

Regional Intellectual Disability Community Care Agency (RIDCA) Service Specification

Purchase Unit code: DSS RIDCA

1. Definition

The Disability Support Services (DSS) has developed a framework of interconnected specialised services for people with an intellectual disability whose levels of need for behavioural support are so complex as to require specialist clinical support and intensive levels of co-ordination and agency interface. The definition of eligible service users includes those covered by the provisions of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R Act) and the RIDCA eligible civil population who are not subject to court order.

To ensure that there exists the full spectrum of effective and complementary services that succeed in supporting the person with complex needs DSS wishes to purchase the following national and regional network of services:

- Regional Intellectual Disability Care Agency – a specialist needs assessment and service coordination agency (RIDCA). Eligibility for all of the following services is determined through RIDCA.
- Regional Intellectual Disability Supported Accommodation Service (RIDSAS) providing community secure, supervised and independent supported living accommodation and/or services including vocational services and day activities.
- Hospital level services provide inpatient assessment, triage and longer stay components National Intellectual Disability Secure Services (NIDSS) (Hospital level forensic assessment and longterm placement).
- Regional Intellectual Disability Secure Services (RIDSS) (Hospital level \ forensic assessment).
- Attached to the RIDSS but with a community focus are Community Liaison Teams (CLT).

This specification defines the RIDCA content of this framework.

2. Service Objective

2.1 General

Services for people with intellectual disabilities who have high and complex behavioural needs will work collaboratively and co-operatively together. RIDCA has a central role in facilitating and supporting the allocated region, ensuring that the individual needs of service users across their defined geographical area are effectively met.

The provision of RIDCA functions must be separated from the provision of support services. The RIDCA provider will not also be the provider of support services, thus ensuring that no actual or perceived conflict of interest exists.

The key function of RIDCA is to work closely with services to ensure a seamless pathway for the service user beginning with referrals and co-ordinating effective needs assessment and service provision for:

- All RIDCA - eligible service users **see 2.1.1 below.**
- Civil Population i.e. individuals who have behavioural needs that are high and complex who are not subject to compulsory care **see 2.1.2 below** and:
- Proposed Care Recipients and Care Recipients subject to the provisions of the ID(CC&R) Act and The Criminal Procedure (Mentally Impaired Persons) - CP(MIP) - Act 2003 **see 2.1.3 below.**

These are detailed below:

2.1.1 All Service Users

Needs assessment

A needs assessment is a process determining the current abilities, resources, goals and needs of a service user with a disability and identifying which of those needs are the most important. The purpose of the process is to decide what a service user needs to maximise independence and participate as fully as possible in society, in accordance with their abilities, resources, culture and goals. A service user's needs will also include, where appropriate, the needs of their family and whānau and carers; the person's recreational, social and personal development needs; the person's training and education needs and vocational and employment needs.

Budget Management

- Budget Management involves managing cost effective packages of services within an indicative budget, as determined by the funder, for the identified population of the RIDCA provider. Budget management includes:
- Overall management, planning and monitoring of the utilisation levels of a specific budget.
- Promoting and arranging innovative and flexible service user focused service packages.
- Promoting consistent and equitable outcomes for people with disabilities.

Crisis Response

The RIDCA will provide a crisis response service when required. This will have a 24-hour emergency call system through which service users, families, carers or police experiencing genuine emergencies can access services such as emergency assessment /care when required.

To fulfil this function the RIDCA will need to be able to source crisis response options.

Needs Assessment and Service Coordination (NASC) Service Liaison

NASC liaison is a function where the RIDCA will provide the following additional support to the other NASCs in their region:

- support the NASC to maintain services users in order to minimise the likelihood that they will require RIDCA level services
- support the NASC to make appropriate referrals to the RIDCA
- support the NASC to develop and maintain linkages with their regional Mental Health services and other inter-sectoral services in relation to specific individuals
- support the NASC to refer to appropriate specialist who are able to establish intellectual disability
- transition services users from RIDCA level services back to mainstream services in accordance with agreed transition plans

2.1.2. Civil Population In addition to 2.1.1:

Intensive Service Co-ordination

The RIDCA provider is responsible for providing intensive service co-ordination for the RIDCA eligible civil population. The needs of this group of service users usually require the involvement of multiple providers and ongoing problem solving. Intensive service coordination requires that there be an ongoing relationship between the service user and the coordinator.

It is the intention of this service to prevent the need for increased levels of service provision (i.e. under the ID(CC&R) Act). Intensive service co-ordination must follow best practise principles and apply least restrictive alternative to service delivery.

Review

The Intensive Service Co-ordinator is responsible for ensuring there is an appropriate timeframe for a review for the service user who is not under an order. The date will be determined with the service user. The time interval will be indicated by the service user's needs but generally will be 6 monthly for the first 12 months in services and then by negotiation after that period. All service users will undergo a review at least once every 18 months following

the initial 12 months in services. The service user/family and whānau may at anytime seek a review if the service is not meeting their needs, or if any eligibilities have expired e.g. eligibility for community services card. Review periods for service users with particularly high or complex needs or those in a crisis period may be considerably shorter and more frequent.

Reassessment

Should the service user's needs or circumstances undergo significant change and the support plan no longer meets their needs, a reassessment will be undertaken. The services user, RIDCA or Provider, can initiate a reassessment at any time.

Should it be likely that the service user's support will increase or reduce over an identified period of time as the result of recovery, rehabilitation or the passing of a crisis, a reassessment may also be required but this could be an indicator when setting a timeframe for review.

2.1.3. Proposed Care Recipients and Care Recipients subject to the ID(CC&R) Act In addition to 2.1.1:

Care Co-ordination

The Care Co-ordinator is responsible for the administration duties for proposed Care Recipients and Care Recipients subject to proceedings of the ID(CC&R) Act.

This role replaces the function of intensive service co-ordination with the RIDCA-eligible civil population. The Care Co-ordinator is responsible for ensuring the comprehensive assessment of the person's support needs and for ensuring seamless pathway for the person across a range of services and environments. The Care Co-ordinator appoints the Care Manager to the proposed Care Recipient. The Care Manager reports to the Care Co-ordinator on matters pertaining to management under the Act.

Care Co-ordinators will be appointed by the Director General of Health and appointments will be notified in the Gazette. The Director General of Health will determine the terms and conditions under which each Care Co-ordinator is appointed. Guidelines for the powers, duties and responsibilities of Care Co-ordinators have been developed and include particular reporting requirements to DSS.

Specialist Assessments for Proposed Care Recipients under the ID(CC&R) Act.

The Care Co-ordinator is responsible for co-ordinating specialist assessments. These are undertaken by Specialist Assessors. Specialist Assessors are professionals experienced in assessment of people with intellectual disability who have been appointed by the Director General of Health. Specialist Assessors will recommend the treatment and services required to meet service user need. Specialist Assessors will also conduct six monthly clinical reviews of the Care Recipient and the Care Plan, ensuring that the Care Plan has been implemented; is meeting need, is cognisant of risks, and manages these risks to the proposed/ Care Recipient and/or community.

Specialist Assessors under the ID(CC&R) Act are required to be accredited to carry out this role by the Director General of Health. They will be required to meet accreditation requirements. DSS will notify RIDCA of appointed Specialist Assessors.

Review

Care recipients under the ID(CC&R) Act will have Court imposed reviews. s.

Reassessment

Should the service user's needs or circumstances undergo significant change and the support plan no longer meets their needs, a reassessment will be undertaken. The services user, RIDCA or Provider, can initiate a reassessment at any time.

