

Disability Support Services

Tier Two Service Specification

Home and Community Support Services

1. Introduction

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

2. Service Definition

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

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

The Services may include Personal Care, sleepover/night support; and Household Management for disabled people in the homes they live in.

2.1 Key Terms

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

Term	Definition
Approved Assessor	An assessment facilitator employed by a Needs Assessment Service Coordination Service organisation (NASC). The Approved Assessor may have the title of Needs Assessment Facilitator or Assessment Facilitator.
Goal/s	An aspiration or target, or objective or future condition that the Person wishes to achieve in relation to the Person leading an everyday life.
Home	Home means residential premises in New Zealand in which the Person lives. Home does not include any hospital, rest home, or other institution. Note: Where a contractual arrangement exists whereby the resident pays for, or the facility owner is obliged to provide the Home and Community Support Services usually purchased by Whaikaha, then this definition does not apply.

Term	Definition
Personal Plan	A plan agreed with the Person that specifies how the Goals identified in the Support Plan will be met.
Needs Assessment Service Co-ordination (NASC)	These organisations are funded by the Ministry. Their roles are to determine eligibility, assess the Person's level of disability support needs, and to co-ordinate support services to meet those needs. NASCs co-ordinate such services, but do not themselves provide the services.
Other Staff Member	An individual who is responsible for delivering Services on behalf of a Service Provider. This includes the provision of direct care or support Service to the Person and covers all staff who are: (a) Employed; or (b) Contracted
People/Person	The use of the term "People" or "Person" should be read as substitutive for Service User or Client. It refers to the people who are eligible, have been referred by NASC, and are receiving the services described in this specification.
Personal Plan	Used in this specification to describe the various planning exercises and their output that relate to the Person being supported.
Support Plan	A plan agreed with the NASC and the Person that specifies their overall Goals and Type or Amount of Services.
Support Worker	An individual who is responsible for delivering the Service on behalf of a Service Provider. This includes the provision of direct care or support Service to the Person and covers all staff who are: (a) Employed (b) Contracted; or (c) Volunteer support workers accountable to the service provider
Type or Amount of Services	The quantity or nature of Services approved by the NASC in accordance with their legislation, contractual obligations, and operational policies, as set out in the Support Plan.
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 by 1 August 2023 and must be fully compliant with the new standards by 1 February 2024.

3.

4. Service Objectives

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

Successful services occur when:

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

The Person needs to be satisfied that:

- they have been, and are, respected as an individual
 - they have an ongoing voice in, and their wellbeing is central to, the Services being delivered
 - progress is made on the Person's Goals
 - the Goals are regularly reviewed with the Person
 - they have received Services at the agreed times without any unexpected interruptions to the Services, such as the support worker not attending.
- b) Where the Person is not satisfied with Services the Service Provider will put in place a corrective action plan in a timely manner.
- c) The Service links with any other agencies that provide support Services so that they work together to achieve the Person's Goals.
- d) The potential for further injury, harm, or decline in the Person's health is prevented or reduced.

5. Service Performance Measures

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

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

	How much	How well	Better off
1.	# of satisfaction surveys sent	% satisfaction surveys returned	# / % of people who reported satisfaction with the service
2.	# personal plans completed within three weeks of entry into the service	% of personal plans completed within three weeks of entry into the service	
3.		% of personal plans reviewed and signed-off at least once every 12 months	

	How much	How well	Better off
4.			#/% of goals in personal plans achieved
5.	# of people who reported their support worker did not turn up	% of people who reported their support worker did not turn up	
6.	# of people who reported their support worker did not turn up at the agreed time (defined as within 15 minutes of the agreed time)	% of people who reported their support worker did not turn up at the agreed time (defined as within 15 minutes of the agreed time)	
7.	# of complaints that have been received	% of complaints that have been resolved (i.e. a corrective action plan has been implemented)	
8.		% of staff turnover	
9.	# people you employ to provide Ministry funded HCSS for a disabled family member that they live with by month		
10.	# hours those people are employed for by month		

6. Service Users

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

6.1 Costs

There are no costs to be paid by the Person.

