Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

ASD Developmental Coordination Service Specification (DSS221)

1 Definitions

ASD	Autism Spectrum Disorder. This encompasses a number of disorders which are characterised by problems with impairments in understanding and using verbal and nonverbal communication, in social behaviour and in the ability to think and behave flexibly, which may be shown in restricted, obsessional and repetitive activities. [Reference: NZ ASD Guideline Glossary of Terms and Abbreviations]
Developmental Surveillance	A shared parent/health professional activity which uses both parties knowledge about the child to monitor development in an ongoing way. [Reference: NZ ASD Guideline Glossary of Terms and Abbreviations]
Dual Diagnosis	The presence of an intellectual disability, physical disability, and/or a sensory disability, and a concurrent (DSM-IV-TR) diagnosis of autism spectrum disorder
DHB	District Health Board as defined in the New Zealand Public Health and Disability Act 2000
DHBs geographical areas	DHBs geographical areas are as set out in the New Zealand Public Health and Disability Act 2000. They are representative geographical areas based on territorial authority and ward boundaries.
(DSM-IV-TR)	Diagnostic and Statistical Manual of Mental Disorders Fourth Edition –Text Revision.
DSS	Disability Support Services
ID	Intellectual Disability: A condition manifested before the age of 18, in which people have both significantly subaverage intellectual functioning, and significant deficits in adaptive function.[Reference: NZ ASD Guideline Glossary of Terms and Abbreviations]
NZ ASD Guideline	*The New Zealand Autism Spectrum Disorder Guideline.* Published by the Ministries of Health and Education (March 2008). Also is considered to include any guideline supplementary papers or updated printings.

Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Needs Assessment and Service Coordination organisation (NASC)	All references to NASC in this document, unless otherwise stated, refer to Disability Support Services (DSS) funded NASC organisations. The NASC organisations assess people's needs, and then prioritise and coordinate services to meet those needs. DSS NASC organisations are only contracted to provide this service for people who
	meet the eligibility criteria for Disability Support Services.
NASC ASD guideline	*Working with People with Autism Spectrum Disorder: An interim guideline for NASC organisations.*
Provider	The provider who has entered into contract with DSS.

PD	Physical Disability: A person is assessed by a DSS NASC as meeting DSS' physical disability eligibility criteria - having long-term impaired limb function affecting independence in activities of daily living and/or mobility and requiring ongoing support. This includes people with chronic medical conditions who, following active treatment and rehabilitation, are assessed as having a long-term physical disability and an ongoing support need where physical disability (as opposed to physical incapacity) is the primary reason for support.
SD	Sensory Impairment or Sensory Disability: A deficit in sensory function (e.g., reduced visual acuity secondary to a primary eye abnormality or to damage of the visual cortex or impaired hearing or any other sensory deficit.) Impaired sensory processing functions can affect learning, play, work, socialisation, health and well-being. [Reference: NZ ASD Guideline Glossary of Terms and Abbreviations]
Service Users	The child or young person who is receiving the service.

2 ASD guideline

2.1 Background

2.1.1 The New Zealand Autism Spectrum Disorder Guideline was published in March 2008. It contains the following recommendations which this service aims to support.

- All District Health Boards (DHBs) should have in place processes that ensure:

a. referral pathways for children and adults who may have ASD or another developmental problem are clearly understood by professionals
b. services are coordinated within and across sectors
c. multidisciplinary, multiagency assessments are provided
d. all services are provided in a timely manner.

- Age of detection/diagnosis of all developmental problems, including ASD as a specified disorder, should be audited.
- All health and education professionals involved in care of children should know referral pathways for those children about whom concerns are raised.
- Formal pathways for diagnostic assessment of young people and adults should be developed.
- A developmental services coordinator should be appointed in each local area. This person would manage the referral process for all children about whom there are developmental concerns.
- A coordinated approach to planning and implementing services should be developed to meet the identified needs of an individual with ASD, including linkage or integration and coordination of multiple services.
- The appointment of a kaiarahi (guide) should be considered. The kaiarahi would work in conjunction with, and be supported across, the health, education and disabilities sectors involved with ASD.