Should it be likely that the service user's support will increase or reduce over an identified period of time as the result of recovery, rehabilitation or the passing of a crisis, a reassessment may also be required but this could be an indicator when setting a timeframe for review.

2.1.4 Māori Health and Disability

The Crown Statement of Objectives outlines the Government's medium term objectives for, and expectations of, DSS. 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 H&DNS 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) i.e. the use of Te reo, appropriate protocols, participation in Marae activities and regular whānau, hapu or Iwi initiatives.

3. Service Users

3.1 Inclusions

RIDCA will provide services for service users with an intellectual disability who it has assessed as meeting the following criteria:

3.1.1 Are adults (17 and over) exhibiting behaviour that poses a serious risk of physical harm to themselves or others **and:**

- Access is limited or prevented not only to ordinary opportunities and facilities, but also to mainstream disability support services.

or;

- Appears to manifest a psychiatric disorder, requiring mental health professional assistance for assessment, treatment or management.

or;

- Behaviour has resulted in a breach of law, requiring involvement of criminal justice personnel (including Police, Correction or the Courts).

3.1.2 Or are subject to the provision of the ID(CC&R) Act. This service is not age specific i.e. children and young people who are tried as adults in court may be included.

Child, Youth and Family Service are responsible for the case management and the development and funding of support packages for children and young persons with high and complex behavioural needs. RIDCA may provide assessment for children and young people with intellectual disability not included in 3.1.2 above though this should mostly be undertaken through NASC. RIDCA will support transition planning for young people who are leaving the case management responsibility of the Department of Child Youth and Family Services into RIDCA services.

The decision of whether to accept or decline a service user who has not offended but does have high and complex behavioural needs lies with the RIDCA. Depending on the circumstances of the service user this decision may need to be informed by the recommendations of a Specialist Assessor.

The RIDCA may action referrals in emergencies and where intellectual disability is not yet established until eligibility has been confirmed. If intellectual disability is confirmed the referral may be accepted if all other criteria are met. If intellectual disability is not present then the referral is declined.

3.2 Exclusions

RIDCA will not provide a service:

- For persons who do not fulfil criteria for entry to NASC services.
- For persons for whom it is already established there is no intellectual disability.
- For persons for whom the presence of intellectual disability is established but the person:

- Requires an assessment solely as a result of a mental health need – these assessments are contracted for by DSS through mental health assessment services or community mental health teams.
- Has needs that can be more appropriately assessed and met by generic NASC services (according to principle of least restrictive intervention).

3.3 Interface With Mental Health

It is expected that many service users under this specification will require the involvement of Mental Health services. DSS expects that in all such instances providers will work together to achieve the best outcomes for the service user.

- For those people whose needs are subject to Court Orders, formal relationships with Forensic Services and/or community Mental Health will need to be agreed upon for provision of assessment and review related to reports to the court and for all other specialist assistance available to meet the service user's needs.
- For non-offenders who may present with an associated mental illness, Community Mental Health services will be accessed. Roles and responsibilities of mental health and H&DNS will be documented and reflected in the service users Individual Plan and monitored by the Intensive Service co-ordinator.

4 Service Access

4.1 Referrals

The referral to RIDCA of the civil population will be mainly through the NASC who will also be included in any referrals from other sources. In emergencies referrals may come from a number of sources including Corrections Services, Courts and other mental health and disability support services. MOU's (Memorandum of Understanding(s)) will be required with key referring agencies.

The ID(CC&R) Act Guidelines will outline the referral process that will be followed for offenders.

Referrals shall be considered in the context of the specialist nature of the service. The RIDCA will need to manage referrals into the service. It is important to ensure continuity for people moving in and out of the region and within the spectrum of support need. This will require effective working relationships with other RIDCA and the appropriate general service (e.g. local NASC Agency) particularly for the civil population.

The RIDCA may action referrals in emergencies and where intellectual disability is not yet established until eligibility has been confirmed, and either may at that point accept the referral formally or decline.

Initial contact shall be made within 24 hours. The ID(CC&R) Act will set response rates to referrals for proposed care recipients.

4.2 Prioritisation

In keeping with the H&DNS philosophy and policies, the provider will promote selfdetermination, quality of life and create an environment that enables community participation and maximum independence for service users. The RIDCA has an important role in coordinating the use of all resources to ensure that they are used well and complement one another. These include voluntary, H&DNS and Mental Health funded services and those funded by other government agencies.

Proposed Care Recipients and Care Recipients subject to the ID(CC&R) Act are expected to receive services as ordered by the Court as a priority. Capacity to manage Court referrals will need to be ensured.

4.3 Inter Region Transfers

The RIDCA Provider will provide service to all service users specified wherever they currently live or subsequently shift to within the specified RIDCA geographic boundaries. RIDCA cannot refuse service users moving into its catchment area if the move is lawful and based on assessed need.

The RIDCA provider will establish protocols and procedures with NASC agencies and fellow RIDCA providers in other areas of New Zealand to ensure continuity of service for people both moving into and out of the RIDCA provider geographic boundaries. 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 or RIDCA, subject to the provisions of the Health Information Privacy Code (Office of the Privacy Commissioner 1994).
- Immediate commencement of services by the new NASC or RIDCA 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/RIDCA.
- A process for, and agreement on, a transition plan developed by both NASC/RIDCA 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 DSS for payment and planning purposes.
- A process for temporary moves between areas e.g. for education, holiday, study. Note: In this situation the original RIDCA retains responsibility for ensuring that the person's disability support needs continue to be met while away and as outlined in the support plan.

DSS requires that the transfer of service users between regions occur with the minimum level of disruption to their treatment goals. Where transfers in budget are required, this will be addressed by DSS at the end of each financial year or as required.

5. Service Components

5.1 Civil Population

5.1.1 Needs Assessment

The purpose of needs assessment is to enable the service users needs to be comprehensively identified. This process differs depending on nature of referral for care recipients (see section 5.2 below for the population under compulsory care orders).

The level of detail required in the needs assessment for the civil population is defined by the needs of the individual and the current principles of best practise and the outcome will reflect the nature and complexity of the needs of the person being assessed. The process identified by Part Three of the ID(CC&R) Act may be used, but is not compulsory for the civil population.

The process will include:

1. Collection of information that will assist in identifying eligibility for RIDCA service and Identification of any need for further specialist assessment. The further information required may include (but will not be limited to) cultural needs, vocational needs, health needs.
2. Working with the service user to identify their prioritised needs arising from their disability.

The RIDCA must ensure that it has in place a suitable network of qualified and competent staff to provide adequate coverage of the entire geographic area contracted for, including remote and rural areas. Any sub-contracting of assessment facilitators must have prior approval from DSS.

Further information about the process and requirements for delivering facilitated needs assessment is provided in the Standards for Needs Assessment (1999) and Information Reporting Guidelines and subsequent updates.

An assessment tool and supporting guidelines for all RIDCA referrals are available in the current DSS ID(CC&R) Procedures Manual and ID(CC&R) Guidelines.

5.1.2 Specialist Assessment

While a specialist assessment is required for all proposed Care Recipients under the ID(CC&R) Act, the Intensive Service Co-ordinator may refer an individual from the civil population for a specialist assessment where appropriate. Specialist Assessments requested under the ID(CC&R) Act must take priority. The specialist assessment will provide more detailed information and knowledge required to accurately assess the needs and identify a range of recommendations. The RIDCA is to identify and facilitate access to specialised assessments as required.

