear understanding of empowerment of disabled people
- have a commitment to staff management and workforce development in a complex environment
- implement the Board's (governance body) vision and mission
- take the vision intersectorally and support non-disabling attitudes
- develop and maintain relationships
- undertake innovative leadership and mentoring of the NASC team, holding together the vision and implementing the Ministry/NASC contract
- be a contract manager for/with the funder and maintain that role and relationship
- know relevant law and legislation
- be a role model
- be prepared for complexity and the need for flexibility and to work creatively within constraints.

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NEEDS ASSESSMENT AND SERVICE CO-ORDINATION ASSOCIATION

One of the key support agencies for NASC managers is the New Zealand Needs Assessment and Service Co-ordination Association. This 'not for profit' incorporated society, working within constitutional guidelines, is open to NASCs to join.

The mission statement of NASCA is 'to provide leadership and assistance of members to implement New Zealand's foundation document (Treaty of Waitangi) and the two sector documents, New Zealand Disability Strategy and Health of Older People Strategy to change New Zealand/Aotearoa from a disabling to a fully inclusive society'.

The key objective of NASCA is to form a vision for needs assessment and service co-ordination that:

- focuses on the process and outcomes of the NASC functions
- includes agreed standards to ensure the NASC functions are concentrated on the needs of disabled and older people and their family/whānau
- incorporates the NASC functions intersectorally.

Membership of NASCA enables members to attend quarterly meetings, which are organised with common interests in mind and to which the Ministry of Health is a regular contributor. Attending them provides a positive way to network and a safe environment in which to discuss issues. Relevant information is disseminated to NASCA membership throughout the year and members are often invited to represent a NASC viewpoint, or their region or service (under 65 year NASC or over 65 year NASC) in national projects.

INTO THE FUTURE

This Manual seeks to support NASC managers so that:

- they are able to maintain their focus on achieving positive outcomes for disabled people and their families/whānau, while managing a challenging role
- they can ensure NASC obligations as contracted services are met
- their leadership is informed and forward looking
- their management ensures consistency and competency in all aspects of NASC work.

> In an ever-changing environment the NASC manager must engage in thorough planning and strategic thinking in order to anticipate or respond to events. By being proactive and planning strategically, the NASC manager will develop a service that is more responsive to the requirements of disabled people and the funder, and better positioned to take advantage of opportunities that present. The NASC manager will also develop a workplace culture and workforce that are more professional and innovative.

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While planning gives the NASC organisation direction, the preparedness of the organisation for unplanned change is essential. While the NASC framework is both valuable and entrenched in the delivery of services to disabled people, there are no guarantees on the future shape of any services because they are constantly developing and evolving. Strategic thinking will support the NASC in anticipating and responding to change and increase the NASC's resilience to risk.

Key challenges for NASC managers are keeping up to date and keeping in touch.

Keeping Up to Date

Keeping up to date with changes both within and external to the NASC organisation requires an investment in establishing strong professional relationships with key stakeholders.

It is especially important for the NASC manager to keep up to date with new policy and protocols and contractual requirements. A strong working relationship with the DSD Service Manager will assist with keeping informed and being assisted with how these might be implemented. Having an established mechanism to access newly

released relevant key governmental documents from ministries other than the Ministry of Health and from government departments will also assist.

Changes will occur at two levels: firstly, planning, funding, strategy and policy; and, secondly, operational. Identifying and implementing the linkage between the two levels will require energy, lateral thinking and collegial support.

Membership of NASCA provides opportunity for formal and informal sharing of information and networking. This is where the NASC manager may be exposed to new practice models and new learning about quality. Mentoring and peer support will also provide these opportunities.

Keeping the team motivated and forward looking is challenging. Opportunities for staff to be supported in maintaining and improving best practice need to be actively identified and responded to.

Additionally the NASC manager must identify and action their own professional development needs. These needs cannot be limited to the technical nature of NASCs. Opportunities to observe and learn alternative ways of managing will provide stimulation and impetus for critical appraisal of existing methods of service delivery. Universities, technical education institutes and private training providers offer a wide range of short- and long-term management and governance courses that may be relevant.

The primary responsibility of the NASC manager is to manage. Keeping in touch with the purpose of the NASC and its daily work will help the manager to maintain focus. Planned and purposeful contact must be maintained with key stakeholders, including disabled people, disability groups and providers.

Examples of current and developing foci for NASC managers include:

- reviewing and restating 'the basics' of intent and purpose of the NASC
- determining best models of practice
- developing model coherency
- determining the NASC role in service design
- determining quality and best practice
- identifying how best to respond to the need for consistency and equity
- establishing how to promote and measure an outcome focus
- understanding and developing fiscal responsibilities and competencies
- responding to professional issues: workforce development, training, qualifications
- determining the NASC role in service development
- determining how to operationalise new forms of support such as Supported Independent Living, Individualised Funding.
- exploring alternative models for assessment and developing resources and tools
- developing an intrasectoral and intersectoral needs assessment and service co-ordination service.

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Keeping in Touch

There is a significant amount of information available to the NASC manager that will keep them informed about activity within the Ministry of Health and Ministry of Social Development. Websites and mailing lists both provide such information.

Resources

- The Ministry of Health, Disability Services Directorate, has a Strategic Plan outlining its priorities for future development and direction within the sector, for July 2003 to June 2006. The six objectives outlined in the Strategic Plan are aligned with the *New Zealand Disability Strategy* and aspire to meet the Directorate's overall vision 'of a society that highly values the lives of disabled people and continually enhances their full participation'.