2.2 Principles

2.2.1 Children and young people with development issues have those issues addressed faster and more efficiently resulting in improved levels of satisfaction from families and whānau about the support they are receiving.

2.2.2 The Service includes the establishment (and ongoing support) of a development plan that is based around the family, and the development needs of the individual.

2.2.3 Identification of developmental issues that are in need of coordination will be based on the NZ ASD Guideline.

2.2.4 The Service must accept appropriate referrals for any child or young person with identified developmental concerns requiring paediatric assessment from the Providers geographical area and coordinate the assessment process.

2.2.5 Following assessment and diagnosis of ASD, the Provider must ensure appropriate referrals are made to meet the needs of the individual.

2.2.6 Diagnosis must be made by professionals with appropriate clinical qualifications, and in accordance with evidence based best practice.

2.2.7 The Service will not replicate the needs assessment and service coordination functions of NASCs[1] for people with a dual diagnosis of ID, SD and/or PD.

2.2.8 Where there is no Dual Diagnosis of ID, PD, and/or SD, the Provider will offer a set of services similar to a NASC organisations coordination function for those individuals.

In doing so, the new NASC guidelines on ASD (2009) will be used, so that there is little variation in service delivery between those with Dual Diagnosis and those without.

2.2.9 Where possible, Māori will be provided with the option of Kaiarahi support once they are referred to the service and receive a diagnosis of ASD.

[1] NASCs require a diagnosed intellectual, sensory and/or physical disability to co-exist with a diagnosis of autism in order to coordinate access to Disability Support Services (additional restrictions may apply and various interpretations of eligibility criteria may be applied by NASC around the country). NASCs may apply eligibility criteria that differ from the wide definition of autism adopted by the NZ ASD Guideline.

2.2.10 While an adult with a developmental stage that is the equivalent of someone in the age range 0-19 may be accepted to the service, the priority for pre-assessment, assessment and post assessment coordination services will be for children and young people under the age of 19.

2.2.11 The Service user, their family/whānau/fono and carers are informed of, and understand, the role and scope of the Service.

2.3 Objectives

2.3.1 This service is intended to support, and be supported by, the existing resources and services available to children and young people within the DHBs as providers of this Service. The core objectives of the Service are that:

a) all referrals for children and young people (Service Users) identified as having developmental concerns that require professional assessment are coordinated to multidisciplinary, multiagency diagnosis and assessment pathway in an effective and timely manner.
b) post-diagnosis referrals into services for children and young people who receive a diagnosis that includes ASD are managed in a coordinated manner to meet the identified needs of the individuals with ASD. This includes linkage or integration and coordination into multiple services.

Providers may choose to identify a specific role responsible for completion of the tasks associated with the core objectives however; this specification is intended to describe the functions required rather than specifying a role that must complete them.

3 Service

3.1 Service provider duties

3.1.1 The Provider must coordinate the assessment processes for children and young people appropriately referred to the Service (ages 0-19) with identified developmental concerns and then coordinate the post-diagnosis services for people who receive a

diagnosis that includes ASD. The Service is further defined by the outputs and requirements as set out in clauses 3.1.2 – 4.4.4 ("the Service").

3.1.2 The Provider will coordinate the assessment process including the development of a written assessment plan specific to the individual Service User.

3.1.3 The Provider will coordinate and support the Service User to access the Services associated with the Service User's development plan for children and young persons who have received a diagnosis of ASD but do not have a co-existing diagnosis of sensory, physical or intellectual impairment.

3.1.4 The provider will supply relevant information to the Service User, their family/whānau/fono so they can understand the role and scope of the Service and as appropriate any diagnosis of ASD.

3.2 Service pathway

3.2.1 Upon receipt of a referral, the Provider will work within a multidisciplinary and multiagency approach (i.e. referral intake meeting) including education where appropriate, and child health services to ensure that the process of Developmental Surveillance has been appropriate. Where there are concerns about appropriateness for the referral, the referral may be passed back to the referrer for further action. The Provider may use their discretion as to whether or not to accept the referral and start organising an assessment process in this instance.

