AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
Chief Executive's Office
Level 1
Building 37
Auckland City Hospital
PO Box 92189
Victoria Street West
Auckland 1142

19 March 2020

[redacted]

[redacted]

Re **Official Information Request – Home and Community Support Services contract for support of older people**

I refer to your official information request dated 22 February 2020 to the Ministry of Health and transferred from the Ministry of Health to Auckland DHB on the 27 February 2020 requesting the following information:

- **A copy of the contract between Auckland District Health Board and the Home and Community Support Provider/Agencies for the provision of in home support to older people.**

I have attached a copy of the original service specification which was introduced on 01 July 2012 and the most recent variation of the contract (01 July 2019) that the DHB has with its Home and Community Support Services providers. Please note that we have redacted the name of the supplier and the prices contained in the contract under section 9(2)(i) as the information would prejudice commercial activities of Auckland DHB and under section 9(2)(b)(ii) as making this information available would unreasonably prejudice the commercial position of the person who is subject to the information.

I trust this is information you were seeking.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive

[redacted] Provider No. / Contract No.

Variation to Agreement

between

Auckland DHB

NZBN: 9429000097895

Private Bag 92 189
Victoria Street West
Auckland 1142

Ph: 09-307 4949
Fax: 09-375 4305

Contact: Katie Daniel

and

[redacted]

NZBN: 9429043095490

Enhanced Home Based Support Services

PO Box 5104
Auckland Central
Auckland 1141

Ph: 09-623 7631
Fax: 09-630 8956

Contact: [redacted]

[redacted]

CONTENTS OF THIS AGREEMENT

[redacted]

A: SUMMARY

A1 Definitions

a. "we", "us", "our" means Auckland DHB
b. "you", "your" means [redacted]
c. "either of us" means either we or you
d. "both of us" means both we and you

A2 The Agreement

In 2009 both of us entered into a Health and Disability Services Agreement (the Agreement). The Agreement commenced on 1 July 2009 and ended on 30 June 2014 and was numbered [redacted]

A3 Variation

This is the 14 variation to the Agreement and extends the Agreement term and changes the Agreement price. This variation to the Agreement begins on 01 July 2019 and ends on 30 June 2020.

A4 Section B

The attached Section B includes all of the adjustments to this Agreement as a result of this variation.

A5 Remainder of Agreement

The remaining terms and conditions of the Agreement are confirmed in all respects except for the variations as set out in this document.

A6 Signatures

Please confirm your acceptance of the Agreement by signing where indicated below.

For Auckland DHB:

(signature)

Name ..... Dr Debbie Holdsworth

Position ..... Director Funding

Date ..... 29 JUL 2019

For [redacted]

[redacted] (signature)

Name ..... [redacted]

Position ..... [redacted]

Date 6/8/19

[redacted]

B: PROVIDER SPECIFIC TERMS AND CONDITIONS

B1 It is agreed that the following details apply to this Variation

Legal Entity Name	[redacted]
Legal Entity Number	[redacted]
Contract Number	[redacted]
Variation Commencement Date	01 July 2019
Variation End Date	30 June 2020

B2 Details of all purchase units which apply to this Variation

Purchase Unit (PU ID)	Total Price excl. GST	GST Rate (%)	Payment Type
HOP1010 Home Based Support - Enhanced	[redacted]	15	CMS
PE0002 Home Basd Support Pay Equity	[redacted]	15	CMS
Total price for the Service Schedule	[redacted]		

PAYMENT DETAILS

B3 Price

B3.1 The price we will pay for the Service you provide is specified above. Note that all prices are exclusive of GST.

B4 Invoicing

B4.1 We will pay you on the dates set out in the Payment Schedule below for the services you provide in each invoice period so long as we receive a valid GST tax invoice from you. The invoice must meet all legal requirements and must contain the following information:

a. provider name (legal entity name)
b. provider number (legal entity number)
c. provider invoice number
d. contract number
e. purchase unit number or a description of the service being provided
f. date the invoice is due to be paid/date payment expected
g. dollar amount to be paid
h. period the service was provided
i. volume, if applicable

[redacted]

j. GST rate
k. GST number
l. full name of funder

If we do not receive an invoice from you by the date specified in the payment schedule below, then we will pay you within 20 days after we receive the invoice.

B5 Invoicing Address

Send invoices to:

providerinvoices@health.govt.nz

or post to:

Provider Payments
Ministry of Health
Private Bag 1942
Dunedin 9054

B6 Payment Schedule for HOP1010 Home Based Support - Enhanced

Payments will be made by us on these dates:	On invoices received by us on or before:	For services supplied in the period:
15 July 2019	1 July 2019	1 – 14 July 2019
1 August 2019	15 July 2019	15 – 31 July 2019
15 August 2019	1 August 2019	1 – 14 August 2019
2 September 2019	15 August 2019	15 – 31 August 2019
16 September 2019	1 September 2019	1 – 14 September 2019
1 October 2019	15 September 2019	15 – 30 September 2019
15 October 2019	1 October 2019	1 – 14 October 2019
1 November 2019	15 October 2019	15 – 31 October 2019
15 November 2019	1 November 2019	1 – 14 November 2019
2 December 2019	15 November 2019	15 – 30 November 2019
16 December 2019	1 December 2019	1 – 14 December 2019
3 January 2020	17 December 2019	15 – 31 December 2019
15 January 2020	1 January 2020	1 – 14 January 2020
3 February 2020	15 January 2020	15 – 31 January 2020
17 February 2020	1 February 2020	1 – 14 February 2020
2 March 2020	15 February 2020	15 – 28 February 2020
16 March 2020	1 March 2020	1 – 14 March 2020
1 April 2020	15 March 2020	15 – 31 March 2020
15 April 2020	1 April 2020	1 – 14 April 2020
1 May 2020	15 April 2020	15 – 30 April 2020
15 May 2020	1 May 2020	1 – 14 May 2020
2 June 2020	15 May 2020	15 – 31 May 2020
16 June 2020	1 June 2020	1 -14 June 2020
1 July 2020	17 June 2020	15 – 30 June 2020

[redacted]

B7 Payment Schedule for PE0002 Home Based Support – Pay Equity

Payments will be made by us on these dates:	On invoices received by us on or before:	For services supplied in the period:	Amount (excl GST)
22 July 2019	1 July 2019	July 2019	[redacted]
20 August 2019	31 July 2019	August 2019	
20 September 2019	31 August 2019	September 2019	
21 October 2019	30 September 2019	October 2019	
20 November 2019	31 October 2019	November 2019	
20 December 2019	30 November 2019	December 2019	
20 January 2020	31 December 2019	January 2020	
20 February 2020	31 January 2020	February 2020	
20 March 2020	29 February 2020	March 2020	
20 April 2020	31 March 2020	April 2020	
20 May 2020	30 April 2020	May 2020	
22 June 2020	31 May 2020	June 2020	
Total			

B8 Health Emergency Planning

a You must develop a Health Emergency Plan to ensure that your clients/patients and staff are provided for during a Health Emergency and ensure that this is reviewed periodically to maintain currency.

b The plan must identify your response to a worst case scenario pandemic event (40% of the population affected with 2% death rate).

c A copy of the plan shall be made available to the DHB on request and will be consistent with the DHB's pandemic and emergency plans (available from the DHB).

d When requested by the DHB you will be involved in processes to ensure that emergency responses are integrated, coordinated and exercised. The level of participation required will be reflective of the nature of the services you provide and the expected roles and services in an emergency situation.