Specialist Assessments will include but are not limited to clinical, diagnostic or specialist 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 rehabilitation or habilitation (e.g. behavioural support).
- Determine the individual'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, mobility assistance).
- Provide advice on how support services can assist in furthering the rehabilitation process.
- Establish if co-morbidity is present.

The RIDCA provider will also identify and facilitate access to assessors funded by other government departments e.g. education, vocational.

5.1.3 Cultural Assessment

Specialist assessment entails a full assessment of a person's cultural identity and needs. This cultural assessment is carried out in parallel to a specialised or specialist assessment. It is important to facilitate the integration of cultural assessment and specialist assessment recommendations within the cultural contexts involved (including Deaf culture).

It is important that the cultural and support needs and specialist assessments complement each other and have a clear focus on the best outcome for the person and their family and whānau. Cultural assessment must try to identify the service user's culture, ethnicity, language and any religious or ethical beliefs.

RIDCA will generally purchase cultural assessments on a fee-for-service basis. However, this process is currently under review and the purchase method may change. DSS will inform the RIDCA of change when a process is finalised. The purchase of assessments will be a charge against the budget managed by the RIDCA provider.

There will be instances where a cultural assessment is provided by a service with whom DSS has an existing contract that includes the provision of cultural assessment. In this instance RIDCA will make a referral to that service and is not expected to make additional payment.

The Ministry has developed Cultural Assessment Guidelines for Māori. The Māori Cultural Assessors:

- 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 Māori and Pakeha perspectives may be different on certain issues. This will reduce the possibility of

cross-cultural misunderstandings and incorrect interpretations occurring during the assessment process.

Areas of cultural assessment may include identifying with the service user:

- Their needs and preferences (through a form of communication appropriate for them).
- Cultural supports, including key people that need to be involved.
- Their whānau and turangawaewae.
- Cultural information, including the persons hapu and iwi, any information relating to the whānau and whakapapa; tinana; hinengaro; wairua and mana.

5.1.4 Intensive Service Co-ordination

The RIDCA is responsible for providing intensive service co-ordination for the RIDCA-eligible civil population and those under assessment for eligibility. The involvement of multiple providers and ongoing problem solving is usually required. Intensive service co-ordination requires that there be an ongoing relationship between the service user and the co-ordinator balancing the need for support whilst maintaining maximum independence of the individual.

The tasks of Intensive Service Co-ordination include:

- Negotiating the most appropriate means for achieving the outcomes and responsibilities with service providers and other sectors e.g. education, justice, police.
- Arranging interim and crisis service revision pending further assessment.
- Involvement with specialised services e.g. DHB mental health teams for assessment and treatment planning, integrated with facilitated needs assessment and service coordination for people with a dual diagnosis of intellectual disability and mental health.
- Convening or participating in meetings as required with the service user and those involved in the development and/or implementation of a support plan.
- Monitoring the delivery of the support plan, review of needs with the view to revising the support plan at regular specified intervals.

The RIDCA will:

- Ensure that intensive service co-ordination is offered to people with high and complex needs who meet the eligibility criteria, or those undergoing eligibility assessments.
- Work with others involved in supporting the person to ensure everyone has a common understanding of intensive service co-ordination.

5.1.5 Review

The Intensive Service Co-ordinator is responsible for ensuring there is an appropriate timeframe for a review for the service user who is not under an order. The date will be determined with the service user. The time interval will be indicated by the service user's needs but generally will be 6 monthly for the first 12 months in services and then by negotiation after

that period. All service users will undergo a review at least once every 18 months following the initial 12 months in services.

RIDCA will conduct formal reviews of each service user.. The time interval will be indicated by the service user's needs but generally will be 6 monthly for the first 12 months in services and then by negotiation after that period. All service users will undergo a review at least once every 18 months following the initial 12 months in services. The RIDCA will determine an appropriate timeframe if this is to be more frequent. The service user/family and whānau may at anytime seek a review if the service is not meeting their needs, or if any eligibilities have expired e.g. eligibility for community services card, carer support. Review periods for service users with particularly high or complex needs or those in a crisis period may be considerably shorter and more frequent.

5.1.6 Reassessment

Should the service user's needs or circumstances undergo significant change and the support plan no longer meets their needs, a reassessment will be undertaken. The services user, RIDCA or Provider, can initiate a reassessment at any time.

Should it be likely that the service user's support will increase or reduce over an identified period of time as the result of recovery, rehabilitation or the passing of a crisis, a reassessment may also be required but this could be an indicator when setting a timeframe for review.

5.1.7 Service Exit

The process used for individuals exiting RIDCA funded services will comply with the *Guideline for the transfer of RIDCA clients to NASC, 2006, DSS*.

5.1.8 Crisis Response

RIDCA will ensure the provision of a crisis response service through a 24-hour emergency call system for RIDCA eligible service users, (or those undergoing eligibility assessments), meeting also the legislative requirements of the Care Co-ordinator.

RIDCA will also need to be able to access emergency short-term care options for eligible service users and manage the resources that are capacity funded by DSS for such emergencies. Court referrals have greatest priority.

5. 2 Proposed Care Recipients And Care Recipients Under the ID(CC&R) Act

5.2.1 Needs Assessment

The purpose of needs assessment is to enable the service user's needs to be comprehensively identified. This process differs depending on nature of referral for proposed/care recipients (for the civil population see section 5.1 above):

For referrals for proposed Care Recipients the assessor must comply with the assessment process stipulated under Part Three of the ID(CC&R) Act. The Care Co-ordinator will either conduct or delegate the task of “needs assessment” to another person.

The objectives of the assessment process under Part Three of the Act are:

1. To collect information that will assist in confirming eligibility for RIDCA service and also identify area as where assessments additional to those specified in the Act may be required. The further information required may include (but will not be limited to) cultural needs, vocational needs, health needs.
2. Work with the proposed Care Recipient to identify their prioritised needs arising from their disability.

This “need assessment” is called “**initial assessment**” in the DSS Procedures Manual ID(CC&R). This is in order to prevent confusion over the terminology used for the legislative process and that used in mainstream NASC process – (the terminology in the Act is at times inconsistent with that used in mainstream NASC process).

The RIDCA must ensure that it has in place a suitable network of qualified and competent staff to provide adequate coverage of the entire geographic area contracted for, including remote and rural areas. Any sub-contracting of assessment facilitators must have prior approval from DSS.

Further information on the process and requirements for delivering facilitated needs assessment is provided in the Standards for Needs Assessment (1999) and Information Reporting Guidelines and subsequent updates.

An assessment tool and supporting guidelines for all RIDCA referrals are available in the current DSS ID(CC&R) Procedures Manual and ID(CC&R) Guidelines.

5.2.2 Care Co-ordination

The role of the Care Co-ordinator is to oversee and manage the pathway for each service user referred by the Court, prisons or forensic services to the RIDCA under the ID(CC&R) Act. This will require the Care Co-ordinator to act with a high level of flexibility and accountability for the completion of key duties, powers and functions, including:

- Processing applications and referrals.
- Designating a Care Manager for each referred service user.
- Arranging specialist assessments and reviews from non-accredited specialist assessments as required e.g. Speech Language, Occupational Therapy and Cultural Assessments.