3.2.2 Where an adult over the age of 19 has a developmental stage that is the equivalent of someone in the age range 0-19, they may be referred and accepted into the Service, but the priority for the Service will be for children and young people. In this scenario the Provider may choose to accept the referral for assessment but should only do so following consultation with the assessment providers, the person with the behaviour concerns and their family/whānau/fono. This means that referrals for people over the age of 19 to this service are accepted only at the discretion of the Provider.

3.2.3 Where the Provider accepts that a referral is appropriate, the Provider should responsively and equitably administer entry to the Service in response to the local and regional availability of assessment resources. This may include the use of prioritisation processes i.e. 'waitlisting' or similar.

3.2.4 The Provider must offer the referrer and the child or young person (including their family/whānau/fono) feedback about the status of the referral within 21 calendar days of receipt of referral. This includes referrals when a person has been waitlisted or similar. Ideally this contact would occur as early as possible and will provide the family with contact information and expected waitlist delay times. Once a person who was waitlisted is accepted into the service, the referrer must be notified of this status change as soon as reasonably possible.

3.2.5 All children and young persons, referred to the service, who have been identified by health and/or education professionals as having developmental concerns must,

following diagnosis of ASD, have access to the coordination component of the Service.

3.2.6 All children and young persons accepted into the Service and who have been diagnosed with ASD receive an individualised developmental plan within 28 calendar days of diagnosis unless exempted as set out in clause 4.4.2.

3.2.7 The Provider should responsively and equitably administer entry to the Service in relation to the local and regional availability of assessment resources. This may include the use of prioritisation processes i.e. 'waitlisting' or similar.

3.2.8 The Provider will support the transition to NASC services for children and young persons who have received a diagnosis of ASD with a co-existing diagnosis of sensory, physical or intellectual impairment.

3.2.9 The NASC organisation will lead post diagnosis service coordination for children and young people who have a co-morbid ID, PD and/or SD, and are determined as eligible by the NASC for DSS.

3.2.10 In those geographical areas where the NASC organisations policy is to accept and coordinate services for Children and Young people with ASD without a co-existing diagnosis of sensory, physical or intellectual impairment, the Provider will support the transition to NASC services for children and young persons who have received a diagnosis of ASD. The Provider will work with the NASC to ensure the efficient and effective coordination of services to meet the children and young person's individual developmental needs. NASC disability eligibility criteria still apply.

3.2.11 The Provider is generally not intended to provide continued service coordination for an individual over a term exceeding two years; however, the appropriate length of coordination support should be decided on an individual basis in consultation with the Service User, their family/whānau/fono.

3.3 Service Outputs

3.3.1 The specific outputs associated with this Service are:

a) Upon acceptance of an appropriate referral, Information is provided to the Service User, their family/whānau/fono and carers within 21 calendar days that provides expected waitlist time (if any), status of their referral, contact details for the Service and any other relevant details such as your assessment process for children or young people presenting with developmental delay.
b) This information should be supplied to the families at time of acceptance of a referral, even if the child or young person is waitlisted.
c) From time-to-time general information content for use by the Service Providers may be developed and agreed through a working party of Provider representatives and DSS.
d) All children and young person's receive, on acceptance into the Service, a developmental assessment, or Diagnostic assessment as clinically appropriate, within 8 calendar weeks.
e) a written assessment plan specific to the individual Service user.

f) a written development plan for each person diagnosed as having ASD (without dual diagnosis of PD, SD and/or ID) as set out in clauses 4.4.1 – 4.4.4.
g) The developmental plan is reviewed and updated regularly as required in this specification.
h) Memoranda of understanding (or similar arrangements) between the Provider and the relevant key agencies within the geographical area that describe how they will work together, share information (in a lawful manner), not duplicate their services, and support the assessment and development needs of children and young persons with ASD. This includes DHBs cooperating to provide this Service jointly.
i) accurate and timely reporting submitted to DSS as set out in clause 14 of this specification.
j) All children and young persons who have been identified by health and/or education professionals as having developmental concerns and referred to the service must receive, on acceptance into the Service, a developmental assessment, or diagnostic assessment as clinically appropriate, within 8 calendar weeks.
k) The developmental plan is reviewed and updated regularly as set out in clause 4.4.3 and 4.4.4.