B9 Children's Act 2014

According to section 15 of the Children's Act 2014[1], children's services cover the following:

- services provided to one or more children
- services to adults in respect of one or more children

NB At a future date, the scope of children's services can be expanded by regulations. Expansion may include services to adults which could significantly affect the well-being of children in that household.

Child Protection Policy

If you provide children's services as per section 15 of the Children's Act 2014 you will adopt a child protection policy as soon as practicable and review the policy within three years from the date of its adoption or most recent review. Thereafter, you will review the policy at least every three years. In accordance with the requirements set out in section 19(a) and (b) of the Children's Act 2014, your child protection policy must apply to the provision of children's services (as defined in section 15 of the Act), must be written and must contain provisions on the identification and reporting of child abuse and neglect in accordance with section 15 of the Oranga Tamariki Act 1989.

Worker Safety Checks

If you have workers that provide children's services, the safety check requirements under the Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015 will need to be complied with.[2]

[1] http://www.legislation.govt.nz/act/public/2014/0040/latest/DLM5501618.html

[redacted]

B10 Healthy Food and Beverage Environments Contract Clause

DHBs believe all Providers of healthcare services have a role in promoting the health and wellbeing of their clients/service users/patients3, staff and visitors to their service/s by supporting them to make healthy food and beverage choices. From January 2017, you were expected to have a Healthy Food and Drink Policy covering all foods and beverages sold on site/s, and provided by your organisation to clients/service users/patients1, staff and visitors under your jurisdiction. Foods and beverages on offer for clients/service users/patients1, staff and visitors should align with the National Healthy Food and Drink Policy, which reflects the Ministry of Health's Eating and Activity Guidelines for New Zealand Adults. Your policy should consider the following principles, taking into account culturally appropriate approaches to food and food preparation as pertinent to your organisation and the diversity amongst your clients/services users/patients, staff and visitors:

1) Offer a variety of foods from the four food groups including:
   - Plenty of vegetables and fruit
   - Grain foods, mostly whole grain and those naturally high in fibre
   - Some milk and milk products, mostly low and reduced fat
   - Some legumes, nuts, seeds, fish and other seafood, eggs, poultry (e.g. chicken) and/or red meat with the fat removed.

2) Food should be mostly prepared with, or contain minimal saturated fat, salt (sodium) and added sugar, and should be mostly whole or less processed.
   - Some foods containing moderate amounts of saturated fat, salt and/or added sugar may be available in small portions (e.g. some baked or frozen goods).
   - No confectionery (e.g. sweets and chocolate)
   - No deep-fried foods

3) The cold beverages available across all health provider settings will predominantly be plain water and unflavoured milk
   - The availability and portion sizes of artificially sweetened beverages, and no-added-sugar juices should be limited
   - Providers of healthcare services should not sell or provide sugar sweetened beverages[4] on their site/s.

A template to support the development of your policy is available at:
https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations

B11 Recovery of Funding

In addition to our rights under this agreement, Auckland District Health Board may recover a proportion of the Agreement Price in the event Auckland District Health Board determine that the Service Provider, for whatever reason

- does not provide the deliverables as outlined in this contract
- has accrued any underspend at the end of the contract period

The Recoverable Portion will be set by the Funding and Planning Team

- after discussion between both parties
- having regard to the extent of the delivery failure or, as the case requires the quantity or quality of the service delivery not provided

[2] http://www.legislation.govt.nz/regulation/public/2015/0106/latest/DLM6482241.html
[3] Note: the policy excludes inpatient meal services and Meals on Wheels are excluded
[4] "Any beverage that contains added caloric sweetener, usually sugar. The main categories of sugary drinks include soft-drinks/fizzy-drinks, sachet mixes, fruit drinks, cordials, flavoured milks, flavoured waters, cold teas/coffees, and energy/sports drinks" – New Zealand Beverage Guidance Panel

- having regard to what the Funding and Planning Team considers to be fair and reasonable.

B12 Provider Specific Terms and Conditions

Payment Details

Price
The indicative annual funding amount included in this Agreement is an estimate to enable calculation of the monthly base payment prior to wash up calculations. Your actual funding for 2019/20 may be different and will be your proportion of available funding allocated using prices determined by the case mix cost model. It is noted by all parties to this Agreement that HCSS funding in the ADHB is regulated by a capped budgetary amount of [redacted] and it is understood that the entire budget will be distributed during the course of the year.

Daily Rates
The daily reimbursement rates for clients based on their acuity category are detailed in the tables below.

Non-complex client rates:

Category	1A	1B	2A	2B	3A	3B
Rate	8.40	8.37	9.04	8.78	14.07	14.00

Non-complex client rates (case management):

Category	1ACM	1BCM	2ACM	2BCM	3ACM	3BCM
Rate	1.64	1.64	1.64	1.64	1.64	1.64

Complex client rates

Category	C1	C2	C3	C4	C5	C6	C7	C8
Rate	16.62	21.57	21.97	25.15	24.13	24.62	28.42	43.24

Category	Average complex
Rate	27.46

Quarterly Reports

The provider will report quarterly on the template provided.

You shall forward your completed Performance Monitoring Returns in electronic form to:
The Performance Reporting Team
Sector Services
Ministry of Health
Email performance_reporting@health.govt.nz

Please note that only one copy of your Performance Monitoring return is required, (please do not send a hard copy as well).

[redacted]

Home and Community Support service – Quarterly reporting
The provider will report quarterly on the following information:

Clients				
Total number of clients (excludes clients over 10 days on hold):				
Total number of clients coded as 1As at the beginning of the quarter				
Total Number of clients coded as 1As discharged within the quarter				
Total Number of 'stable complex' clients on the last day of the quarter				
Number of 'stable complex' clients transferred from DHB during this quarter				
Number of 'stable complex' clients who had an increase in complexity within the quarter				
Number of 'stable complex' clients who had a decrease in complexity within the quarter (remain with 'complex' categories)				
Number of 'stable complex' clients transferred to non-complex within the quarter				
Number of admissions in the quarter of clients who identify as Māori				
Discharge destination for clients identifying as Māori				
Workforce				
Ratio of clients to care/case manager *Ratio calculated based on case manager FTEs against actual number of active clients as at the last day of reporting period.* *Case Managers are Registered Health Practitioners*	No. of Case manager FTEs:			
Total number of new staff employed in this period	Case managers:	Support workers:	Other:	Total:
Total number of staff who identify as Māori and proportion of total staff	Case Managers		Support workers:	
Proportion (%) of support workers trained: *Support workers highest qualification should be included and counted only once*	No certificate:		Level 2:	
	Level 3:		Level 4 or above:	
Narrative on any concerns regarding staff retention.				