- Facilitating the integration of cultural assessment and specialist assessment recommendations within the cultural contexts involved (including Deaf culture).
- Arranging interim and crisis service provision pending further assessment.
- Determining the eligibility of the service user for high and complex needs services.
- Allocating referrals to Care Managers to undertake development of a Care and Rehabilitation Plan.
- Facilitating access to legal representation for service users.
- Sign off the Care & Rehabilitation Plan developed by the Care Manager.
- Monitoring the Care & Rehabilitation plans developed through 6 monthly reviews or on direction from the Court.
- Liasing with providers, courts and other government agencies.
- Reporting to the Courts as required for service users under the ID(CC&R) Act.
- Negotiating with providers.
- Managing the budget.

The Care Co-ordinator must ensure that:

- There is a suitable network of designated Specialist Assessors in place, who are able to assess service users within the RIDCA geographic area.

There is access to crisis support including residential accommodation or support into the service user's home.

Outcomes will be:

- Timeframes and duties, functions and process requirements stipulated in the ID(CC&R) guidelines for the application of the Act are met.
- Application of the service principles are evident.

The appointment process for the Care Co-ordinators will be established by the Director General of Health.

5.2.3 Specialist Assessment

All service users whose referral has been accepted by RIDCA may receive a specialist assessment.

The Care Co-ordinator will request a specialist assessment for all proposed Care Recipients. The specialist assessment will provide more detailed information and knowledge required to accurately assess the needs and identify a range of recommendations. The RIDCA is to identify and facilitate access to specialised assessments as required.

Specialist assessments include the key duties of:

- Establishing the basis, extent and context of disability (e.g. testing, diagnosis and medical/physical prognosis, implications for learning, behaviour and prognosis).
- Identifying any risks associated with the person's behaviour.
- Making recommendations on how the specific needs of the person can be met (e.g. treatment and therapy options).
- Make recommendation on how the risks associated with the person's behaviour can be managed.
- Provide advice to RIDCA on how support services can assist in furthering the habilitation process.
- Contribute to the development of the Care & Rehabilitation Plan.
- Provide advice to support services.
- Provide a 6 monthly (or earlier) review of the Care Recipient's Care & Rehabilitation Plan and make recommendations on how the specific needs of the individual can be met.

5.2.4 Cultural Assessment

Specialist assessment entails a full assessment of a persons cultural identity and needs. This cultural assessment is carried out in parallel to a specialised or specialist assessment. It is important to facilitate the integration of cultural assessment and specialist assessment recommendations within the cultural contexts involved (including Deaf culture).

It is important that the cultural and support needs and specialist assessments complement each other and have a clear focus on the best outcome for the person and their family and whānau. Cultural assessment must try to identify the service user's culture, ethnicity, language and any religious or ethical beliefs.

RIDCA will generally purchase cultural assessments on a fee-for-service basis. However, this process is currently under review and the purchase method may change; DSS will inform the RIDCA of change when a process is finalised. The purchase of assessments will be a charge against the budget managed by the RIDCA provider.

There will be instances where a cultural assessment is provided by a service with whom DSS has an existing contract that includes the provision of cultural assessment. In this instance RIDCA will make a referral to that service and is not expected to make additional payment.

DSS has developed Cultural Assessment Guidelines for Māori. The Māori Cultural Assessors:

- 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 Māori and Pakeha perspectives may be different on certain issues. This will reduce the possibility of

cross-cultural misunderstandings and incorrect interpretations occurring during the assessment process.

Areas of cultural assessment may include identifying with the service user:

- Their needs and preferences (through a form of communication appropriate for them)
- Cultural supports, including key people that need to be involved.
- Their whānau and turangawaewae.
- Cultural information, including the persons hapu and iwi, any information relating to the whānau and whakapapa; tinana; hinengaro; wairua and mana.

5.2.5 Review

RIDCA will conduct formal reviews of each service user at least every 6 months or as directed by the court. Review periods for some service users may be shorter, when prompted by a change in needs or circumstances.

5.2.6 Crisis Response

RIDCA will provide a crisis response service through a 24-hour emergency call system for RIDCA eligible service users.

RIDCA will also need to be able to access emergency short-term care options for eligible service users and manage the resources that are capacity funded by DSS for such emergencies. Court referrals have greatest priority.

5.3 Māori Service Components

The RIDCA 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 RIDCA will establish and implement a Māori Service Plan that covers governance, management, organisational competencies, Māori health and disability gain, assessment and coordination practices, and how these will contribute to improving outcomes for Māori through the needs assessment and service coordination process.

In developing the plan the RIDCA will take into account DSS'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 DSS.

The RIDCA will specify how it intends to implement this plan. In particular, the RIDCA 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 RIDCA 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 RIDCA 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 the equitable distribution of resources.
- Provide the NASC service in Te Reo Māori where necessary or appropriate or specifically requested by the person.

The RIDCA 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 coordinators have appropriate cultural competencies and/or support from cultural experts and resources.
- That people have access to kaumatua (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 RIDCA can demonstrate progress toward implementation of cultural competencies to be developed by DSS during the term of this contract.

5.4 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 RIDCA 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 coordinated, culturally competent and clinically sound.

The RIDCA is required to ensure:

- It can demonstrate progress toward implementation of cultural competencies to be developed by DSS during the term of this contract.

5.5 Other Cultures

RIDCA is 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.

5.6 Information Management

Access to information is a vital function to support people's independence and is an integral component of the RIDCA business. The RIDCA has the dual role of both providing information and acting as an information broker.

It is expected that the RIDCA will capture and store data according to specifications provided by DSS and will use any system, designated funded and supported by DSS 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.

RIDCA is responsible for providing and facilitating a range of information to and from a number of sources. Information managed by RIDCA will include:

- Information about individuals e.g. needs assessment and service coordination information.
- Information for individuals regarding RIDCA processes e.g. information on RIDCA service users' rights and complaints processes.
- Information on service availability e.g. contracted providers for RIDCA (and other disability) support services and occupancy information.
- Information for business management e.g. 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.

5.6.1 Individual Information

Management of information on individuals is a core function of NASC/RIDCA. NASC/RIDCA must comply with the *Health Information Privacy Code 1994*.

RIDCA is required to work to key principles and practices under the code and in accordance with legislation

At a minimum information must be:

- Necessary.
- Collected lawfully.
- Stored securely.
- Accurate, up to date, complete, and not misleading.

People must be informed that, (subject to any court orders) 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.

RIDCA 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).

5.6.2 Disability Sector Information

RIDCA has 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 RIDCA 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 H&DNS 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 RIDCA is not expected to compile and duplicate specific detailed information already available from other disability information agencies in their area. However, the RIDCA 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.

DSS considers it important that persons:

- Are supported through the process by having relevant information.
- Have a co-ordinated and comprehensive method for accessing information.

5.6.3 Provider Information

The RIDCA will provide support services with sufficient information to enable it to provide service to people referred to them. To ensure this happens RIDCA 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 Memorandum of Understanding with providers to cover such things as:

- Specifying what information is to be provided by RIDCA.
- 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 RIDCA will provide information to other disability support service providers on trends, un-met needs etc, for the purpose of fostering creative, innovative, flexible services.

5.7 Monitoring Of Support Service Delivery

5.7.1 ID(CC&R) Act

RIDCA will report legislative requirements to DSS on a same day basis for new care recipients of ID(CC&R) Act through the required mechanism.