  A copy of the Disability Services Directorate Strategic Plan for July 2003 to June 2006 can be downloaded from the Ministry of Health website: www.moh.govt.nz under the Publications section.

- The Ministry of Health, Post Census Disability Surveys Report, *Living with Disability in New Zealand* is a useful resource for NASC managers in terms of planning.

  A copy can be downloaded from www.moh.govt.nz/disability and linking to Publications.

- The Ministry of Social Development has developed the Sickness and Invalids Benefit Strategy in keeping with the overall aim of the *New Zealand Disability Strategy* to develop a fully inclusive society.

  As part of this strategy a new service will be delivered through Work and Income which will aim to support people on an Invalid or Sickness Benefit towards achieving employment and independence, recognising people's potential for work.

  Information about the Sickness and Invalids Benefit Strategy can be found at: www.msd.govt.nz/work-areas/people-with-disabilities.

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Annex A: Useful Resources

This list is not exhaustive. The NASC manager is encouraged to identify and share useful resources.

Area	Source
ACC	www.acc.co.nz
*access*able	www.accessable.co.nz
Ageing Strategy	www.mosp.govt.nz www.beehive.govt.nz/minister.cfm Annual Report 2002–03 NZPAS www.moh.govt.publications.disability
Allocation Resource Tool December 2003	DSD Service Manager
Carers' Information	Complexcarers@xtra.co.nz team@eldernet.co.nz www.eldernet.co.nz www.carers.net.nz info@carers.net.nz
Case Management	Geron S, Chassler D. 1994. Guidelines for Case Management. Practice Across the Long Term Continuum Report. Report prepared under a grant by The Robert Wood Johnson Foundation. Case Management Society of Australia cmsa@cmsa.org.au
Child, Youth and Family	www.cyf.govt.nz/ Department of Child, Youth and Family. 2000. Towards Well Being: Responding to the needs of younger people. Department of Child Youth and Family
Code of Health and Disability Services Consumers' Rights	Health and Disability Commissioner
Communication	www.write.co.nz/training/index.html 'What did you Say?' info@no.ccs.org.nz
Community Residential Services within Aged Care Facilities for Younger People with Lifelong Disabilities	DSS 1034 Service Specification.
Community Residential Support Services	DSS 1030 Service Specification
Disability	www.weka.net.nz www.dpa.org.nz
Disability Resources	info@ho.ccs.org.nz www.odi.govt.nz/nzds

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Area	Source
Enable	www.enable.co.nz
Environmental Support Services	www.disabilityfunding.co.nz
Ethics	Bond T. 1993. *Ethical Problem Solving*. London: Sage
Ethnic diversity in New Zealand	Cultural diversity tables www.stats.govt.nz Ethnic Communities and Disability: How to communicate with a person from a certain culture with a particular disability www.mdaa.org.au/ethnic www.odi.govt.nz www.arms-mrc.org.nz
Financial Management in the Public Sector	Treasury. Putting It Together: An explanatory guide to the New Zealand public sector financial management system. www.treasury.govt.nz/publicsector/pit/
Foster Care	Ministry of Health DSS 1036 Service Specification Foster Care June 2004
Governance	www.carvergovernance.com/pg-np.htm www.help4nonprofits.com/NP_Bd_WhyBoardsExist_Art.htm
Guide to Eligibility for Publicly-Funded Health and Disability Services in New Zealand	www.moh.govt.nz
He Korowai Oranga: Māori health strategy	www.Māorihealth.govt.nz www.moh.govt.nz
Health and Disability Consumer Advocacy Service pamphlet Local advocacy services pamphlets	www.hdc.org.nz
Health of Older People Strategy	www.moh.govt.nz/publications/hops
High and Complex Needs Guidelines for the Application and Plan Processes	hcn@cyf.govt.nz www.hcn.govt.nz
Home Support	Service Specification DSS Home Based Support
IDCCR/CPMIP and RIDCA Services	www.moh.govt.nz/idccr
Individualised Funding; Guidance and Good Practice 2003	www.moh.govt.nz
Intellectual Disability – Community Residential Support Services	DSS 1031 Service Specification

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Area	Source
Intellectual Disability Eligibility Assessment: Guidelines for Requests and Reports	Ministry of Health June 2003
Intersectoral	www.msd.govt.nz/documents/publications/strategic-social-policy/integrated-service-delivery
Management	New Zealand Institute of Management www.nzim.co.nz www.business.auckland.ac.nz/ Jones R, Gregory J, Hill C. 1998. Contemporary Management. Boston: Irwin McGraw-Hill Lasher W. 1994. The Perfect Business Plan Made Simple. New York: Doubleday
Mandatory Letters to Service Users	DSD Service Manager
Māori	www.treatyofwaitangi.govt.nz Information on Māori health and disability workforce issues and initiatives www.hauora.com Online English and Māori word translators www.kel.otago.ac.nz/translator Māori Language Commission www.taurawhiri.govt.nz Ministry of Health Guidelines for Cultural Assessment – Māori under the IDCCR Act Kingi J, Bray A. Māori Concepts of Disability. Donald Beasley Institute
Memorandum of Understanding between the Department of Child, Youth and Family Services and the Health Funding Authority 1999	DSD Service Manager
Ministry of Education – Special Education support services	www.minedu.govt.nz/index.cfm?layout=document&documentid=7303&data=l
Ministry of Health Disability Service Newsletters	www.moh.govt.nz/moh.nsf
Ministry of Health: **Disability in New Zealand**	www.moh.govt.nz/disability
Ministry of Health Guidelines for NASC Discretionary Funding	DSD Service Manager DSD/NASC Service Specification 2005
Ministry of Social Development	www.msd.govt.nz
Nationwide Mental Health Service Framework	Mental Health Commission: General Requirements 2001 (MHCS31)