[redacted]

Discharge	Complex	Non-complex
Admission to residential care		
Regained or increased independence		
Natural supports		
Deceased		
Moved out of the area(internasc)		
Client requested change in provider		
Provider requested change in provider		
Client declined support after assessment		
Other provider already in place		
Other		
Quality Assurance		
Number of clients surveys undertaken during this quarter:		
Number of questionnaires received from Clients:		
Number of compliments received:		
Positive feedback – key factors identified in compliments:		
Number of complaints received :		
SAC 1		
SAC 2		
SAC 3		
SAC 4		
Total		
Negative feedback – key factors identified in complaints:		
Changes made to service following all feedback		

[redacted]

Missed Visits:		
Number of missed visits *Missed visits is defined as the service not responding to meet the needs of a client.* *Include if: a support worker does not turn up, scheduling error, if a visit is rescheduled without agreement from client.* *Do not include if: Client is out at time of visit, client initiates or is comfortable with rescheduling agreed time in advance.*		
Missed visits as a proportion (%) of total visits:		
Key reasons for missed visits:		
Adverse Events		
Number of falls (all falls both when HBSS staff present and otherwise):	Witnessed Falls (Provider present):	Unwitnessed Falls:
Stop and Watch		
Number of Stop and Watch reported		
Escalation outcome for each S&W reported	GP NOK DHB CLTC Multi- escalation points Other	
Innovations		
Narrative on any service innovations introduced in this quarter.		
Paid Family Carers		
Attach to this report • Number of paid family carers employed • NHI(s) of clients who are receiving services from a paid family carer • Relationships of the paid family carer(s) to the client(s).		

Service Specification – Enhanced Home Based Support Services

1.0 Introduction and General Overview

1.1 Background

The desire to move to a goal based model of service design and delivery both within Auckland District Health Board (ADHB) and nationally is not new. Supportive international and more latterly national literature combined with extensive consultation across ADHB's key populations in 2006 clearly pointed to the fact there were many aspects of ADHB's services that could be delivered in a way more responsive to the needs of older people.

This led to the development of 'Healthy Ageing 2020' a local strategic document which outlined our commitment to improving health outcomes for older people. Specifically the strategy focuses on the achievement of the following four deliverables:

1 Streamlined access for service users to all aspects of older persons health services ensuring a 'right place, right time' experience

2 A delivery model for Home Based Support Services (HBSS) which is 'strengths based', promotes independence and utilises formal goal setting when appropriate

3 Flexible packages of funding to better meet the needs of clients wishing to remain at home with support

4 A comprehensive suite of assessment tools for use across all aspects of the sector.

These objectives can all be met to a greater and lesser degree through the service model for HBSS detailed in this specification.

We wish to purchase services for older people that are restorative and strengths based.

Services will be governed by the following specific requirements and will be monitored according to the quality and data requirements outlined.

1.2 Transition

The transition to an enhanced model of delivery began on 1 July 2009 with additional aspects of the service introduced thereafter. Currently all providers of enhanced HBSS provide services according to the restorative model of care and are using the electronic version of the InterRAI Contact Assessment for each new client entering the service. A goal setting tool is also used and clear steps to achieve a distal goal are developed for each client, irrespective of their care level. A tiered approach to introduction of InterRAI tools was a requisite for providers and during 2012/13 the Service Development Group (SDG) will consider introduction of InterRAI CHA. The SDG will continue to function as the collective governance group for the implementation of the service model.

1.3 Definition

The purpose of enhanced HBSS is to flexibly assist older people to achieve quality, cost-effective outcomes to enable them to live as independently as possible. The services are not limited to the purchase and delivery of domestic assistance or personal care but are designed to achieve goal based outcomes which are co-designed and owned by the client.

The focus is on shorter, more intensive interventions with an increased proportion of clients being discharged from the service than was the case prior to 1 July 2009 using a set of tools developed and agreed by the HBSS SDG during the 2009/10 year.

1.4 Roles and Responsibilities

1.4.1 The Service Development Group (SDG)

The SDG will be retained for the duration of the initial five year contract term to collectively design the outstanding details of the model and monitor its implementation.

The group will assist with:

- Implementing the staged approach to achieving the service redesign
- Facilitating integrated information system developments
- Reviewing key milestones against performance indicators as they relate to establishment
- Collectively monitoring overall expenditure against budget and designing strategies to help mitigate risk
- Developing further value added enhancements to the service model once the initial implementation has taken place
- Discussing any other issues facing services for older people that arise and recommending changes to current service specifications and guidelines.

In the event that a dispute cannot be resolved by the SDG, issues will be raised with ADHB's Chief Planning and Funding Officer. In the event that a resolution can still not be achieved then the Disputes Resolution clause as per the General Terms and Conditions of the contract can be called into practice.

1.4.2 The Operations Group

The Operations Group, established by the SDG **will** meet on a monthly basis and also when required to discuss the day to day areas of service development, to agree on key changes at an operational level and to resolve any issues as they arise. The Operations Group will work within the scope of the agreed terms of reference as established by the SDG. Membership of the Operational Group includes representatives from each of the four community based providers, the Team Leader from the ADHB Community Care Access Centre and the Charge Nurse of the A+ Links specialist service.

1.4.3 Community Care Access Centre

The Community Care Access Centre (Access Centre) **will** continue to provide support and coordination functions for the sector. Access Centre staff will be responsible for allocation of clients to providers (as per agreed protocols with the SDG and in line with contractual requirements) and will be the main point of contact for providers in the event that a reassessment is required or a package of care needs to be revisited.

The Access Centre will have a customer support role. The provider will appoint a key contact for the Access Centre who is familiar with your clients and able to assist with resolution of queries, including those relating to other NGO providers, Sector Services, Ministry of Health and other organisations or individuals.

Functions of the Access Centre include:

- Receipt and screening of referrals
- Triaging clients and referral to the appropriate provider, including to A+ Links specialist services (see business rules for referral below)
- Coordinating residential care as appropriate
- Storing accurate information and data relating to all clients including those referred to and not accepted to the service

- Establishing comprehensive information systems that enable the understanding, monitoring, responsive review and planning of care and support provided.

In addition to existing activity data, Key Performance Indicators will be collected and reported for the Access Centre to SDG based on the following objectives:

- Completeness of referral information
- Accuracy of initial triage
- Fair and transparent allocation of referrals
- Accurate collation and timely reporting of consolidated referral data.

1.4.4 The triage process

All referrals for community Health of Older People services must be channelled via the Access Centre. Upon receipt, these referrals will be logged, checked for accuracy and then triaged by a triage clinician.

Referrals may be clarified by phone; thereafter they will be categorised into non complex or complex for the purpose of allocating to the appropriate provider.