5.7.2 All Service Users

RIDCA will report quarterly to DSS on:

1. Delivery to Support Service Providers contracted by DSS. Frequency may be quarterly or as often as daily where this is required through IDCC&R administration (see 10.1 below.) It is expected that RIDCA will implement a process of monitoring for:
 - Negotiated and actual delivery timeframes and;
 - Actual delivery to the Support Plan or Care & Rehabilitation Plan as negotiated between Intensive Service Co-ordinator and Provider/Care Manager(s).
2. Whether services being delivered are able to meet the needs of service users. The RIDCA might, for example, comment on the willingness of the service provider to understand the needs of the service user and be flexible, within reason, in how these are met.
3. Gaps in services available from the providers – particularly services that are being purchased in significant volumes outside of DSS contracted providers (using flexible funding). DSS will meet with RIDCA at least annually to jointly plan the possible purchase by Ministry of services to fill identified gaps.
4. Any unresolved issues, problems or complaints and significant risks with service delivery by contracted providers.
5. RIDCA will report to DSS any major risk or complaint within 24 hours of it occurring.
6. Discretionary funding expenditure. The RIDCA is responsible for ensuring the quality of services purchased from their discretionary funding budget. Further details in this requirement are in Schedule 1.

The RIDCA will report to DSS any major risk or complaint concerning service users under RIDCA management within 24 hours of its occurrence. The RIDCA 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/RIDCA Discretionary Funding”.

5.8 Reviews

The RIDCA will make available information to all people detailing the procedure by which people may request a review of the outcome of a part, or the whole, of the assessment or service coordination 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 RIDCA if the person remains dissatisfied.

The RIDCA is required to ensure:

- That the protocol for reviews, as included in the NASC Managers' Manual (2005), is known, consistently applied and monitored.
- Implementation of the DSS procedure for reviews specific to RIDCA once current work is completed.

The above steps will be at the RIDCA's expense. If a complaint still exists, the person may contact the Ministry. The standard review procedure provided by DSS at that time will be followed.

5.9 Budget Management

RIDCA will manage a defined indicative budget based upon an annual allocation on behalf of DSS. RIDCA and DSS will review the budget figure on a quarterly basis.

RIDCA will ensure access to priority services for the specified service user group within the contracted geographic area. RIDCA will also ensure that budget and commitments made to purchase service packages for service users are such that they will not exceed the indicative budget for the current and out years.

In managing the budget RIDCA will need to take into account the following factors:

- That a percentage of their budget will be committed to residential and crisis response services that have been capacity purchased.
- The need to ensure service users transfer to H&DNS services as appropriate.

- The need to retain a percentage of the budget that can be used to purchase flexible options i.e. options that do not already have a contract to provide a particular service with DSS.
- The need to retain a percentage of the budget that can be used to purchase specialist assessments that are Court ordered.
- The method for funding specialist assessments, including cultural assessments, is on a fee for-service basis. However, this is currently under review and the purchase method may change; DSS will inform the RIDCA of change when a process is finalised.
- Priority of service provision is to those service users under Court Orders through the ID(CC&R) Act.

In general, requirements for budget management are contained in Appendix 1 of the NASC Service Specification DSS 1004 and DSS 1005. These are attached as Appendix 1 of this specification. Exceptions that may arise because of the nature of RIDCA services will have prior approval from DSS.

5.10 Payment Processes and HealthPAC

The requirements for payment processes relating to HealthPAC are contained in Appendix 2 which forms part of this service specification.

5.11 Discretionary Funding

The requirements for Discretionary Funding are contained in Appendix 3 which forms part of this service specification.

5.12 Key Inputs

Infrastructure

RIDCA will be purchased as a service that sits within a NASC Agency that has an existing contract with Health & Disability National Services. The core functions, responsibilities and standards of performance of the NASC will apply to the RIDCA. (Refer to service specification NASC DSS1004 and DSS 1005).

RIDCA is a small specialist service and will receive support from its parent organisation for infrastructure and management support e.g. business support, information systems.

Staffing

The Director General of Health will appoint Care Co-ordinators as required under the ID(CC&R) Act. Care Co-ordinators will be required to attend training programmes as directed by DSS. DSS requires Care Co-ordinators to be qualified health professionals, or health professionals in training, with recognised work experience with people with intellectual disabilities.

The RIDCA shall:

- Ensure that staff are supported to develop and maintain competence and undertake formal training and qualifications as they are developed.
- Be an Equal Employment Opportunity organisation.
- Provide for the cultural aspects of the RIDCA Service Components.
- Fulfil the responsibilities of budget management.
- Have systems to provide access to the RIDCA service, fulfil the quality, information and monitoring requirements of this specification, and maintain records and reporting.

6 Service Linkages

RIDCA is required to maintain effective links with RIDCA in other regions for the purpose of:

- Sharing knowledge, ideas and information on the role of the RIDCA as it develops.
- Sharing ideas, knowledge and understanding of treatment and service options for service users.
Peer review as part of performance management system.
- Ensuring that when service users are transferred between regions there is minimum disruption to their treatment goals, risk is minimised and transfers occur with the interests of the service user foremost.

It is critically important that RIDCA and the other providers work together to ensure that:

- Service users have access to the full range of services.
- Disputes among providers concerning service coverage are resolved without adversely affecting any service user.
- Disputes among providers concerning the course of treatment of any service user are resolved in a timely manner.

RIDCA is required to demonstrate effective linkages with these Key Agencies or Providers:

- Hospital level secure services.
Supported accommodation providers.

- Specialised and Specialist assessors.
- Needs Assessment and Service co-ordination Agencies (NASC) throughout the geographical region served and other RIDCA.
- Dual diagnosis services.
- Māori Primary and Community Care services.
- Court and Correction services.
- Forensic Services.
- Community Liaison Teams.
- NZ Police.
- Department of Child Youth and Family services (for children and young persons)
- District Inspectors.
- Mental Health Services.
- Other supported accommodation providers.
- Behaviour support services.
- Vocational services and day programmes including Marae.

DSS requires evidence of effective relationships particularly with RIDCA(s), Māori and Secure Services. Protocols and evidence will be subject to audit.

There is a range of other services that linkages must be established with:

- Māori primary and community care services.
- Other appropriate Māori organisations.
- Other mental health services.
- Consumer advocacy services.
- Vocational services and day activity providers.
- Other sector agencies.

The Funder will require RIDCA to provide evidence of the effectiveness of relationships. For Key Agencies or Providers the RIDCA should have in place Memoranda of Understanding, Protocols or other liaison mechanisms that agree how the relationship will be conducted. These will be an area for audit.

7 Service Exclusions

Nil.

8. Quality Requirements

The service is required to comply with the DSS General Contract Terms and Conditions. In addition the following quality standards and requirements also apply:

8.1 Quality Standards

The service is required to comply with the DSS General Contract Terms and Conditions. In addition, the following quality standards and requirements also apply.

National Health & Disability Sector Standards (and any updates).

Only specific parts of the Health & Disability Sector Standards (HDSS) are relevant to RIDCA. All RIDCA providers are required to meet the standards and criteria identified by in the HDSS.

It is envisaged that RIDCA will work towards compliance with the HDSS over time. Until which time as RIDCA is fully compliant it must met 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) and subsequent updates.

8.2 Quality Requirement

8.2.1 Access

8.2.2 Timeframes for Civil Population

- Initial contact with the service user will be made within 24 hours of receipt of the referral.
- Time to commence specialist assessment should be **within 5 working days in 95% of cases.**
- Time to complete specialist assessments should be **within 10 working days**
Time to complete support plan should be within **10 working days of specialist assessment being available.**

8.2.3 Timeframes for Court, Prison and Forensic Referrals

- The timeframes for service referrals and transfers are set out in the ID(CC&R) and CP(MIP) Act, and must be met as legislative requirements.