6.2 Access/Entry Criteria

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

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

7. Service Components

7.1 Start of Service

At the start of the Service the Service Provider will:

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

7.2 Personal Plan

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

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

In this discussion will ensure that:

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

The Personal Plan will include but is not limited to:

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

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

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

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

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

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

7.3 When urgent services are required

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

7.4 Where Services are delivered

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

7.5 Delivering services

The Provider will:

- a) Deliver Services as agreed in the Personal Plan.
- b) Provide the Support Worker/s or Other Staff Member/s with any required health and safety equipment or supplies.
- c) Visit the Person at a time agreed with the Person to deliver Services in a way that respects the dignity, rights, needs, abilities and cultural values of the Person, and their family / whanau / aiga.
- d) Respect the Person's Home and privacy within that Home.
- e) Ensure Services are delivered by suitably trained and culturally competent Support Workers and Other Staff Members to meet the Goals of the Person as identified in their Support Plan.
- f) Improve the health and independence of Māori by targeting Services to best meet Māori need and where possible to provide Services by Māori for Māori.
- g) Contact the NASC to arrange a new assessment for the Person if the Service Provider or the Person considers that support needs or goals have changed.
- h) Use the Person's feedback to continuously improve the service and ask the Person if they are happy with the service, using an independent process to do this.
- i) Ensure the Person knows:
 - how to make a complaint and who to complain to
 - how to access an independent advocate
 - that, where a complaint is made, an acceptable solution will be agreed and reached in a timely manner.

7.6 Type of Services Delivered

The Provider may deliver a combination of the following services.

7.6.1 Household Management

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

7.6.2 Personal Care

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

7.6.3 Sleepover Care or Night Support

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

7.7 Contingency planning

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

- when the Support Worker is on leave or unable to attend
- on public holidays
- in case of a natural disaster or publicly declared pandemic.

8. Guidelines/Policies/Legislation

The Service Provider must provide Services in accordance with:

- The Code of Health and Disability Services Consumers' Rights 1996
- The Health Act 1956
- The Health Information Privacy Code 1994
- The New Zealand Disability Strategy 2001
- Home and Community Support Sector Ngā Paerewa Health and Disability Services Standard NZS 8134:2021
- Health Practitioners Competence Assurance Act 2003
- All other relevant law relating to employment, health and safety, privacy.

9. Exit Criteria

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

The Provider can stop Services when:

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

10. Linkages

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

- Primary medical services
- Needs Assessment and Service Coordination (NASC) services
- Independent advocates or advocacy services
- Client/carer community support services
- Equipment Management Services (EMS)
- Specialised assessment services
- Mental Health Services
- Behavioural Support Services
- Assessment Treatment & Rehabilitation Services
- Secondary medical and surgical services
- Appropriate ethnic and cultural groups
- Disability consumer groups and relevant NGOs
- Government departments such as Work and Income etc
- Māori social and community services, support groups, and social service organisations e.g. local Kaumatua, marae, whanau groups, counselling, budget and family support services.

11. Exclusions

There are some closely related Services that are not covered under this Service specification. Any Service funded by a separate Service specification or agreement through Whaikaha, ACC, a Te Whatu Ora – Health New Zealand or any other government agency not covered under this Service specification including:

- a) Any equipment provision for the Person.
- b) Payment of a family carer that lives with the Person unless that person has been assessed as having high or very high disability support needs by the NASC.
- c) There are some closely related services that are not covered under this Service specification. Any Service funded by a separate Service specification or agreement

through Whaikaha, ACC, a Te Whatu Ora – Health New Zealand or any other government agency, or through a non-government entity directly funded by any of those parties, are not covered under this Service specification.

d) Ministry of Health, Whaikaha or Te Whatu Ora – Health New Zealand funded service including:

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

e) ACC funded services including:

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

12. Quality Requirements

11.1 Evaluation

DSS may conduct an:

- a) Independent survey to evaluate People's satisfaction with the service.
- b) External audit against the Home and Community Support Sector Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.
- c) Independent evaluation of service performance and effectiveness against this service specification, and its intended outcomes.

11.2 Certification

The Provider is required to maintain Certification as required under the Home and Community Support Sector Standards NZS8134:2021.

13. Purchase Units

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

Purchase Unit Codes	Purchase Unit Description	Measure	Purchase Measure definition
DSS1009	Home Based Support - Household management	Hour	Household Management services that enable a person to continue living with their own environment. This service is specifically for clients who meet the Ministry definition of disability.
DSS1010	Home Based Support - Personal Care	Hour	Personal Care, Sleepover service(s) that enable a person to continue living with their own environment. This service is specifically for clients who meet the Ministry definition of disability.

14. Reporting Requirements

14.1 Reporting Requirements

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

14.2 Complaints and Categorisation Service Outcomes

1. We both acknowledge your obligation to comply with the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021, and, in particular, your obligation to improve:
 - a. the experience and outcomes of clients and their whānau
 - b. service equity for clients who identify themselves as Māori or as a Pacific person, that the Services are underpinned by Māori or Pacific worldviews
 - c. opportunities for clients and their whānau to make decisions about their own care and support in order to achieve their goals; and
 - d. ensure all providers of Whaikaha services have access to a tool (Appendix 5) which encourages Providers to monitor disabled people's responses towards raising service quality concerns/complaints.