This process is inclusive of all clients, including patients who are being discharged from inpatient services, either Health of Older People or non-Health of Older People wards. In the case where a client is known to a particular provider, contact will be made with that provider directly from the inpatient ward to establish timing for the return home of the client and any changes to support required.

Referrals coming from community sources will also be sent to the Access Centre.

Clients who are triaged using the Triage Validation Tool (TVT) will be directed to the care of A+ Links specialist services or to a community provider.

The following minimum data for all new referrals will be sent electronically on a standard template to the relevant community provider:

- Client sticky label detailing: client's full name including title; gender; NHI; date of birth and age; address; phone number; GP name, phone and Fax numbers and address.
- Client's preferred name
- Client's ethnicity
- Language(s) spoken
- Date of referral to Access Centre
- Confirmation of upload to Momentum
- Date of referral to provider
- Referral type: (select one): new, update, change in level
- Referred by (select one): client choice or Access Centre allocation
- Referred to (select one): Lifewise, RDNS NZ, Enliven, HCNZ
- Has client changed from an existing provider? (if yes, state reason)
- Emergency contact/next of kin: full name, relationship, phone number
- Who to contact in regards to referral? (select preference) client or next of kin
- Outcome of triage: complex or non complex
- Triaged by:

- If complex or non-complex: name of case manager if known, contact details
- Attached documentation: (please attach and tick) Care Plan, Specialist/GP letters, additional information
- Specific health/safety alerts
- Community Services Card if available - if yes, add numbers

1.4.5 A+ Links Specialist Services

In determining the optimum client pathway, clinical safety is a paramount consideration, as is maximising the use of resources within the sector. The triage and package of care allocation tools that underpin the enhanced HBSS model are designed to identify where specialist services are required to manage clinical complexity and/or risk within our older persons population.

The role of A+ Links specialist services is to perform the initial assessment of clients that are triaged as complex, develop a care plan and then oversee the implementation of the care plan in conjunction with the allocated community HBSS provider and have responsibility for case management. Regular reviews as outlined in section 3.2 are the responsibility of specialist services but joint visits by agencies are encouraged where appropriate. Any changes in roles and responsibilities between A+ Links specialist services and the community providers will be assessed and agreed by the SDG for example management of stable complex clients by community providers.

Care plans are to be documented by A+ Links specialist services in such a way that makes meeting the goals and support needs of the client open to discussion between the community HBSS provider and the client. Any changes to the plan need to be discussed with the case manager prior to implementation. Any significant change in client condition should be referred to the designated specialist case manager who will undertake a formal review of the client's needs.

2.0 Generic Service Requirements

2.1 Cultural Competency

2.1.1 Maori Health

Enhanced services must recognise the particular needs of Maori and the commitment to Maori under the Treaty of Waitangi. Maori have a disproportionate burden of chronic disease/ co-morbidities and at a younger age than other groups, however access proportionally less support/health services.

The service must identify and respond to the cultural values and beliefs that influence the effectiveness of care and support for Maori clients and their whanau. The service will consider appropriateness of care and support and address inequalities in access to and provision of care and support to Maori. The service will work within the whanau-ora framework of He Korowai Oranga Maori Health Strategy and all assessment of needs will follow a holistic model.

The concept of home based support as an isolated service component is foreign to a holistic approach that is integrated with whanau, hapu and iwi resources. Assessment and service coordination for Maori should take a broader perspective with an understanding of the wider range of supports that may be available and / or important to kaumatua (Baird 2005)

2.1.2 Pacific Health

The service must recognise the particular needs of Pacific people who have a disproportionate burden of chronic disease/co-morbidities and at a younger age than other groups, however access proportionally less support/health services.

The following issues have been highlighted in relation to services for Pacific People (New Zealand Guidelines Group 2003, Ministry of Health 2002, 2004a):

- Average age of onset of disability for Pacific People is earlier than European
- There has typically been an expectation that people will be supported within the extended family structure
- There may be some stigma associated with disability and a reluctance to ask for assistance
- There may be significant communication difficulties and a reluctance to complain about the nature of services received
- Support services that are integrated with specific communities reflecting church and different ethnic groups are important

The service must understand and respect the key principles and frameworks outlined in relevant Pacific health and disability strategy documents, including the Pacific Health and Disability Action Plan 2002, and demonstrate a commitment to these principles in the provision of services. The service will consider appropriateness of service and address inequalities in access to and provision of services for Pacific communities.

2.1.3 Asian and New Migrant Service Users

The service must identify and respond to the needs of clients from other ethnic populations e.g. South Asian and new migrant groups who also access services disproportionately relative to health need in the ADHB catchment area.

2.2 Eligibility

The service will be provided to the following eligible clients (as defined under the 2003 Eligibility Direction) residing within the ADHB catchment area, who meet the following criteria:

- A person with an age related disability which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required
- Older people aged 65 years or over and the 50-64 years age group with early onset of conditions more commonly associated with older age, e.g. Alzheimer's dementia.

2.2.1 Exclusions

The following people will be excluded from this service:

- People under 65 years of age who do not meet the above criteria
- People who reside outside the ADHB catchment area or are not a resident
- ACC clients unless they have been assessed by the specialist team as having an age related physical disability requiring HBSS
- Mental Health Services for Older People clients unless they have been assessed by the specialist team as having a physical disability requiring HBSS.

2.3 Linkages

The provider will have established and sustained effective relationships with other organisations providing services to the eligible population. These relationships will reflect the profile of the population and their communities and will include primary, secondary, and tertiary health services, community organisations, voluntary groups, support service providers and other public sector agencies. In the initial stages the Access Centre will be able to assist with facilitating these linkages and supporting key workers source alternative providers of vocational, support and restorative care.

Care Managers will be required to source care and support not only from providers contracted by the funder but also from other providers and services available within communities. This should include those contracted with other funding bodies. Particular attention should be given to establishing effective working relationships that will ensure people are aware of and understand the processes for referral and services available through the Access Centre.

The provider will also need to supply evidence when required (i.e. in the event of an external audit) of effective linkages with the community, involving Maori, Pacific, disability groups, support networks and advocacy groups. Relationships will be managed in a way that has regard for the interrelationships that exist between clients and their social support systems.

Significant interfaces will exist with but will not be limited to:

- Consumer support/advocacy services, including Maori and Pacific support/advocacy services
- Sector Support (Ministry of Health)
- Chaplaincy
- Citizens Advice Bureau
- Disability Information NASCs
- Interpreting services
- Maori community care services
- Other appropriate Maori organisations
- Pacific community care services
- Other appropriate Pacific organisations
- Other ethnic/cultural advocacy/support groups

2.4 Access

Access to the service will be directly from the Access Centre for all ADHB funded clients. Those who self refer or who are referred from other sources will need to be directed to the Access Centre in all instances to have eligibility verified and triage undertaken.