8.2.4 Person/Family and Whānau/Aiga Involvement

The persons, family, whānau/aiga members, and advocates shall be central to service delivery. This requires:

- The person be given an opportunity to identify who to include or exclude from their assessment process where they are able to exercise informed consent.

- The person, family and whānau/aiga members, support workers and advocates be provided information on how they can be involved in needs assessment and service co-ordination processes.
- The person, family and whānau/aiga members, support workers and advocates be notified of complaint procedures.
- The person, family and whānau/aiga member is involved in a culturally appropriate manner.
- Meeting the requirements of involvement of others to the needs assessment process as set out in the ID(CC&R) Act.

8.2.5 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 must be consistent with the DSS Guidelines for Consumer Surveys.

The methods used will identify the acceptability of the following areas of the service as indicated by service users, support service providers, support staff, family, whānau and the service users 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 RIDCA services.
- Complaint and feedback systems.

Safety

There are documented operational programme/policies/protocols and guidelines that identify and minimise risk areas for the RIDCA. The use of these systems is included as part of the RIDCA Providers Quality Improvement system. These areas must include but are not limited to:

- Reporting of abuse.
- Poor service delivery identification and how this will be reported to DSS.
- Service gap identification and how this is reported to DSS.
- Support service provider withdraws services to service users and reporting this to DSS.
- Any declines by RIDSAS.

8.2.7 Reporting Change

The RIDCA is required to advise DSS of any significant change in the organisational structure or capability of the RIDCA, and of any other matters significantly affecting, or likely to affect, RIDCA function and quality.

9 Purchase Units

9.1 Forms

The provider will use the forms for administrative and legislative requirements provided in the DSS Procedure Manual ID(CC&R) Act.

9.2 Service User Details

There are two forms for the purposes of the ID(CC&R) Act that must be completed within timeframes as identified in the procedures : PM 009 and PM 009 (a), (b) & (c).

The administrative form should be completed for each new service user accessing the service for any changes to service user details. Specific details of the information required from these forms as well as instructions for completing these forms is contained in the separate guide notes and sample form.

Alternatively, the information from Service User Details forms can be supplied in electronic format using the nationally consistent file specifications supplied by DSS. The completed forms or electronic data should be sent to DSS within several days of completion for administrative reporting and on the same day for legislative reporting.

9.3 Purchase Units

The service will be purchased for the eligible population of the region of coverage for a contract price.

PU ID	PU Description
DSDRIDCA	Care Co-ordination
DSDRIDCA	Intensive Service Co-ordination
	NASC Liaison
DSDRIDCA	Specialist assessment (initial)
DSDRIDCA	Specialist assessment (review)
DSDRIDCA	Discretionary funding

10 Reporting Requirements

10.1 Quarterly Report

Quarterly reporting is to be supplied to HealthPAC and a copy sent directly to the National Contracts Manager on a quarterly basis. These reporting requirements are subject to review during the course of the contract. This information should be supplied within seven days after the end of each quarter, using the DSS template format. The report for each quarter is due by the 20th of the month following the end of the quarter. Delays beyond this date will be notified to us.

The Quarters for reporting are:

1 July to 30 September	due by 20 October	1
October to 31 December	due by 20 January	
1 January to 31 March	due by 20 April	
1 April to 30 June	due by 20 July	

Where the agreement begins or ends part way through a reporting 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:

The Monitoring Team
HealthPAC
Ministry of Health
Private Bag 1942

You shall also submit a copy of your template to the Agreement Manager named on the front of this agreement or electronically to firstname_lastname@moh.govt.nz

The RIDCA will provide a written report which meets the requirements of); Māori Service Components (5.3); Monitoring of Support Service Delivery (5.7.1) and includes at least,



updates and trends in un-met needs and service gaps, including Māori, Pacific Peoples and other populations; allocation patterns; quality initiatives and risk management; complaints, issues, including any equality issues.



DSDRIDCA	Referrals		Monthly	Number of referrals of new Compulsory Care clients (under following categories) - Proposed (ID(CC&R) care recipients transfer from Mental Health - Transfer from current Special Patient status - Transfer from Prison - Proposed Care recipients declined following assessment Compulsory Care Referrals Declined Narrative – brief report with action and expenditure by client name. Number of clients on ID(CC&R) Court Orders Number of clients on other Court Orders (Mental Health) Total number of clients (Court Orders) compelled to receive care. Number of new civil population referrals - Accepted - Declined Number of Re-entry civil population referrals - Accepted - Declined Total number of civil clients Civil Population Referrals Declined Narrative – provide a brief narrative report with action and expenditure by client name.
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	Needs Assessments		Monthly	Number of needs assessments completed Number of needs assessment reviews completed Number of exits from service Needs Assessment Exits Narrative – please report reasons for exit.
	Specialist Assessments		Monthly	Number of specialist assessments for ID(CC&R) • Initial • Review Number of specialised assessments for Civil Population • Initial • Review Specialised Assessments Narrative – please describe type of assessment carried out Number of Maori Cultural assessment referrals to Practitioners. Number of non Maori Cultural Assessments
	Requests for Services		Monthly	Requests for Service Narrative to include • Numbers of referrals for placement RIDSAS/RIDSS/Mainstream by named provider. • Number on waiting list by named provider. • Total time waited before placement made (report only once person placed) by named provider. • Total service users currently receiving RIDSS/Mainstream services (including new placements) by provider.

	Emergency/Assessment Beds		Monthly	Number of referrals for emergency/assessment beds. Emergency/Assessments Narrative to include • Number of occupied emergency/assessment bed days by named provider • Number of declined requests for beds by named provider

In addition to above, a qualitative narrative report is required on a quarterly basis.

	Discretionary Funding		Monthly	Discretionary Funding Narrative to include • Use of discretionary budget - % of line spent • Number of clients receiving supports options through discretionary funding • Types of support provided • Number of contracts with prices • How spend relates to service gap/unmet need
			Quarterly	Narrative report detailed in 10.1 below.

The RIDCA will also report the following on a quarterly basis:

Staffing

1	Number of FTEs in position	
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Disability Support Services

	Care co-ordinators	
	Intensive Service Co-ordinators	
2	Vacancies by FTE	
	Care co-ordinators	
	Intensive Service Co-ordinators	
3	Average caseload	
	Care co-ordinators	
	Intensive Service Co-ordinators	

11 Other requirements

11.1 Legislation

RIDCA will also be required, under the terms of contract to abide by all relevant New Zealand Legislation including but not limited to:

- Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003.
- Mental Health (Compulsory Assessment and Treatment) Act 1992.
- Criminal Procedure (Mentally Impaired Persons) Act 2003.

11.2 Policy

The RIDCA provider will be required to abide by all relevant Policy including but not limited to the following (or the current version of same):

- 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.
- DSS Discussion Document Strategy for People with High and Complex Behavioural Needs 2000.
- Best Practise Indicators of Specialist Support of People with High and Complex Behavioural needs.
- DSS Policies/Guidelines/RIDCA procedures manual related to administration of the ID(CC&R) Act.

- Guidelines for Cultural Assessment.
- NASC Information Reporting Guidelines (where relevant).
- H&DNS Policy/Process to follow when Out of Home Placement may be necessary for Children and Young People.
- *Guideline for the transfer of RIDCA clients to NASC, 2006, Ministry of Health*

11.3 Agreements

The RIDCA Provider will observe the following (or the current version of same):

- Memorandum of Understanding between DSS 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 RIDCA will also observe other protocols and/or memoranda of Understanding between the Ministry and other government departments or agencies.