4 Service Processes and Components

4.1 Referral management and Prioritisation

4.1.1 The Provider must accept all appropriate referrals from health and/or education professionals who have identified demonstrable need for developmental assessment into the Service or waitlist (or similar prioritisation method).

4.1.2 The Provider must document the rationale and process for prioritisation and be able to provide this to DSS on request. The process should clearly identify points such as when the Service Users “referral is accepted” and a point were they are moved from the waitlist to actively receiving the Service. This will be used as the date from which a Service User is “accepted into the Service”. Once a Service User is accepted into the Service, further wait-listing of that person is considered inappropriate. For example prior to a Service Users transition from “accepted referral” to “accepted into the service”, the Provider should ensure that sufficient resource is available to adhere to the required timeframes set out in this specification.

4.2 Assessment coordination

4.2.1 As clinically appropriate the Provider must**:**

a) take and respond to enquiries from families and professionals but only initiate an assessment process based on referral and information provided by health and/or educational professionals.
b) coordinate a response, which includes arranging a general developmental assessment for all children under six years who meet the criteria for significant developmental concern. The general developmental assessment will be carried out by a developmental paediatrician or general paediatrician with appropriate competencies.

c) coordinate a response for all children and young people referred to the service who are greater than six years of age, who meet criteria for significant developmental concern, and on occasions, for any child or young person attending any compulsory education sector facility.
d) coordinate a response for all children and young people where it is clinically indicated that a diagnostic assessment should be undertaken.
e) identify possible duplications in assessment processes and work with local professionals to eliminate all real and unnecessary duplications.

4.3 post-diagnosis service coordination

4.3.1 For people diagnosed as having ASD[2] without an intellectual disability (ID), sensory disability (SD) or physical disability (PD) the Provider will:

[2] This means people with a new diagnosis of ASD. The service is not intended for people who received a diagnosis prior to referral to this service.

a) put in place a plan that centres around the developmental needs of the child or young person within the context of their family/whānau/fono circumstances

b) ensure that the family and likely service providers (e.g. respite providers, behavioural support providers) are involved in the development of the plan

c) ensure that the family are given prime responsibility for the maintenance of the Development plan and supported to enable them to carry out that responsibility

d) support the family at planned intervals to ensure that the developmental plan is kept upto-date and relevant to the changing needs of the person with autism (such support is likely to include liaison with health and education professionals).

4.3.2 For people who have a Dual Diagnosis i.e a co-morbid presentation with a DSS eligible disability, the Provider will refer them to the local NASC organisation and work with the NASC to put the appropriate supports in place. The NASC organisation will lead the coordination process in this scenario.

4.3.3 For people diagnosed with only ID, SD or PD, (but not ASD), the Provider will limit further involvement to a handover to the NASC unless otherwise agreed with the NASC.

4.3.4 In those geographical areas where the NASC organisations policy is to accept and coordinate services for Children and Young people with ASD without a co-existing diagnosis of sensory, physical or intellectual impairment, the Provider will support the transition to NASC services for children and young persons who have received a diagnosis of ASD. The provider will work with the NASC to ensure the efficient and

effective coordination of Services to meet their individual developmental needs. NASC disability eligibility criteria still apply.

4.3.5 The Provider will ensure that the processes for assessing needs and coordinating services are commensurate with the NASC ASD guideline.