2.5 Legislative Requirements

Your service is governed by a number of NZ Regulations and Legislation, specifically:

- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health (Infectious and Notifiable Diseases) Regulations 1966
- Health (Retention of Health Information) Regulations 1996
- Health and Safety in Employment Regulations 1995
- Human Rights Regulations 1993
- Privacy Act 1993
- Health Practitioner Competency Assurance Act 2003
- Health and Disability Services (Safety) Act 2001
- Health Information Privacy Code 1994
- Crimes Act – duty of care Section 151

3.0 Specific Service Requirements

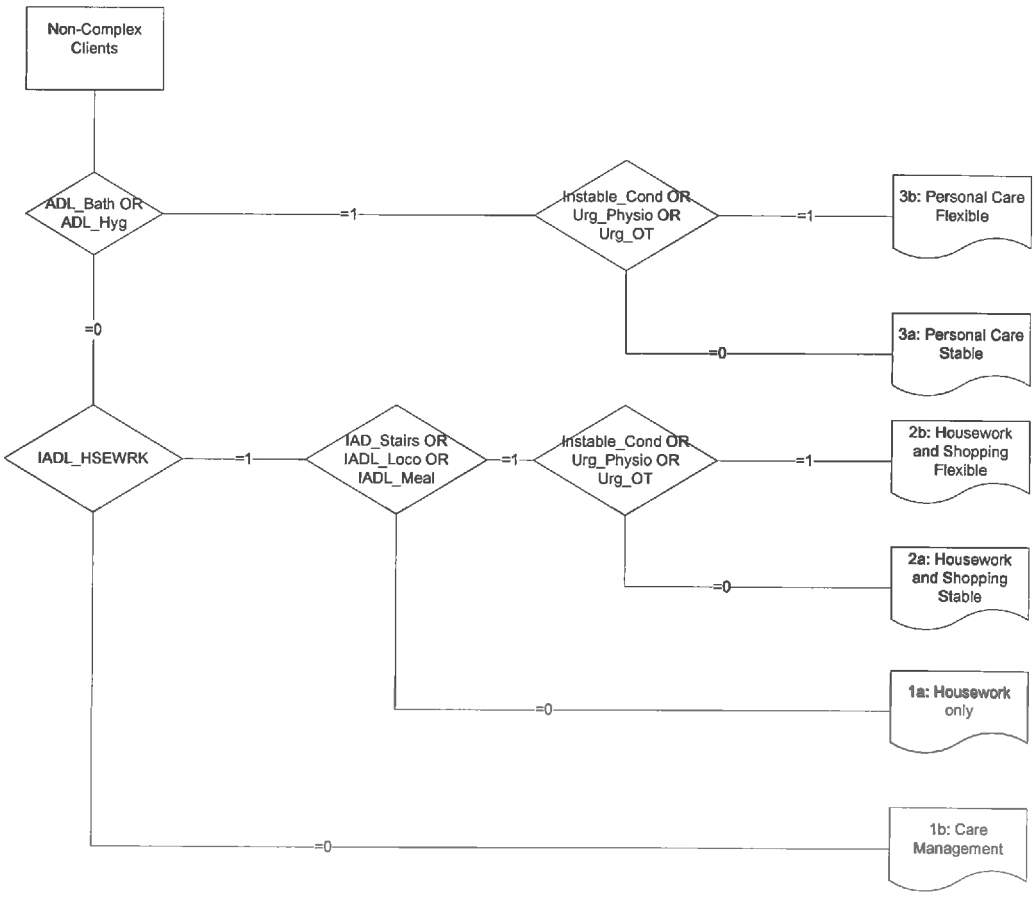
3.1 Assessments

Once referred from the Access Centre, both the community provider and specialist service are required to perform an initial assessment using either the InterRAI Contact Assessment (community providers) or the InterRAI MDS-HC assessment (specialist service) loaded via momentum and then an appropriate goal setting tool, before developing a support or care plan.

Note: pending a decision from SDG the InterRAI CHA may be introduced for non complex clients. Specialist services will use the MDS-HC, however if a clients has had a CHA completed in the previous three months then a functional assessment / mental health assessment will added to equate to an MDS-HC.

The Packages of Care Algorithm (POCA) will be used as a manual process to inform the client categorisation immediately following the assessment. The Algorithm will be reviewed and updated after SDG agreement by consensus, when required.

3.2 Packages of Care Algorithm Non Complex Clients



3.2.1 Non-complex clients

Following a client's initial assessment the provider will send completed information to the Access Centre including:

- Notification of service details for Access Centre form including POCA Score
- Summary of services and commencement date
- Change of level form if appropriate

In undertaking the assessment for non complex clients, each of the four community providers will also undertake a brief validation of the triage using the following key agreed triage criteria and definitions:

- Has the client presented to ED in the past month?
- Does the client require assistance with washing and dressing bottom half
- Does the client require medication management?
- Does the client have brittle support systems in place/suspected abuse, neglect?
- Is the client cognitively impaired?

In the event that the answer to any of the above questions is "yes" then each provider organisation must ensure a peer review occurs back at the office between the Registered Health Professional and Manager to ensure agreement is conclusive regarding each client determined to be 'complex' via the triage validation tool. If the peer review is conclusive that the client is 'complex' then this feedback should be sent back to the Triage Nurse via the Access Centre.

Additional key performance indicators for community and specialist providers include the following:

- Acknowledgements of referrals sent to Access Centre by e-mail and/or fax at least weekly
- First contact to client made within one working day (this may be a phone call)
- Initial assessment undertaken within five working days except when the referral is marked urgent or the client is unable to be contacted or delay requested by client or next of kin
- Initial assessment includes InterRAI assessment, Service Plan including Goal Ladder and agreement of triage outcome
- Service by community providers commences within five days of the initial assessment unless urgent as above. Other exceptions include:
    - Specific requirements – language skills, mental health expertise etc.
    - Training required from support worker in special equipment or similar
    - Safety issues in the home need to be addressed prior to service starting
    - Equipment required to be in place prior to service starting
    - Client/next of kin request a delay

In the event that a client is assessed by specialist services as requiring a support package likely to total more than 35 hours per week direct care (exclusive of care coordination, carer support and respite care) then this must be authorised via e-mail with the relevant Planning and Funding Manager or delegated person, who will ensure that the authorisation is communicated to the requisitioned support agency in addition to the specialist key worker and the Access Centre.

3.2.2 Respite care

Allocated funding for respite care can be used for non-complex clients who meet the following criteria:

- The caregiver provides care for a significant period of each day/week (not necessarily live in)
- If the caregiver was not there additional support services or residential care would be required
- Use of respite care supports the caregiver/recipient relationship to be sustained over the long term.

The respite care options may be part of planned/scheduled component of a package of care or may be a one off or occasional component in response to a specific situation. The packages may be delivered in the client's home or in a residential care facility or a mixture of arrangements. The main options are:

- Episodes of care in a rest home, dementia unit or private hospital
- Half-day/full-day care in the client's home
- Weekend care in the client's home
- Night care in the client's home.