GLOSSARY OF TERMS

ACTS

ID(CC&R) Act: Refers to the *Intellectual Disability (Compulsory Care and Rehabilitation) Act (2003)*

CP(MIP) Act: Refers to the *Criminal Procedure (Mentally Impaired Persons) Act (2003)* (replaces Part 7 Criminal Justice Act (1985) (CJA))

MHA: *Mental Health (Compulsory Assessment and Treatment) Act 1992*

DSS FUNDED AGENCIES for RIDCA SERVICES

RIDCA: *Regional Intellectual Disability Care Agency. This is the administration agency of the legislation. The Care Coordinator function sits within RIDCA.*

RIDSAS: *Regional Intellectual Disability Supported Accommodation Service. These services provide community assessment beds, residential and vocational agencies. The Care Manager function sits within RIDSAS.*

RIDSS: *Regional Intellectual Disability Secure Services. Hospital level secure services and assessment beds. RIDSS also provide the Community Liaison Team (CLT) contracts. The Care Manager function sits within RIDSS which functions mainly around transition into or out of hospital level services or prisons, however individual circumstances of the service user will inform the decision around who would best fill this function. (See also Community Liaison Team below)*

OTHER

District Inspector (DI): Means a person designated under Section 144 (IDCCR) as district inspector or deputy district inspector under the IDCCR. A District Inspector is a barrister or solicitor whose role it is to ensure service users' rights are upheld.

Disability Support Services

Regional Intellectual Disability Community Care Agency

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Care Co-ordinator: (referred to as Compulsory Care Co-ordinator, or Co-ordinator under the ID(CC&R) Act. A person who is appointed by the Director General of Health under Section 40 of the ID(CC&R) Act in a designated geographical area, defined in the appointment. The role is described in section 40. In general, the role of the Care Co-ordinator is to oversee and manage the pathway for each service user referred by the Court, prisons or forensic services to the RIDCA as proposed care recipients. This will require the Care Co-ordinator to act with a high level of flexibility and accountability for the completion of key duties, powers and functions.

Care Manager: A person appointed by the Care Co-ordinator for a specific Care Recipient under section 141 of the ID(CC&R) Act. In general the role of Care Manager is to fulfil the functions and duties as set out in section 141, including work with the care recipient to develop a Care & Rehabilitation Plan that reflects the support needs of the care recipient.

Civil Population: Those service users receiving services from the RIDCA who are not care recipients under the ID(CC&R) Act. This population would receive services from the Intensive Service Coordinator

Community Liaison Team (CLT): Team of multi disciplinary professionals who offer consultation liaison services to all RIDCA eligible service users. The CLT has a role within RIDSS and in the community. For RIDSS, the role of the CLT is mainly around transition into or out of hospital level services or prisons. However individual circumstances of the service user will inform the decision around who would best fill this function. In the Community the role of the CLT is to proactively assist RIDCA eligible service users, both those under IDCC&R and the civil

population, and the providers supporting them. This includes, but is not limited, to supporting the development of and/or maintenance of management and rehabilitation programmes

Crisis Response: This is defined as a situation requiring immediate action that falls either outside the working hours of agencies who might otherwise (more appropriately) respond, or that requires immediate attention over and above that normally expected of service providers. I.e. Additional staffing, temporary accommodation. The RIDCA will develop MOUs with providers

Facility: The definition of facility is that used in section 9 of the ID(CC&R) Act.

Section 9. Facility and secure facility –

(1) A “facility” is a place that is used by a service for the purpose of providing care to persons who have an intellectual disability (whether or not the place is also used for other purposes). (2) A “secure facility” is a facility that—

- (a) has particular features that are designed to prevent persons required to stay in the facility from leaving the facility without authority; and
- (b) is operated in accordance with systems that are designed to achieve that purpose.
- (3) A facility that is not a secure facility need not have any particular features and, accordingly, a building (such as a residential house) that is not an institution can be used as such a facility.
- (4) In no case can a prison be used as a facility.
- (5) Subsection (3) is subject to any other enactment.

Intensive Service Co-ordinator: This is a role developed specifically for service users eligible for RIDCA services who are not subject to ID(CC&R) Act. The role provides levels and intensity of service co-ordination usually requiring the involvement of multiple providers and ongoing problem solving. Intensive service co-ordination requires that there be an ongoing relationship between the service user and the co-ordinator.

Intellectual Disability: The definition of intellectual disability is that used in Section 7 of the ID(CC&R) Act.

Section 7. Meaning of intellectual disability—



(1) A person has
intellectual disability
the person has a permanent

an
if

Impairment that—

- (a) results in significantly sub-average general intelligence; and
 - (b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and (c) became apparent during the developmental period of the person.
- (2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.
- (3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—
- (a) as 70 or less; and
 - (b) with a confidence level of not less than 95%.
- (4) The skills referred to in subsection (1)(b) are—
- (a) communication:
 - (b) self-care:
 - (c) home living:
 - (d) social skills:
 - (e) use of community services:
 - (f) self-direction:
 - (g) health and safety:
 - (h) reading, writing, and arithmetic: (i) leisure and work.

(5) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

(6) This section is subject to section 8.

Needs Assessment: The terminology in the Act is at times inconsistent with that used in mainstream NASC process. The Act requires needs assessment to be completed near the end of the assessment process as opposed to the more usual NASC process of commencing provision of services with the Needs Assessment.

For the purposes of meeting the requirements under the ID(CC&R) Act the procedural manual will make reference to the term 'Initial Assessment Tool' This initial assessment tool is the tool that is usually referred to by mainstream NASC as a

"needs assessment."

In order to remedy the matter of timing within the Act, the executive summary, called "Executive Summary Needs Assessment" is the document that will signal the fulfilment of the needs assessment requirement under Part 3 of the ID(CC&R) Act.

Proposed Care Recipient: The definition is that used in section 5 of the ID(CC&R) Act.

Section 5. Meaning of care recipient and related terms—

(1) "Care recipient" means a person who is—

- (a) a special care recipient; or
- (b) a care recipient no longer subject to the criminal justice system.

(2) "Special care recipient" means—

- (a) a person who is liable to be detained in a secure facility under an order made under—

(i) section 24(2)(b) or section 38(2)(c) or section 44(1) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or

(ii) section 171(2) of the Summary Proceedings Act 1957; or

(b) a person who is remanded to a secure facility under an order made under section 23 or section 35 of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or

(c) a person who is liable to be detained in a secure facility under an order made under section 34(1)(a)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 and who has not ceased, under section 69(3), to be a special care recipient; or (d) a person who—

(i) is liable to be detained in a secure facility under a compulsory care order, made under section 45; and (ii) is also liable to detention under a sentence; and

(iii) has not ceased, under section 69(3), to be a special care recipient; or (e) an inmate who is required, under section 35, to stay in a facility; or a person who, in accordance with section 47A(5) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, must be held as a special care recipient.

(3) "Care recipient no longer subject to the criminal justice system" means a person who—

(a) is, or continues to be, subject to a compulsory care order, made under section 45, but is not, or is no longer, liable to be detained under a sentence; or

(b) is subject to an order made under section 25(1)(b) or section 34(1)(b)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or

(c) is subject to a compulsory care order resulting from the operation of section 69(3) or section 94(1); or (d) is a former special patient who is required, under section 35, to stay in a facility.

(4) "Proposed care recipient" means a person— (a)

who is being assessed under Part 3 or Part 4;

or

(b) in respect of whom an application for a compulsory care order is pending before the Family Court.