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Area	Source
Needs Assessment and Service Co-ordination	Bray A. 2002. Review of Policy Developments in Needs Assessment Service Co-ordination in New Zealand. Paper prepared for New Zealand Guidelines Group donald.beasley@stonebow.otago.ac.nz Foster S. 2002. An Analysis of the Skills and Knowledge Base for Needs Assessment and Service Co-ordination.
New Zealand Disability Strategy 2001	www.nzds.govt.nz
New Zealand Government	www.beehive.govt.nz www.beehive.govt.nz/ViewDocument.cfm?DocumentID=2004
Office for Disability Issues – What's Happening newsletter	www.odi.govt.nz/whats-happening
Official Information Act	www.justice.govt.pubs/other/pamphlets/2001info-act.html www.dol.govt.nz
OSH requirements	www.osh.dol.govt.nz
Pacific Health and Disability	Minister of Health. 2002. *Pacific Health and Disability Action Plan*. Wellington: Ministry of Health. Ne'emia S. 2002. *Capital Support in the Lives of Pacific Disabled People*. Wellington: Capital Support.
The Pacific Health and Disability Action Plan	www.moh.govt.nz/pacific
Parent to Parent	www.parent2parent.org.nz
People First	PO Box 9199, Marion Square, Wellington victoriast@xtra.co.nz
Privacy Act 1993	www.privacy.org.nz
Quality	Improving Quality : A System Approach for the New Zealand Health and Disability Sector www.moh.govt.nz
Quality Improvement: Improving Quality: A Systems Approach for the New Zealand Health and Disability Sector	www.moh.govt.nz
Referral Requirements	Service Specification DSS 1004 and 1005 and 1004D, N/A and S/C
Standards for Needs Assessment for Disabled People	Ministry of Health, Wellington
Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines	DSD Service Manager

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Area	Source
Supported Independent Living	Ministry of Health DSSL 2620 Supported Independent Living Service Specification DSD Ministry of Health Supported Independent Living Guidelines for NASCs and providers www.daagroup.co.nz/about_audit.html
Template Allocation of Band 5 Hours	DSD Service Manager
To Have an Ordinary Life	www.nhc.govt.nz
Vocational and Day Activities	www.msd.govt.nz www.work.income.govt.nz/get-financial-assistance/extra-help/disability-child-allowance.html

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Annex B: Overview of Volume 2

Please see *Volume 2 Appendices* which contains the following appendices.

1. DSD NASC Service Specification
2. Ministerials
3. Competencies for Needs Assessment Facilitators and Service Co-ordinators
4. Intellectual Disability Eligibility Assessment: Guidelines for Requests and Reports
5. Out of Home Placement for Children and Young People
6. Regional Intellectual Disability Care Agency
7. Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
8. High and Complex Needs Unit
9. DSD Mandatory Communication Tools 2004
10. DSD NASC Fact Sheet
11. Service Users' Frequently Asked Questions
12. DSD Service Utilisation Reports
13. Accessing Long-term Residential Care and the Residential Support Subsidy
14. Residential Care – Progressive Removal of Asset Testing
15. Supported Independent Living Guidelines for NASCs and Providers
16. Quality NASCs for Māori – Three Examples of NASC Experiences
17. Excerpt from 'Guidelines for Cultural Assessment – Māori', Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
18. Memorandums of Understanding

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Annex C: Glossary of Terms and Abbreviations

ACC	Accident Compensation Corporation
ADL	activities for daily living
ART	Allocation Resource Tool
AT&R	Assessment, Treatment and Rehabilitation
CCPS	Client Claims Processing System
CMS	Contract Management System
CQI	Continuous Quality Improvement
CSSITO	Community Support Services Industry Training Organisation
CTA	Clinical Training Agency
CYFS	Department of Children, Youth and Family Services
CYPFA	Children, Young Persons and Their Families Act 1989
DDG	Deputy Director-General
DHB	District Health Board
DIAS	Disability Information and Advisory Service
Disabled person	a person who has been identified as having a physical, intellectual or sensory, or age-related disability (or a combination of these) which is likely to continue for a minimum of six months and reduce independent function to the extent that ongoing support is required. In some instances, this term will include the disabled person and their carer and/or family/whānau/aiga.
DSD	Disability Services Directorate
DSS	disability support services
ESS	environmental support services
FMIS	Financial Management Information System
GP	general practitioner
GSE	Group Special Education
HCN Strategy	High and Complex Needs Strategy
HCN Unit	High and Complex Needs Unit
HDSS	Health and Disability Sector Standards
HealthPAC	Health Payments, Administration and Compliance
IB	Invalids Benefit
IDDCR Act	Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
IEP	Individual Education Plan
IF	Individualised Funding
IFA	Individualised Funding Agency