The HBSS provider will work with the client and caregiver to develop a package of care that best meets the client's needs.

3.3 Formal Reassessment and Clinical Review

There is an expectation all clients will be subject to regular reassessment and clinical review. A formal InterRAI reassessment will be undertaken annually unless otherwise indicated through clinical review.

Case mix has assisted in clustering groups of clients together with similar need and has enabled us to set clinical review dates based on the relative stability of each of the clusters. Therefore, reviews will occur according to the table below.

Note: The client POCA levels and review frequencies will be updated by consensus of the SDG when required.

Client POCA Level	**Review Frequency**
1A – Maintenance (Housework only)	12 monthly
1B – Reintegration (Care Management only)	3 Monthly
2A – Maintenance+ (Housework +Shopping)	6 Monthly
2B – Maintenance+ Flexi (Housework +Shopping Flexi	3 Monthly
3A – Personal Support (Personal Care Stable)	6 Monthly
3B – Personal Support Flexi (Personal Care Unstable)	3 Monthly
Complex	3 monthly

Category Definitions

Client POCA Level	**Generally defined by:**
1A – Maintenance (Housework only)	Disability prevents client from maintaining a safe home environment. Restorative within

	boundary
1B – Reintegration (Care Management only)	Active Care management. Need short term supports from coordinators. No hours assigned
2A – Maintenance+ (Housework +Shopping)	Longer length stay. 1A +/-exercise (restorative) +/- shopping, stable conditions.
2B – Maintenance+ Flexi (Housework +Shopping Flexi	Shorter more intensive. Could include combinations of any of the following: exercise, shopping, restorative. Possible unstable condition
3A – Personal Support (Personal Care Stable)	2A + extras - could include meals, medication supervision, showering, dressing, Conditions stable. Low risks with good supports
3B – Personal Support Flexi (Personal Care Unstable)	Higher care. Possibly potential from rehabilitation to lower level or discharge. Possible unstable condition. Potential longer term client

3.4 Business Rules to Support the Allocation Process

Over the previous two years providers have been limited to 25% of new client volumes. The process from 2012/13 will be when client choice is clearly expressed or where there is a clear, validated niche or specialist skill within your workforce then the Access Centre will channel referrals accordingly. In the event that neither a client choice is expressed nor a specialist skill is required, then the Access Centre will balance referrals according to client volumes and triage scores.

This process will be monitored by the operational group and reports will be provided, as required, to SDG meetings for information and review.

In the event that an agency has concerns about allocations then this can be addressed by way of an e-mail to the Planning and Funding Manager who will instigate an enquiry outside of the operational group/SDG forums.

For the purpose of Waiheke clients, these will all be allocated to Royal District Nursing Service New Zealand Limited and a balancing of allocation is expected to take place as detailed above to allow for this to take place.

This formula applies to all new clients, and is exclusive of clients who are known to the agency (i.e. there will be no double counting of clients for whom a reassessment is required in cases where the initial assessment has been revisited).

In addition, there will no longer be any expectation that providers will accept all referrals, or that they will sub contract if they do not have the capability or capacity to meet demand. However there will be a shared commitment across the provider group to ensure capacity to manage referrals. If a provider does not have capacity to accept referrals then that provider must inform the Access Centre including the likely duration and the reasons why e.g. staff shortages. This will then be shared with the other providers so that proactive planning can occur in regards to likely increased referral volumes.

There is an expectation that a core service is maintained 52 weeks a year to meet basic referral patterns. Providers should liaise with the Access Centre in respect of any capacity issues that may arise.

3.5 Managing Packages of Support

A package of support is a combination of services, interventions and actions informed by the client's goals and their support needs. The ultimate objective of the package of support is to facilitate improvement in independence and ultimately discharge from funded services. For this reason reintegration to unfunded, sustainable support services in the person's community should be a key feature of the package of support.

Agencies are encouraged to identify clusters of need within and across their population of clients and to coordinate events and functions.

3.6 Discharge of Clients

There is an expectation that with the correct application of the suite of assessment and decision making tools, combined with clinical judgement, in conjunction with the family support that many clients will over time be able to be safely discharged from service. This will be undertaken using the protocol outlined below.

Safe and consistent decisions about the reduction of service and discharge of clients will be made on an individual client basis drawing on a combination of clinical assessment and the decision support tool.

The application of the triage validation tool enables care managers to make evidence based decisions on the general level of care that is required. The tool importantly leaves room for individual support plans to be developed in conjunction with the older person and his/her family as to how independence through goal setting can be improved or maintained.

In terms of clients who have been managed down through the levels or for whom discharge directly from level two or three is probable, it is important that definitive assessments are available to share with the client and his/her family. This will assist with the discharge planning conversation. It may also be helpful and appropriate to discuss the discharge plan with the client's primary care team where appropriate. Other points to note include:

- At all available opportunities ensure that eventual discharge is factored into conversations between care/case managers and clients to try to avoid what might be perceived as sudden discharge decisions
- Where possible, involve family members and other groups involved in the person's care so they can assist in ensuring a united message is being given to the client.

Assuming the discharge decision is accepted by the client, follow the steps listed under the Discharge Protocol.

3.6.1 Discharge protocol:

- Discuss with the client and/or his/her family when the last date of service will be
- Where appropriate ensure the following items are covered and documented with the client and or relevant family members:
    - referrals to other services and details of how these will be accessed
    - activities to be continued outside of structured activities to maintain independence (sit to stands, balance, exercise etc.) and health promotion and symptom management strategies
    - actions to be taken in the event the client feels low, depressed or unwell (contact family, identified close friend or primary care health professional)
    - what to do in the event the discharged client or his/her family believes the services need to be restarted at a future date (notify their GP in the first instance, also provide details to the Access Centre)
- Provide a copy of all the above information
- Send a copy of the above information to the GP and Access Centre.

3.6.2 Grounds for a provider to discharge a client:

- From time to time a provider may need to decline to provide services or withdraw services from a client due to:
    - inappropriate client or family behaviour
    - non compliance
    - Health & Safety issues which pose a serious risk to staff.
- A Provider is required to discuss reasons for declining or withdrawing services with the Team Leader at the Access Centre before doing so.

3.6.3 Disputed discharges

In the event that clients and/or their families are not accepting of the decision to discharge, the conversation should be referred to the agency designated manager who can peer review the assessment tools and revisit the client history with the care/case manager. Each agency will have its own internal review process for this situation. If it is agreed there is clear and valid evidence that services are no longer warranted and that discharge is a safe option, then the designated manager should speak with the Access Centre. The provider may wish to engage in a wider conversation or meeting with the client and/or his/her family

In the event that there is still no acceptance then families should be referred to the DHB Planning and Funding Manager or delegate who will act as the arbitrator in the event that an appeal is requested.

The DHB will support the provider's decisions to discharge if there is sufficient evidence the provider has considered and mitigated any risk to the client due to being discharged from the service and that all reasonable steps have been taken by the provider to maximise independence, strength and confidence to ensure the client can successfully manage without formal supports.