(5) In Parts 2, 3, and 9, a reference to a care recipient includes a reference to a proposed care recipient.

Disability Support Services

(6) "Care recipient liable to detention under a sentence" means a special care recipient to whom subsection (2)(c) or (d) applies.

Region: (please see map below)

Secure Care: The definition of secure is that used in the ID(CC&R) Act (please refer to section 63 and 64 of the Act).

63. Designation notices relating to secure

care— (1) This section applies to every

person— (a) who is a special care recipient; or

(b) who is a care recipient no longer subject to the criminal justice system and who is required to receive secure care.

(2) A care recipient to whom this section applies must—

(a) stay in a secure facility that the co-ordinator designates by written notice given to the care recipient and the care recipient's care manager; and

(b) may not leave the facility without authority given under this Act.

64. Directions relating to supervised care—

(1) The co-ordinator may direct a care recipient who is required to receive supervised care to stay in a designated facility or in a designated place.

(2) A direction under subsection (1) takes effect when written notice of the direction is given to the care recipient and the care recipient's care manager.

(3) A care recipient may be directed, under subsection (1), to stay in a secure facility only for the purpose of receiving care that—

(a) is required to deal with an emergency; and

(b) is of a kind provided for in the care recipient's care and rehabilitation plan.

(4) While a direction under subsection (1) is in force, the care recipient to whom the direction relates must stay in the facility or place designated by the direction.

(5) If a direction under subsection (1) requires the care recipient to stay in a facility, the care recipient may not leave the facility without authority given under this Act.

Specialist Assessment: A specialist clinical assessment in any area of expertise completed by Specialist Assessors who will be suitably qualified health or disability professionals. For the purpose of the ID(CC&R) Act or CP(MIP) Act, these assessments will be requested by the RIDCA or NASC to establish eligibility and management or planning

APPENDIX 1

BUDGET MANAGEMENT:

Main Principle: RIDCA/NASC need to ensure the same systems are used for the same purpose. For the following NASC refers to RIDCA in all cases unless otherwise specified.

The NASC is required to:

- Manage and maintain data on the NASC's Portfolio to make sure that the Service user 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 service user 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 DSS review panel processes for complex and high cost support packages.
- Identify to DSS 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 DSS, 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 DSS.
- Meeting regularly with DSS.

To assist the NASC with budget management DSS 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 Service user 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 DSS, 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.

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 DSS. Projects managed by DSS 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

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 DSS to ensure consistency of approach by NASC's.
- Allocating support packages for the disability population of the region consistent with the population service indicators.
- Managing boundary and other eligibility issues so that DSS 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. DSS will discuss and review this crisis pool with the NASC quarterly.

DSS will assist with forecasting by providing relevant information on demographic trends and other information to input into trend analysis. DSS will develop with the NASC allocation guidelines according to service users' 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 DSS 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.

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 Service user Claim Processing System (CCPS). The information transmitted must be complete, accurate and timely.

Disability Support Services

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% 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 DSS.

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 DSS Contract Manager, of any data issues that prevents the NASC from meeting these targets.

DSS will provide NASC with access to invoice and eligibility data stored in CCPS to assist with the management of invoice rejections. DSS will also provide monthly reports on NASC and HBSS provider rejections.

Service user Portfolio

The list of eligible persons is central to the NASC budget management system. DSS 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 RIDCA DISCRETIONARY FUNDING**

Main Principle: RIDCA/NASC need to ensure the same systems are used for the same purpose. For the following NASC refers to RIDCA in all cases unless otherwise specified.

1.**BACKGROUND**

This appendix is to be read in conjunction with DSS 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 DSS.

However, DSS notes that there may be occasions when an individual's needs are not able to be met through DSS directly contracted services and therefore may require access to other support options tailored to meet an individual's needs.

Therefore, DSS 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 DSS contracted services and/or discretionary funding support.

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 Health & Disability National Services (H&DNS) 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.

DSS notes that in the past it has allowed the development of direct payments, self-managing contracts or individualised hosting for individual service users. However, DSS 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 service user 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 DSS 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 coordination 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 & Family, Education and Work and Income.
- Reimbursement of payments for services that require a user charge.
- Provision of the same services/supports that are already purchased through other H&DNS contractual arrangements such as environmental support, residential care, home based support services or supported independent living, including services which are capacity funded.

6. SERVICE COMPONENTS

DSS 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 DSS targets and priority areas.

The NASC may have sub-contractors provide goods and services through its discretionary funding budget (in accordance with any Court orders or DSS policy or frameworks). The NASC remains liable for ensuring that all subcontracts 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 DSS requirements.

NASC must have contracting, accounting and payment policies and processes for the utilisation of discretionary funding.

6.2 Quality Requirements

DSS expectations are that any sub-contract set up through a NASC will reflect the same level of quality as outlined in all DSS contracts and meet any legal requirements to which the individual person may be subject.

NASC should ensure that they do not enter into sub-contractual arrangements that expose themselves, and therefore DSS, 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 DSS) 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.
- DSS 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.
- DSS right of veto of agreements which do not meet requirements specified in this agreement.
- Any legislative requirements to which the individual person is subject.

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 i.e. rate must be realistic.
- With rest homes or hospitals which do not have a current contract with DSS for the provision of residential support services.
- With organisations that are business partners of the NASCs (without the express agreement of DSS).
- Where the proposed service is estimated to cost greater than \$10,000 per annum without the specific prior agreement of DSS. In this instance the NASC needs to

work with DSS with a view to trying to establish a direct contract between the provider and DSS.

- 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).
- For RIDCA specialist assessments as required by the Court, in excess of the guidelines by more than \$2000, without agreement of DSS.
- For RIDCA specialist assessments in excess of the DSS Schedule of Prices without agreement of DSS.

DSS 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 H&DNS Service Manager detailing:

- Use of discretionary budget - % of line spent.
- Types of support provided (as per DSS format).
- How spend relates to service gap/unmet need.
- Number of people receiving support options through discretionary funding.

8. INVOICING

The NASC is required to submit an invoice to DSS 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 grand-parented 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

NASC will observe the *Support Needs Assessment and Service Coordination Policy and Procedure Information Reporting Guidelines*, MOH 2002.

9.1 NASC

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 DSS Contract Manager.

9.2 RIDCA Specific

9.2.1 Current processes

Below are the reasons for using discretionary spend until other mechanisms are implemented by DSS:

- Specialist service outside of those available for generic DSS contracts i.e.
- Eligibility assessment
- Crisis behaviour support Specialist assessment
- Travel (ETAT guidelines)
- Expenses for families (ETAT guidelines)

9.2.2 Travel and accommodation.

- Use ETAT guidelines for payment amounts and expenses reimbursement. Default to these for \$ and rules until RIDCA specific guidelines are developed.
- Travel is paid for people who live beyond two hours away one way.
- 2:1 staffing will be funded through discretionary, 1:1 will not

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 DSS
- To provide support to NASC in their use of discretionary options
- To ensure that NASC are aware of the responsibilities of DSS 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 DSS for advice.

There are three key responsibilities that DSS needs to consider as it carries out its business that are relevant to NASC when considering using discretionary funding.

10.1.1 The Funding Agreement between the Ministry and Crown

H&DNS 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 service user waits for a residential support service.

DSS 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 H&DNS 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 DSS before they can contract with the parent or one of its subsidiaries.

NASC and DSS 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 DSS 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.

RIDCA Regional Boundaries



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