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Kaimahi	worker
Kaumātua	older men and women
Kuia	older woman/women
Mana whenua	people of the land
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSD	Ministry of Social Development
MSU	Ministerial Services Unit
NASC	Needs Assessment and Service Co-ordination organisation
NASCA	Needs Assessment and Service Co-ordination Association
NGO	non-governmental organisation
NHC	National Advisory Committee on Health and Disability
NZDS	New Zealand Disability Strategy
NZQA	New Zealand Qualifications Authority
OIA	Official Information Act 1982
ORRS	Ongoing and Reviewable Resourcing Scheme
OSH	Occupational Safety and Health
PA	Personal Allowance
PHO	Primary Health Organisation
PPS	proposed payment schedule
PQ	Parliamentary question
PSI	Population Service Indicators
RCS	Residential Care Subsidy
RFP	Request for Proposal
RIDCA	Regional Intellectual Disability Care Agency
RIDSAS	Regional Intellectual Disability Supported Accommodation Service
RIDSS	Regional Intellectual Disability Secure Service
RSS	Residential Support Subsidy
RSU	Residential Subsidy Unit, Work and Income
RTLB	Resource Teacher: Learning and Behaviour
SE2000	Special Education 2000
SEG	Special Education Grant
Service Manager (DSD)	a member of DSD Operations teams who manages contracts and funding of DSD services, and maintains relationships with the disability sector
SIL	Supported Independent Living
SMT	Senior Management Team
SOI	Statement of Intent

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SPA	Support Package Allocation
SSB	Standards Setting Body
Te Reo	Māori language
Tikanga	protocol
TQM	Total Quality Management
Vote:Health	the amount of money allocated by Parliament, at the beginning of the financial year, to be spent on the health sector
Whānau	extended family

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Annex D: Acknowledgements

This Manual is the product of a collaborative process. There have been many conversations and exchanges with people from various geographical regions, in various fields and in various relationships to disabled people, both in and out of NASC organisations.

Please accept our apologies if you have not been acknowledged in this Manual. The developmental nature of this project has meant extensive consultation and collaboration with many people.

The LIFE Unlimited NASC Managers' Manual project team (Jane Pembroke, Jean Lamusse and Michelle Rivers) would like to thank the people listed below.

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GUIDELINES FOR REGIONAL HEALTH AUTHORITIES

SERVICE COORDINATION FOR PEOPLE WITH DISABILITIES

MINISTRY OF HEALTH
FEBRUARY 1995

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FOREWORD

In 1994 a new framework for delivering disability support services was launched with the introduction of the *Standards for Needs Assessment for People with Disabilities*. At the same time, the Government released *The New Zealand Framework for Service Delivery: Disability Support Services* booklet which explained the underlying principles of the framework, how it would work and how it would develop.

The guidelines on service coordination for people with disabilities included in this document set out the Government's requirements for the second part of the new framework.

The guidelines are primarily intended for regional health authorities (RHAs), but are also an important document for people with disabilities, their caregivers and family/whanau, and organisations providing disability support services.

The guidelines, which come into effect on 1 July 1995, will be used by RHAs when purchasing service co-ordination for people with disabilities. The guidelines clearly set out the parameters within which RHAs are expected to purchase service coordination within each region, while ensuring the flexibility to develop service coordination as appropriate for people with disabilities.

The guidelines were developed last year in consultation with people with disabilities, groups representing people with disabilities, regional health authorities and organisations providing disability support services. To incorporate the views of Maori, a national hui on service coordination was held last May.

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The guidelines present RHAs and service providers with the opportunity to develop service coordination processes for people with disabilities that are flexible, innovative and make the most efficient use of available resources. People with disabilities will also have an important role in ensuring that RHAs and providers achieve these aims.

As Minister of Health, I would like to express my appreciation and thanks to the many people and organisations who contributed to the development of these guidelines.

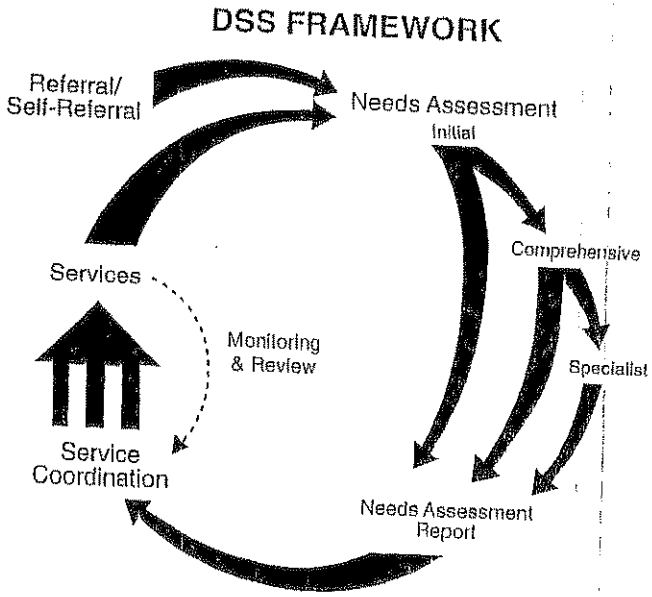
Hon Jenny Shipley
Minister of Health

1 INTRODUCTION

1.1 THE FRAMEWORK FOR DISABILITY SUPPORT SERVICES

The new framework for disability support services has three principal components, each with its own objectives:

1. Needs Assessment: to accurately identify and place in order of priority a person's needs, including preparation of a needs assessment report.
2. Service Coordination: to identify the most appropriate services and support options to meet a person's assessed needs; and to ensure that resources are used as efficiently as possible.
3. Service Provision: to provide high-quality services in response to a person's assessed needs.



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The framework is described in detail in *The New Zealand Framework for Service Delivery: Disability Support Services*, which is available from the Ministry of Health and RHAs.