4.3.6 The Provider will work with other service organisations (e.g. through intersectoral multidisciplinary team meetings) to ensure that the service users receive services that are commensurate with their developmental stage, as opposed to their biological age, including services provided by, but not limited to:

a) education services (special education needs coordinators, special education, resource teachers of learning and behaviour)
b) paediatric services
c) Well child/Tamariki Ora services and primary health care
d) NASCs
e) child development services
f) child and adolescent mental health services
g) regional paediatric networks (as and when they come into being)
h) local area coordinators (LACs as and when they come into being)
i) Non-Governmental Organisations (NGOs) or for-profit private providers that cater for the needs of children and young people with ASD
j) audiology services
k) child, youth and family services.

4.3.7 The Provider must establish and maintain protocols for referral and service coordination to minimise or eliminate any unnecessary overlap of services provided by organisations set out in clause 4.3.6 a-k. The protocols must be developed and maintained in consultation and collaboration with these organisations.

4.4 Development plans

4.4.1 The minimum set of domains for the development plans are outlined in the following table along with the types of issues that should be addressed.

	Domain	Types of information
1	Individual development needs	Description of the person's development needs and goals Methods for meeting development needs Cultural needs Risk assessment and mitigation strategies Dietary needs (as they relate to development) Medication regime (as it relates to development)

Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

2	Development goals for the person with ASD and expected outcomes	• Areas of current and potential interest including identifying areas of strengths • Goals for skill development and activities to be undertaken to achieve these • Expected outcomes
3	Providers of development services and what they will provide	• Description of who will provide development services contained in the development plan • Description of what they will provide and how they will provide it
4	Family/ whānau involvement	• Nature of involvement family/ whānau / carers will have with each of the development goals • Respective roles and responsibilities of providers of development services and family/ whānau / carers and the Provider. The Provider should have a role and responsibility in line with the service specification.
5	Practical arrangements	• Venue – where the services will be provided • Times - when the development services will be provided • Other - e.g. transport arrangements - how the person with ASD will get to the service and return home
	Domain	**Types of information**
		(noting the Provider is not responsible for providing this transport)
6	Risks	• Identify areas where there is a likelihood of serious harm or risk to the person or others arising from their behaviour • Implement appropriate referrals to agencies that will undertake further assessment and develop plans to mitigate such behaviour.
7	Linkages with other services (where relevant)	For example: • School • Work & Income • CYF • Primary care (GP, practice nurse, dental nurse) • Respite care providers • Day activity providers • NGOs like Plunket (if appropriate)

4.4.2 The Development Plan will be developed by the provider with the Service User and their family/whānau/fono or guardian within 28 calendar days of the person receiving a diagnosis of ASD. An exception to this requirement is allowable only if the Provider has made reasonable attempts to engage the family/whānau/fono or guardian in the development of the development plan and the family, whānau or guardian have chosen not to participate at that time.

4.4.3 The Provider must put in place a titrating review programme for the review and update of a Service Users Development Plan so that the Plans are reviewed regularly. Consideration in this titrating review programme must be given to regeneration at points of crisis and the point of exit from the service. The minimum review programme must include three reviews within the first 12 months of Service.

4.4.4 The review and update of a Service Users Development Plan must include the child or young person and their family/whānau/fono or guardians views of progress against expected outcomes, and areas which require further development. The review should also contain the views of the providers of development services applicable for the individual.

5 Māori Health, Pacific and Other Cultural Groups

5.1 The Crown Statement of Objectives outlines the Government's medium-term objectives for, and expectations of, DSS. He Ratonga Tautoko i Te Hunga Haua, the Disability Services Māori Disability Action Plan identifies four strategic goals aimed at increasing responsiveness to Māori.

5.2 The Service is intended to contribute to the achievement of the following goals:

a) Remove barriers for disabled Māori, Pacific and other groups
b) Increase participation by Māori, Pacific and other cultural groups in the disability sector
c) Develop effective disability services
d) Work across sectors.

5.3 There are key objectives for improving services for Māori, Pacific and other cultural groups and these are:

a) establishing appropriate links with mana whenua and iwi
b) promoting the Service in culturally competent ways
c) understanding the population served including the needs and ways of communicating with the range of cultural groups
d) ensuring all staff have cultural competencies e.g. knowledge of tikanga Māori.