3.7 Staff and Training

Enhanced Home Based Support is based on a model of restorative care. Providers will remain committed to a workforce that is largely non-casualised and in the case of care managers, predominantly made up of registered health professionals (RHPs) except in cases where specialist roles cannot be filled by RHPs such as where a niche cultural or disability specific position is unable to be filled. In these instances, a core set of competencies must be demonstrated and utilised in such a way that supports frontline care managers who undertake assessments using the overall suite of tools. Workforce issues such as the recruitment and retention of non RHPs will be reported to the SDG.

The ratio of clients to care/case managers is not to exceed 200 for non complex clients and 100 for complex clients. The exception would be where the SDG is in agreement based on a lower acuity group of clients as overall client mix will impact on the number of clients a care or case manager can appropriately manage.

ADHB will work with providers to ensure staff members are trained in the use of the CHA tool if a decision is made by the SDG to use this tool with non-complex clients. Ongoing provision of training will be managed within the district and will be made available to external providers as well as DHB provider services.

All parties have a commitment to developing the workforce to ensure that relevant training and skills are in place to meet client needs and ensure the delivery of quality services. Where there is a requirement to meet national criteria around training or where the model of service delivery requires specific training then this is discussed and agreed via the SDG including the resources required.

4.0 Information Requirements

4.1 Provider Key Objectives

The provider must aim to:

- Maximise independence and quality of life
- Assist a person to develop and maintain their functional ability
- Support families to provide for the physical and emotional needs of the older person
- Assist independence through the support and maintenance of current skills
- Wherever possible work on restoration with a focus on reducing care as independence improves or discharging clients altogether once sufficient community or family support is in place
- Enable people to remain safely in their own homes as long as possible
- Select interventions from a wide range of agencies, across both health, welfare and social services, working innovatively and in conjunction with the older person to achieve goals
- Facilitate meeting support needs including from formal supports and natural and informal sources to ensure the full spectrum of client need is being met
- Liaise with the Access Centre in the event that respite care, carer support or residential care is required.

4.2 Quality Standards and Monitoring Requirements

The provider must comply with the General Terms and Conditions and the Provider Quality Specifications and all other quality requirements which pertain to the provision of home care and needs assessment.

The provider must have a documented quality improvement and risk management system in place that reflects continuous quality improvement principles. This will involve a best practice approach to organisational management including consumer rights, entry to services, human resource management, exception reporting and complaints management, and service planning and delivery. It will also include a strategy for planning, implementing and reviewing service delivery to consumers, from a consumer perspective. All consumers should be involved in the development of their service plan and personal outcome objectives. In addition, outcome measures should be developed for each consumer and their family/whanau.

The provider will report quarterly on the development and implementation of the quality improvement plan and compliance standards.

4.2.1 Home and Community Sector Standard

All providers must hold and maintain current certification against the Home and Community Sector Standard 8158:2003 and from 1 September 2013 Home and Community Sector Standard 8158:2012. Certification audits shall be completed by an auditing agency authorised by the DHB. All certification audit reports and associated progress reports shall be provided to the DHB.

5.0 Funding Arrangement from 1 July 2011

The funding for 2011/12 was set using Version One of the Case Mix informed cost model as formulated by the University of Auckland on behalf of ADHB. Each client category has been

allocated a unit price based on its relativity to the base price formula and this in turn has been calculated to reflect a daily rate.

Six individual unit prices have been determined for non-complex clients and a single *average* price derived using a validated average hourly rate has been applied to complex clients. Tiered pricing for complex clients is planned to be introduced in late 2012, but until such time the average rate will be used and there will be no retrospective wash up.

Note: There are a group of complex clients (approximately 600) who are currently under the care of the A+ Links specialist service. It is noted that that some or all of this group may be devolved to the care of community providers. Importantly these clients have not been costed into the case mix model and are not covered by the budget allocated to the model for 2012/13. Devolution of this client group would need to be negotiated in conjunction with review of the current funding model.

5.1 Fee for Service Methodology

The concept behind the calculation to determine the monthly HBSS 'fee for service payment' to individual providers is based around their full collection of HBSS clients being advised to ADHB in the first instance (including POCA rating). This initial database is then to be updated on a monthly basis from data supplied by the provider, to establish a revised collection of clients both during, and as at the end of the month in question.

The underlying principle behind this is that at the end of every month, the exact volume and NHI detail of every ADHB HBSS client being serviced as included on the provider's internal database (including POCA rating) should match the spreadsheet held by the ADHB on which payment for the month has been based. This would be the comparative basis around which any independent Audit functions are carried out.

The total monthly 'fee for service' will be calculated by using a specified daily rate based on the POCA rating of all active clients. To help inform the accurate calculation of this total, the following business rules will apply:

- All updates of clients to the database are to be supplied by the provider to the ADHB (or nominee) on a monthly basis as soon as possible after month end - ideally after no more than 6 working days to help ensure the subsequent bi-monthly payment including wash-up takes place on the 15th of the month – or first business day thereafter
- An exception to this may occur around the Christmas/New Year period, when the months of both December and January may be washed-up in the payment due February 15th, or thereabouts. To be determined by SDG by majority
- Funding starts from the day of First Assessment which must include a completed interRAI assessment (also referred to as 'Admission date')
- The daily funding rate changes on the date a reassessment is carried out including completed interRAI assessment (as determined by clause 3.2)
- The funding rate is unchanged by a review as it does not include an interRAI assessment
- The funding ends the day before the date of discharge
- The funding is suspended 28 days after a client is placed On Hold
- The funding resumes after a period On Hold from the first date back in service (referred to as coming 'Off Hold' – note: some providers refer to as 'resumed')
- Clients placed On Hold and subsequently discharged shall be also reported as being Off Hold the same date as the date of discharge. Similarly, an On Hold client that may somehow be reported as having a Review or Reassessment will not be updated until reported as coming Off Hold. (i.e. All On Holds are therefore matched with an Off Hold)
- All On Hold clients will be brought forward by ADHB from the previous month's database, and will be assumed to remain On Hold until advice otherwise is provided

5.2 Funding rates

The daily rates for a specific funding period will initially be based on the following format for the 2012/13 financial year, but will be updated via Contract Variation at appropriate periods (no less frequently than annually).

ADHB daily reimbursement rate re HBSS care for 2012/13 Financial Year							
Care Type	House work	Care Management	Housework & Shopping - Stable	Housework & Shopping - Flexible	Personal Care - Stable	Personal Care - Flexible	Complex
Code Level	1A	1B	2A	2B	3A	3B	Complex
Daily Rate per client NZ$							

5.3 Subsequent wash-up, corrections and audit

While it is anticipated that systems will be put in place by providers and ADHB to help ensure accurate and timely data supply, analysis and payment, it is possible that subsequent amendments may come to light during the reporting process, especially in the formative stages of the new process. To this end, all stakeholders have the right to request that prior period adjustments are made via the wash-up process (timing within reason).