1.2 WHAT IS SERVICE COORDINATION?

Service coordination is the process of identifying and planning the package of services required to meet a person's assessed needs. Service coordination will also determine which of those needs can be met by publicly-funded services and will explore options for addressing needs which cannot be met. Providers of service coordination are expected to:

- have comprehensive knowledge of the range of disability support services available in the region;
- communicate all necessary information regarding eligibility and any financial targeting regimes for the range of services available;
- develop service plans with individuals on the basis of their assessed needs;
- negotiate access to services and the timetable for delivery of services;
- refer individuals to services not purchased by RHAs as appropriate.

1.3 PURPOSE OF THE GUIDELINES

Requirements on Regional Health Authorities

These guidelines set out the Government's requirements for service coordination for people with disabilities.

The Government's requirements for service coordination are grouped into four categories:

- *General Requirements:* which set out the primary requirements RHAs are expected to meet in purchasing service coordination for people with disabilities;
- *Service Coordination Process:* which sets out the key requirements that RHAs should expect from organisations providing service coordination for people with disabilities;
- *Integrity of the Framework:* which sets out the key requirements for ensuring that the objectives of each component of the framework for disability support services are realised;
- *Implementation:* which sets out the implementation requirements, including timetable, for RHA-purchased service coordination.

Interface Issues for Service Coordination

Various 'interface' issues arise from the relationships between service coordination purchased by RHAs and services for people with disabilities funded or purchased by other agencies. Section 3 of the guidelines outlines what action is being taken to address 'interface' issues with the ACC, Vocational Services and Education.

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2 GOVERNMENT REQUIREMENTS FOR SERVICE COORDINATION

2.1 GENERAL REQUIREMENTS

Regional health authorities are expected to purchase service coordination for people with disabilities which meet the following general requirements:

- service coordination is a client-oriented process;
- service coordination involves caregiver(s), family/ whanau and friends as appropriate;
- service coordination examines all practical services and support options to meet a person's needs, including all relevant public, private, voluntary and community services[1];
- service coordination matches available resources to need, ensuring that resources are used as efficiently as possible;
- RHA-purchasing strategies include the development of service coordination which is appropriate for Maori and Pacific Nations peoples with disabilities;
- RHAs develop time and distance criteria for access to service coordination.

[1] Providers of service coordination are required to have extensive knowledge of all possible services which may meet a client's needs. This includes not only RHA-purchased disability support services, but all other relevant publicly and privately-funded services.

2.2 SERVICE COORDINATION PROCESS

Service coordination is expected to be purchased by RHAs from organisations which can meet the following process requirements.

Providers of service coordination will:

- use the needs identified and prioritised in the person's needs assessment report as the basis of service co-ordination;
- inform the person, and their caregivers, family and whanau as appropriate, about the role of service coordination and the service coordination process which will be followed;
- assign a 'service coordinator' for the person. The 'service coordinator' will be responsible for carrying out service coordination for a particular person[2];
- discuss with the person the range of support and services available to meet their prioritised needs, including support and services which are publicly and privately-funded;
- inform the person about the eligibility and financial targeting criteria for all support and services that the person may wish to access;
- develop a 'service plan' or 'life plan' with the person, which describes the package of support and services the person requires to meet his or her prioritised needs;
- assist the person to access the package of support and services required to meet the person's prioritised

[2] A 'service coordinator' role will usually be undertaken by a person who, in addition to service coordination, has other professional responsibilities within the health and disability support service sectors.

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needs (taking into account the financial resources of the person and the eligibility and financial targeting criteria which may apply for different services);

- review the services which the person receives as appropriate, and determine whether those services are meeting the person's prioritised needs;
- recommend an adjustment of the services the person is receiving or arrange a re-assessment of the person's needs as appropriate, if the person's needs are not being met by the services provided.

2.3 INTEGRITY OF THE FRAMEWORK

Regional health authorities are expected to adopt purchasing strategies for service coordination which will maintain the 'integrity' of the framework for disability support services, so that the objectives of needs assessment, service coordination and service provision set out in Section 1.1 are realised.

The Government wishes to ensure that auditable boundaries exist between the three principal components of the framework, so that there is a transparent process for assessment and referral to disability support services for both people with disabilities and service providers.

To ensure that the integrity of the framework is maintained, RHAs are required to:

- specify needs assessment, service coordination and service provision as separate services in contracts with providers by 1 July 1997 or earlier if possible;
- put in place monitoring systems to ensure that the integrity of the framework for disability support services is maintained.

Where a provider is contracted to provide more than one component of the framework, RHAs are expected to put in place mechanisms to ensure that the framework's integrity is maintained. For example, where needs assessment and service coordination are purchased from a single provider, they should be specified separately in the contract with the provider.

2.4 IMPLEMENTATION

Regional health authorities are expected to purchase service coordination processes for people with disabilities which meet the following implementation requirements:

- service coordination processes for all people with disabilities are implemented concurrently with the *Standards for Needs Assessment for People with Disabilities* between 1 July 1995 and 1 July 1997;
- RHAs are required to report to the Ministry of Health on purchasing strategies for service coordination in their annual purchasing plans;
- RHA purchasing strategies for service coordination should consider the option of people with disabilities undertaking their own service coordination;
- appropriate monitoring systems for service coordination are developed by the RHAs in conjunction with the Ministry of Health.

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The Government recommends that RHAs evaluate the quality of service coordination processes they purchase by adapting and applying the standards prescribed in the *Standards for Needs Assessment for People with Disabilities* to providers of service coordination. These standards include:

Entry to be easy

Written policies and procedures

The service coordination process will be culturally safe

People-oriented process

The appropriate people will be involved in the service coordination process

Information will be provided to the person receiving service coordination

Collection, storage and transfer of information will be carried out in a secure, confidential manner

The outcomes of service coordination will be an accurate identification of the support and services a person requires to meet his or her identified needs, and an appropriate and efficient use of resources.