5.4 Where possible, the Service must establish processes and relationships for assuring lifelong coordination services for Māori, through the appointment of a kaiarahi, using the model attributes described in Part 7 of the NZ ASD Guideline.

Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

6 Access Criteria

6.1 Inclusions

6.1.1 The Service is for children and young people aged from 0 – 19 years where:

a) developmental concerns have been identified[3] by health and/or educational professionals that require professional assessment, or;
b) ASD is strongly suspected and the child or young person is waiting for a diagnostic assessment.
c) the Provider believes an adult has a developmental stage that is the equivalent of someone in the age range 0-19. Note the priority for the Service is for children and young people under the age of 19.

6.2 Exclusions

6.2.1 This Service excludes people who:

a) do not have developmental concerns associated with ASD that have been identified by health and/or education professionals that require professional assessment
b) do not meet the age criteria (except as allowed in clauses 3.2.2 and 6.1.1c)
c) have received an assessment for diagnosis and do not have a post assessment diagnosis of ASD
d) do not meet the criteria for eligibility as provided for in the Health and Disability Services Eligibility Direction 2003.

[3] As noted in the NZ ASD Guideline (Part 1 Section1.2.a), the identification will be as a result of developmental surveillance followed by identification of developmental concerns and an appropriate referral

6.3 Geographical coverage

6.3.1 The Provider will accept appropriate referrals for all people within the Providers geographical area who are meet the criteria for the Services.

6.3.2 When it is unclear who has geographic responsibility for a Service User the Provider must agree with the other possible Providers involved as to which DHB will deliver the Service. This decision must be in consultation with the Service user concerned and their family/whānau/fono.

6.3.3 Where the Provider and other DHB(s) jointly provide the Service over multiple DHBs geographical areas, the Provider will be responsible for provision of the Service within their own geographical area.

6.3.4 If multiple DHB geographical areas are to be funded through a single contract, the geographical areas will be specified in the contract, and the Provider will be responsible for completing reporting for all areas specified.
6.3.5 When a Service User leaves the DHBs geographical area and at the request of the Service users' family/whānau/fono; the Provider must, as appropriate, facilitate and support transition of the Services User, including transfer of the records such as assessment and development plan, to the receiving DHB.

6.4 Service availability

6.4.1 The Service must be available during the normal working days and hours of the Provider.

6.4.2 The Provider must have appropriate processes to manage an emergency or crisis related to the Service Users diagnosis of ASD outside of normal hours. The minimum appropriate processes is to provide a mechanism for the Service User, or their family/whānau/fono, to be able to obtain information or reference to other appropriate 24-hour support services such CYF (Child Youth and Family services) and/or Child and Adolescent Mental Health Services (CAMHS) outside of the Service's normal business hours.

6.5 Exit

6.5.1 For children and young persons who receive a diagnosis that does not include ASD, the Provider must manage a transition to the appropriate agencies.

6.5.2 The Provider must ensure people who are referred to the Service, but do not meet the criteria for access, are referred to an appropriate agency for further support.

6.5.3 When a Service User receives a diagnosis of ASD has a co-existing diagnosis of sensory, physical or intellectual impairment the Provider will facilitate the Service Users transition to the NASC, where this is agreed with the local NASC. The Provider may agree an arrangement with NASC organisations that means that the Provider maintains a level of involvement in the coordination of ASD services for the person with ASD. This arrangement must be by agreement between the Provider and the NASC (in consultation with the person with ASD, their family/whānau/fono).
6.5.4 Children and young persons who received this service must exit from the Service when they turn 19 years of age. The Provider will facilitate the transition to appropriate adult services including Kaiarahi services for Māori (where they are available).

6.5.5 Service Users who are accepted into the service under 6.1.1c of this specification are exempted from the requirement to exit at age 19. The Provider should however transition these people who are biologically over 19 years out of the Service as soon as possible when it is considered clinically appropriate.

6.5.6 The Service user and or their family/whānau/fono or carer must be informed that the ASD developmental coordination service is not available in all DHB geographical areas in New Zealand. If The Service user transfers to a geographical area where the Service

does not exist for what ever reason, then they do so in the knowledge that your provision of the Service will not be extended outside your geographical area.