Providers should advise the ADHB of any such changes as part of the formal monthly reporting process of data advising of client changes during the month.

This clause will also apply if audit processes highlight anomalies to data previously submitted by Providers.

5.4 Dispute resolution

The DHB agrees where all reasonable efforts to reach agreement with a provider or set of providers to acquire necessary capacity to deliver to the required client volumes, then the DHB will take steps to reasonably assist or intervene.

6.0 Reporting Requirements

6.1 Payment Data

With the introduction of case mix funding, the following data will be required on a monthly basis to inform accurate and timely payments. It is envisaged that this will be increasingly automated over time. The following information is required to be e-mailed to the ADHB Funding Coordinator by the fifth working day of the subsequent month.

New Admission Data

New Admissions by NHI	Date (initial assessment)	POCA Score

Discharge Data

New Discharges by NHI	Date of Discharge	Reason for Discharge

Reassessment Data

Reassessed Client NHI	Date of Reassessment	Reason for Reassessment (Scheduled or change of circumstance)	Original POCA Score	New POCA Score (as applicable)

On Hold Data

Clients on hold during the period by NHI	Date of entry to 'on hold'	Reason for on hold	Date of Return to service (if known)

Off Hold Data

Clients off hold during the period by NHI	Date of return from 'On hold'

Prior Period Adjustments

Category (e.g. admission, discharge, reassessment, On Hold change, Off Hold change)	NHI	Date (as applicable)	POCA	Prior POCA (if reassessment)	Post POCA (if reassessment)	On Hold date	Off Hold date	Reason / narrative (please provide relevant details)

6.2 Health of Older People Scorecard

On the 20th of each month the following data for the previous month should be emailed to the Planning and Funding Manager, Health of Older People (kates@adhb.govt.nz):

- number of compliments received concerning HBSS
- number of complaints received concerning HBSS
- number of non complex clients accessing respite care
- number of clients discharged from HBSS due to admission to age residential care
- number of clients discharged from HBSS due to regained or increased independence
- number of clients discharged from HBSS due to other reasons.

6.3 Quarterly Reports

The provider will report quarterly on the following information using the template provided in appendix 1.

Workforce				
Total number of staff employed to deliver service under this contract *This relates to FTE figures not actual numbers. Excludes corporate overhead FTE (e.g. finance, payroll)*				
Breakdown of care/case managers and support workers *This relates to FTE figures not actual numbers*	Case managers:		Support workers:	
Ratio of clients to care/case manager *Ratio calculated based on FTE figures not case manager actual numbers against actual number of active clients as at the last day of reporting period.*	Clients:		Case managers:	
Total number of staff employed in this period *This relates to FTE figures not actual numbers.*	Case managers:	Support workers:	Other:	Total:
Percentage of permanent versus casual workforce *Number of total staff FTE employed under a permanent employment agreement as compared to number of total staff FTE employed under casual agreement.*	Permanent:		Casual:	
Respite Care				
Number of clients receiving respite care	Home respite:		Residential respite:	
Total funding allocated to respite care in this quarter				
Narrative on benefits and issues on providing respite care as part of the enhanced HBSS model.				
Quality Assurance				
Number of clients surveys undertaken during this quarter				
Positive feedback – key factors identified in surveys				
Negative feedback – key factors identified in surveys				
Amendments made to service following feedback				
Innovations				
Narrative on any service innovations introduced in this quarter including respite care.				

Reporting is to be submitted to Sector Services and should be addressed as follows:

The Performance Reporting Team
Sector Services
Ministry of Health
Private Bag 1942
Dunedin 9054

Email: Healthpac_m@moh.govt.nz

Please also email a copy of your report to: Reporting@adhb.govt.nz

Please note that only one copy of your Performance Monitoring Return is required, (for example, if you send your report by email there is no need to mail a hard copy as well).

Period covered	Report due
1 July 2012 to 30 September 2012	20 October 2012
1 October 2012 to 31 December 2012	20 January 2013
1 January 2013 to 31 March 2013	20 April 2013
1 April 2013 to 30 June 2013	20 July 2013

6.4 Information Systems

You will maintain information systems that allow us to assess the data if requested by ADHB or ADHB's auditing agents.

Patient Information	Referral Information	Service Information	Provider Information
• Patient NHI • Patient ACC Number if applicable • Patient Name • Patient Data of Birth • Patient Gender • Patient Ethnicity • Contact Details • Non Complex, ComplexNext of kin / Carer details including contact details • Residence type • Known access / safety issues • Preferred language • GP details • PHO details	• Referral source • Referring Practitioner name or name of referrer • Referring Practitioner Registration Number (where possible) • Date of referral to service • Reason for Referral (issue/diagnosis) • Known previous medical history / diagnosis • Services referred for • Date referral accepted / rejected (made active)	• Date of assessment (s)/review(s) • Assessor name(s) + contact details where possible • Main problems / issues • Main goals • Other services / providers involved + contact details • Assessment / review information generated for those consumers completing assessment • Summary of identified risks other than clinical e.g. environmental, manual handling • Service(s) / inputs required to achieve objectives • Date of service(s) starting • Dates of service(s) delivered per hour, per day, per month (amount of service(s) required + contacts provided) • Significant changes in consumer or caregiver /family/whanau condition / situation • Processes to be followed in response to episodes that occur outside normal working hours • Provider of service • Contact details of service provider	• Provider Contract details • Cost per service per consumer] • Provider invoice details • Provider payment details

		• Significant changes to service(s) providers – reason/date/new provider + service details • Date service(s) stopped + reason • Review dates + reviewer • Date of discharge (case made inactive) • Discharge summaries	

Appendix 1

Reporting template

Workforce				
Total number of staff employed to deliver service under this contract *This relates to FTE figures not actual numbers. Excludes corporate overhead FTE (e.g. finance, payroll)*				
Breakdown of care/case managers and support workers *This relates to FTE figures not actual numbers*	Case managers:		Support workers:	
Ratio of clients to care/case manager *Ratio calculated based on FTE figures not case manager actual numbers against actual number of active clients as at the last day of reporting period.*	Clients:		Case managers:	
Total number of staff employed in this period *This relates to FTE figures not actual numbers.*	Case managers:	Support workers:	Other:	Total:
Percentage of permanent versus casual workforce *Number of total staff FTE employed under a permanent employment agreement as compared to number of total staff FTE employed under casual agreement.*	Permanent:		Casual:	
Respite Care				
Number of clients receiving respite care	Home respite:		Residential respite:	
Total funding allocated to respite care in this quarter				
Narrative on benefits and issues on providing respite care as part of the enhanced HBSS model.				
Quality Assurance				
Number of clients surveys undertaken during this quarter				
Positive feedback – key factors identified in surveys				
Negative feedback – key factors identified in surveys				
Amendments made to service following feedback				
Innovations				
Narrative on any service innovations introduced in this quarter including respite care.				