In particular, the Government recommends that the standards be adapted and applied where both needs assessment and service coordination are purchased from a single provider.

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3 INTERFACE ISSUES FOR SERVICE COORDINATION

3.1 INTERFACE WITH THE ACC[3]

An important aspect of RHA-purchased service coordination is the interface with service coordination processes for accident-related services funded by the ACC.

Clients who have both accident and non-accident related disability support needs pose significant interface issues. Successful management of these interface issues is important if such people are to have the opportunity to access all appropriate services within both the health and accident rehabilitation and compensation systems.

Consequently, a protocol is required between the ACC and RHAs to clarify responsibilities for people with both accident and non-accident related disabilities who require services from both systems, or people with disabilities who need to transfer from one system to the other.

The ACC and the Ministry of Health, in consultation with the RHAs, are developing a protocol which will take effect from 1 April 1995.

3.2 INTERFACE WITH VOCATIONAL SERVICES

Regional health authorities and the New Zealand Community Funding Agency (NZCFA) are required to establish arrangements to ensure that people with

[3] Accident Rehabilitation and Compensation Insurance Corporation

disabilities between 14 and 65 years of age receive a vocational assessment as part of their needs assessment for disability support services.[4]

RHAs and NZCFA are also required to develop arrangements to ensure that people with disabilities between 14 and 65 years of age who have vocational needs receive coordinated service planning and access to appropriate disability support services.

The Ministry of Health will assist RHAs and NZCFA to develop appropriate arrangements.

3.3 INTERFACE WITH EDUCATION

The Ministry of Education and the Ministry of Health, in consultation with the Special Education Service (SES) and the RHAs, have developed memoranda of understanding for assessment and service coordination to ensure that people under 21 years of age who have disability support and special education needs receive coordinated assessments and service planning from both the health and education sectors.

[4] Standard 8.3 - *Standards for Needs Assessment for People with Disabilities*

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FURTHER READING

The following resources may assist those who wish to know more about service coordination.

Challis, D., and Davies, B. *Case Management in Community Care*, PSSRU, University of Kent, 1986.

Challis, D., and Davies, B. *Matching Resources to Needs in Community Care: An Evaluated Demonstration of a Long-Term Care Model*, Gower Publishing Company, 1986.

Department of Health. *Care Management and Assessment: Practitioners' Guide*, HMSO, London, 1991.

Departments of Health and Social Welfare. *Service Co-ordination - A Resource Paper*, (unpublished paper), 1993.

Disability Resource Centre. "The Waikato Experience: Brokerage Pilot Report to the Department of Social Welfare", Hamilton, July 1991.

Davidson, G., Penrod J., and Kane, R., et al. "Modelling the Costs of Case Management in Long-term Care", *Health Care Financing Review*, Fall, Vol. 13, No. 1, 1991.

McKenney, B. "Service Brokerage, The New Zealand Experience: The Report of the Palmerston North Service Brokerage Project", July 1990.

Meyers, M. K. "Organisational Factors in the Integration of Services for Children", in *Social Service Review*, Chicago, December, Vol. 67, No. 4,1993, pp. 547-575.

Onyett, S. *Case Management in Mental Health*, Chapman and Hall, 1992.

Parker, G. "Whose Care? Whose Costs? Whose Benefit? A Critical Review on Case Management and Informal Care", in *Ageing and Society*, 10, 1990, pp. 459-467.

Parker M., Quinn J., Viebl M., et al. "Case Management in Rural Areas: Definition, Clients, Financing, Staffing, and Service Delivery Issues", in *Journal of Nursing Administration*, Vol. 22, No. 2; February 1992.

Quinn, J. *Successful Case Management in Long-Term Care*, New York, Springer Publishing Company, 1993.

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NEEDS ASSESSMENT

Outcome One: Needs assessment is flexible, and responsive to clients and the community.

Standards

1.1 Needs assessment will have entry procedures that provide for easy access.

1.2 Needs assessment will action all referrals for assessment within contractual timeframes.

1.3 Needs assessment will involve whanau, hapu, and iwi to ensure effective access and availability of services to Maori.

1.4 The needs assessor will direct inappropriate referrals to other relevant services or providers.

Outcome Two: ***Needs assessment respects health as a taonga for Maori and reflects the four dimensions of Maori health: Tinana, wairua, whanau and hinengaro.***

Standards

2.1 Needs assessment will respect Maori cultural constructs in accordance with the client's tikanga, and encompass the kawa of Maori.

2.2 Needs assessment will facilitate participation in Maori tikanga from the person's iwi or other Maori grouup.

2.3 Needs assessment will ensure the cultural requirements of Maori are recognised and met throughout the assessment process.

Outcome Three: Clients are informed of the purpose and proceeds of needs assessment.

Standards

Needs assessment will ensure the client is informed of the purpose and all the steps in the needs assessment process.

3.1 Information will be provided to the client in a way that is responsive to their communication and cultural needs.

3.2 The assessor will through discussion with the client determine the degree of involvement of the person in the assessment process.

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Outcome Four: Needs assessment is responsive to the diversity of people having their needs assessed.

Standards

4.1 Needs assessment will recognise and respond to clients' cultural needs, including ethnicity, disability, sexuality, gender and age.