6.5.7 Providers may also transition individuals out of the Service where it is clear that the goals of the development plan have been met, and there are no new goals to achieve; or where progress

against the goals is so poor that the ongoing involvement of the Provider is unlikely to continue to provide any benefit to the Service Users, their family/whānau/fono. Such a decision can only be made following consultation with the affected person, their family, whānau representatives and local education and health services. Regional and National Health and Education services may also be consulted as appropriate.

6.5.8 Record keeping.

6.5.9 The Provider will maintain a record of all contacts with the person receiving the service, their family/whānau/fono or guardian. The record will include information on the reason for the contact and the outcome of the contact, including any follow-up actions.

6.5.10 The Provider must establish and maintain an information system to capture and report on the outcomes of the Service[4] as required for good practice and to meet the reporting requirements in this Service Specification.

6.5.11 The Provider will ensure that all processes comply with the Privacy Act 1993, Health Information Privacy Code 1994, and the Code of Patient Rights.

7 Key Inputs

7.1 Staffing

7.1.1 The Provider will ensure the Service is appropriately managed and all staff have and maintain appropriate qualifications and competencies.

4 See the NZ ASD Guideline for recommendations on information collection.

7.2 Staff training

7.2.1 The Provider will document a staff training plan. This will include, but not be limited to, providing staff involved in performing the coordination service with training, as appropriate, in the following areas:

a) general understanding of ASD

b) developing and implementing development plans

c) principles of social inclusion.

d) building relationships with families/whānau and carers and fostering networks with agencies that are likely to be involved in the person's development

e) developing development plans, coordinating service delivery against those plans, monitoring the delivery against those plans (to the extent that risks can be identified and raised with providers and their funders, but this is not a contract monitoring role)

f) communication skills (written and oral).

7.2.2 DSS may support the formation of a working group to generate and inform content for this service. Items developed and agreed with DSS and this working party of Provider representatives may be required to be utilised in the delivery of this service nationally.

7.3 Equipment

7.3.1 The Provider must provide staff providing the Service with the equipment they need to meet the requirements of this service specification, including access to transport, communications, and computer equipment.

7.3.2 The Provider must provide staff providing the Service with offices that provide safe storage of service user's records, and sufficient privacy and space in which interviews and phone calls between staff and Service users, their family/whānau/fono and carers can be conducted safely.

7.4 Sub-contractors and joint delivery

7.4.1 Where DSS has given written consent that the Provider may subcontract any part of the services to another party, the Provider will be responsible for all acts and omissions of their employees, agents and subcontractors even if they are done without their knowledge or approval.

7.4.2 When a Provider DHB is co-operating with another DHB to jointly provide the service, the Provider DHB and the DHB jointly providing the Service must enter into a MOU recording their agreement to provide the services prior to commencement of the provision of the service under this agreement.

8 Service linkages

8.1 The Provider must have linkages with:

a) NASC Organisations
b) providers of Disability services including respite services
c) behaviour support services
d) regional Paediatric networks when they become established
e) appropriate ethnic and cultural groups
f) Altogether Autism (Disability Information Advisory Service)

g) schools, special education providers where appropriate
h) transportation services e.g. Total Mobility, to recreational and/or day activities etc
i) Work & Income
j) CYF (Child Youth and Family services)
k) other agencies and service providers, as necessary under the Service Users development plan.

9 Quality Requirements

9.1 Provider quality

9.1.1 The Provider is required to comply with the DSS General Contract Terms, the DSS Provider Quality Specifications and Health & Disability Sector Standards (HDSS) NZS8134: 2001.

9.1.2 In accordance with the Provider Quality Service Specifications other quality indicators will be incorporated as part of your internal evaluation and service development plan.

9.1.3 The Provider must also ensure that all information provided is clear, concise and in a manner appropriate to the audience for which it is intended.