4.2 Needs assessment will be undertaken in an environment and context that is determined by and comfortable for the client.

4.3 As far as practicable, clients will be given a choice of assessment facilitators and will be informed of how they might request that a different facilitator to be assigned to them.

4.4 Family/whanau and carers are encouraged, where appropriate, to participate in the needs assessment process.

4.5 The person being assessed will agree to who will be present during their assessment.

Outcome Five: Needs assessment ensures the client's knowledge and experience of disability is recognised alongside the identification of their needs in the assessment.

Standards

5.1 Needs assessment will respect the client's resources and s work in a manner that encourages and supports self-expression.

5.2 With the client's consent, needs assessment will access other assessment material.

Outcome Six: Needs assessment is facilitated by people who are competent and knowledgeable about disabilities.

Standards

6.1 Needs assessment will ensure assessment facilitators are competent, and maintain their knowledge.

6.2 Needs assessment will ensure co-ordinated and timely referral of the client to specialised assessment services as required.

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Outcome Seven: An accurate summary of the client's goals, needs and abilities is produced.

Standards

7.1 The outcome of the assessment process will not be influenced by the availability or limitations of services or resources.

7.2 The assessment process will produce an accurate records of the client's resources, goals and needs and include recommendations of any specialised assessments.

7.3 Clients will be asked to confirm that their needs assessment reports are accurate and requested changes will be made or appended to the assessment.

7.4 All clients will be informed of the right of review and how to request a review. This will include information about access to advocacy.

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SERVICE CO-ORDINATION

Outcome One: Service co-ordination is flexible, easy to access and responsive to clients and the community.

Standards

1.1 Service co-ordination will involve whanau, hapu and iwi to ensure effective access and availability of services to Maori.

1.2 Service co-ordination will have established mechanisms to ensure responsiveness to clients in crisis.

Outcome Two: Service co-ordination respects health as a taonga for Maori and reflects the four dimensions of Maori health: Tinana, wairua, whanau and hinengaro.

Standards

2.1 Service co-ordination will respect Maori cultural constructs in accordance with the client's tikanga, and encompass the kawa of Maori.

2.2 Service co-ordination will facilitate participation in Maori tikanga from the client's iwi or other Maori group.

2.3 Service co-ordination will ensure the cultural requirements of Maori are recognised and met throughout the service co-ordination process.

Outcome Three: Clients are informed of the purpose and process of service co-ordination.

Standards

3.1 Service co-ordination will ensure that clients are informed of the purpose and all the steps in the service co-ordination process.

3.2 Information will be provided to clients in a way that is responsive to their communication and cultural needs.

Outcome Four: A range of options that reflect the client's choice, resources and self-determination are provided.

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Standards

4.1 Service co-ordination will be in partnership with the client, respecting the client's resources, and so work in a manner that encourages independence, self-determination and participation in the community.

4.2 The client will be treated with dignity and respect during the service co-ordination process.

4.3 Service co-ordination will manage the client's expectations by providing information on eligibility and the range of options available.

4.4 Service co-ordination will ensure that clients are supported in making decisions.

4.5 Service co-ordination will explore all service and support options available to meet the client's needs and goals, including all relevant public, private, voluntary and community services.

4.6 Family/whanau and carers will be encouraged, where appropriate, to participate in service co-ordination and decision-making.

Outcome Five: Service co-ordination is provided by people who are competent and knowledgeable about disabilities, and are able to respond to the diversity of needs and cultures.

Standards

5.1 Service co-ordination will ensure service co-ordinators are competent, and maintain their knowledge.

5.2 Service co-ordination will develop and maintain networks to ensure access to a diverse range of community resources and disability support services.

5.3 Service co-ordination will develop and maintain networks to ensure access to a diverse range of community resources and disability support services for Maori.

5.4 Service co-ordination will recognise and respond to clients' cultural needs, including ethnicity, disability, sexuality, gender and age.

Outcome Six: Service co-ordination is flexible and innovative in the use of resources; ensuring support options provided are consistent with people's prioritised goals and needs.

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Standards

6.1 The views of the client and, where appropriate, their family/whanau or carers will be paramount in the identification of options by the service co-ordinator.

6.2 The service co-ordinator will make decisions that are cognisant of DSS funding principles.

6.3 The service co-ordinator will consider flexible service options and where these are the client's preferred choice, inform the client of their responsibilities.

6.4 Service co-ordination will match available resources to client needs, ensuring outcomes make efficient use of resources.

6.5 Where a client's needs cannot be met by current services within available resources, the service co-ordinator will explore and develop other support options.

Outcome Seven: Service co-ordination will enable the client's choice of support.

Standards

7.1 Service co-ordination will offer the client a choice of support options.

7.2 Service co-ordination will refer the client to the client's preferred provider.

7.3 Service co-ordination will ensure the service provider understands the needs, abilities and goals of the client and, where appropriate, their family/whanau, and is able to provide services that reflect these needs, abilities and goals.

7.4 Service co-ordination will negotiate access to timely delivery of supports for the client.

7.5 Service co-ordination will ensure the accurate transfer of information to service providers.

7.6 Service co-ordination will stipulate the criteria, process for, and timeframe of delivery and review of the support plan.

Outcome Eight: Clients' ongoing needs are met and outcomes are achieved.

Standards

8.1 Service co-ordination will ensure the client has an individualised support plan that reflects prioritised needs and goals.

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8.2 Clients will have information about what the action they may take if at any time they are dissatisfied with the service co-ordination process. This will include information about access to advocacy.