10 Service Satisfaction

10.1 Complaints procedure

10.1.1 The Provider will enable consumers/families/whānau/fono 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/whānau/fono
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/whānau/fono 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 nonresolution of a complaint
g) complaints are handled sensitively with due consideration of cultural or other values
h) Māori consumers and their whānau will have access to a Māori advocate to support them during the complaints process

i) consumers who complain, or on whose behalf families/whānau/fono 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.

10.2 Satisfaction Surveys

10.2.1 The Provider must design and implement surveys appropriate to the audience for which they are intended in order to gauge satisfaction of the Service Users, their family/whānau/fono and carers with the Service. The Provider must obtain consent from the Service Users for DSS, or its agents, to use the information in the surveys for the purposes of service improvement or service evaluation and must make the survey information available to DSS or its designated agents on request.

10.2.2 From time-to-time DSS may provide the Provider with questions to be included in the Provider's survey question set.

10.2.3 The Provider must conduct the surveys at least 6 monthly from the date of a Service Users entry into the Service. An exit survey should be conducted at time of a Service Users exit from the Service.

10.2.4 The Provider must have a process in place to analyse and use the feedback from these surveys to improve your delivery of the service.

11 Purchase Units

The following purchase units ("PU") apply to this service.

PU Code	PU Description	PU Definition	PU Unit of Measure	PU Measure Definition	National Collections and Payment Systems

Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

DSS221	ASD Developmental Coordination	DHB Autism Spectrum Disorder developmental coordination services to coordinate the assessment processes for children and young people (ages 0-19) with identified developmental concerns, and then further coordination of post-diagnosis services for people who receive a diagnosis that includes ASD. The service is delivered by staff to build relationships with families/whānau and carers, and fostering networks with agencies that are involved in the person's development.	Client	Number of clients managed by the service in the reporting period i.e. caseload at the beginning of the period plus all new cases in the period.	CMS

12 Reporting Requirements

Reporting Requirements				
PU ID	**PU Short Name**	**PU Measure**	**Frequency**	**Information**

Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

DSS221	DHB ASD Developmental coordinator	No. of Referrals	Six Monthly	1. Number of referrals received during the period 2. Number of referrals accepted as appropriate during the period 3. Total number of appropriate referrals waitlisted in the period 4. Current Waitlist total for the Period (Number of people on the waitlist at the end of the period) 5. Average calendar days Service Users spend on Waitlist 6. Number of referrals that were sent back to the referrer for more information in the period 7. Provide an overview of the referred population by source of referral (Education, Health or Other) and include for each category a summary showing referral numbers by: • ethnicity (Māori, Pacific, etc) • sex (Male, Female) and, • age in the following groupings: o 0-2 o 3- 5ys o 6 – 8 yrs o 9 – 11 yrs o 12 – 15 yrs o 16 – 19 yrs

Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

		No. of assessments	Six monthly	8. Average number of working days between date of acceptance of into service and the first specialist assessment 9. Average number of working days between date of acceptance of into service and the final diagnosis being confirmed
				10. Number of Service Users who did not receive Diagnosis in the required timeframe (8 calendar weeks) during this reporting period
				11. No. of Service Users diagnosed with ASD within the reporting period 12. No. of Service Users diagnosed with ASD who have a co-existing diagnosis of sensory disability, physical disability or intellectual disability 13. Number of people accepted for the service who received finalised development plans in this reporting period (where 'finalised' means that the person with ASD, family/whānau and development providers have agreed to the plan)

NB. Additional Narrative reports can be submitted at any time if there are issues that you wish to raise e.g. unmet need.

The report for each period is due by the 20th of the month following the end of the period. Delays beyond this date will be notified to us. Throughout the term of the agreement the periods for reporting are:

- 1 July to 31 December - due by 20 January

- 1 January to 30 June - due by 20 July

Where the agreement begins or ends part way through a period, the report will be for that part of the period which falls within the term of the agreement.

The Provider must forward the completed Performance Monitoring Returns to:

The Monitoring Team
Health New Zealand – Te Whatu Ora
Private Bag 1942, Dunedin