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NEEDS ASSESSMENT AND SERVICE CO-ORDINATION-ORDINATION ORGANISATIONS

Principle 1

The organisation will be easy to access and entry processes will be flexible

Outcome: Entry is easy

Standards

1.1 The organisation will be accessible to all people with disabilities and where appropriate their family/whanau or carers.

1.2 The organisation will work with groups to identify barriers to access and develop a plan to eliminate barriers specific to that group.

1.3 The organisation will distribute information about the service, ensuring that it is widely known and is in a style and format that is accessible and appropriate to people of all cultures.

1.4 The organisation will ensure that people have access to advocacy.

1.5 Clients and families will be informed of how to contact the organisation in times of crisis.

1.6 The organisation will provide 24 hour crisis response service.

1.7 The organisation will ensure people who are not eligible are referred to other relevant agencies/providers.

1.8 The organisation will ensure assessment facilitators and service co-ordinators are competent and maintain their knowledge.

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Principle 2

The organisation will respect the Treaty of Waitangi as New Zealand's founding document and in doing so will ensure the principles of the Treaty of Waitangi are given effect through delivery to Maori.

Outcome: The cultural preferences of Maori are met wherever possible.

Standards

2.1 The organisation will demonstrate explicit alignment with the Minis DSS Maori Health Service objectives.

2.2 The organisation will establish and maintain networks with Maori to ensure their service reflects the principles of the Treaty of Waitangi.

Principle 3

The organisation will invite, involve, and respond to the input of community members and groups to support the development of a flexible and responsive service.

Outcome: The organisation is responsive to the community

Standards

3.1 The organisation will establish and maintain a process to ensure the ongoing participation of the local community.

3.2 The organisation will ensure the involvement of whanau, hapu and iwi in the effective development and delivery of the service.

Principle 4

The organisation will develop an maintain effective relationships with others

Outcome: Co-ordinated delivery of services to clients.

Standard

4.1 The organisation will demonstrate access to a range of specialised assessors and services as required to meet client need.

4.2 The organisation will have in place effective working relationships with other providers to enable achievement of outcomes for clients.

Principle 5

The organisation will ensure that there is an auditable boundary between NASC functions.

Outcome: The integrity of the NASC process is maintained.

Standard

5.1 The organisation will be able to demonstrate how the auditable boundary between needs assessment, service co-ordination and referral to support providers has been maintained.

5.2 The organisation will ensure smooth and timely transition between the processes of assessment and service co-ordination .

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Principle 6

Access criteria and guidelines used by the organisation for the allocation of resources will be clear and transparent.

Outcome: Processes for the allocation of resources are fair

Standard

6.1 The organisation will operate within the access criteria and policies for services identified by the Ministry of Health.

6.2 The organisation will have knowledge of all necessary criteria and will use sound judgement when exercising these.

6.3 The organisation will have policies and procedures in place to ensure consistent and fair application of the criteria.

Principle 7

The organisation will ensure people are aware of options available to them within the limitations of publicly funded services.

Outcome: Information is provided to people

Standard

7.1 The organisation will provide information to the person on access criteria, including disability and financial eligibility.

7.2 Information on access criteria will be provided to the person in a format and language that is appropriate to their communication and cultural needs.

Principle 8

The organisation will have information systems that facilitate effective planning, budget management, and identifies service gaps.

Outcome: Information is co-ordinated and accurate.

Standard

8.1 The organisation will ensure they have electronic information processes and systems in place to provide relevant, timely information for both internal business management and reporting to the Ministry of Health.

8.2 The organisation will ensure the information system is secure, retrievable and complies with the Health Privacy Code.

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8.3 The organisation will ensure information in accurately recorded and disseminated.

8.4 The organisation will communicate with providers and other community groups about unmet need for the purpose of developing responsive services.

8.5 The organisation will report information on unmet needs to the appropriate government body.

Principle 9

The organisation will ensure people are treated fairly and equitably within available resources.

Outcome: Resources are used efficiently

Standard

9.1 The organisation will consider all available support options including the person's own resources, voluntary, community and publicly funded options.

9.2 The organisation will have processes in place to ensure equitable access to resources to meet prioritised needs as identified in Needs Assessments.

9.3 The organisation will have policies and procedures in place that demonstrate decision making processes, and that decisions have been made in accordance with the principles and guidelines of the Ministry of Health.

9.4 The organisation will follow the Ministry of Health's principles for prioritising access to resources within the limitations of a defined budget.

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Principle 10

The organisation will ensure the integrity of Needs Assessment process is preserved while recognising the safety needs of people through service co-ordination.

Outcomes: Safety needs are recognised

Standards

10.1 The organisation will ensure relationships with providers of specialised assessments and services are in place.

10.2 The organisation will have policies and procedures in place to ensure that where there are concerns for the safety of the person, this is documented.

10.3 In the event that the client is considered unsafe, the organisation will employ actions appropriate to the client's circumstances.

Principle 11

The person will have the right of review of the outcome of the Needs Assessment and Service Co-ordination process.

Outcome: People are satisfied with processes

Standards

11.1 The organisation will have policies and procedures in place to ensure and facilitate a fair review process.

11.2 The organisation will have a complaint and appeals process.

Principle 12

The organisation will use publicly funded resources to make a positive difference to the ability to participate and the quality of life of people with disabilities.

Outcome: People are satisfied with outcomes

Standards

12.1 The organisation will respect the right of people with disabilities to make choices.

12.2 The organisation will complement the resources of the person with those that are publicly funded.

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