Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4134
Kathleen.Smitheram@cdhb.health.nz;

21 March 2022

9(2)(a)
[redacted]

RE Official Information Act request WCDHB 9669

I refer to your letter dated 24 February 2022 and received in our office on 28 February 2022 requesting the following information under the Official Information Act from West Coast DHB regarding Access Home Help service provider. Specifically:

- **A copy of the contract between the West Coast DHB and the home help service provider Access. I am a client of this service and am concerned to know what services this contract provides for, what services are excluded, and the service standards to be met.**

Please find attached as **Appendix 1** the Home and Community Support Services Community Health, Transitional and Support Services – Tier two service specification and as **Appendix 2** a copy of the National Framework for Home and Community Support Services (HCSS).

The Service Specification document forms part of all publicly funded contracts for Home Based Support Services and we believe will provide you with the information you are seeking regarding services provided, services excluded and the service standards to be met.

The National Framework similarly provides context to the aims of the service. Both of these documents are publicly available on the Ministry of Health website.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

Appendix 1

MINISTRY OF HEALTH
MANATŪ HAUORA

All District Health Boards

HOME AND COMMUNITY SUPPORT SERVICES

COMMUNITY HEALTH, TRANSITIONAL AND SUPPORT SERVICES

(District Health Board Funded)

TIER TWO SERVICE SPECIFICATION

STATUS: **TRANSITIONAL**

Approved by DHB GMs Planning and Funding (February 2020) to be used for the transitional nationwide description of services to be provided. It will be compulsory to use this service specification when purchasing this service from 2022 when DHBs have confirmed they are using the new Home and Community Support Services casemix model.

Review History	Date
First Published on NSFL	2020
Consideration for next Service Specification Review and the replacement of the Purchase unit codes	Within five years

Note: Contact the Service Specification Programme Manager, Ministry of Health nsfl@health.govt.nz for queries about this service specification.

Nationwide Service Framework Library web site http://www.nsfl.health.govt.nz

Contents

HOME AND COMMUNITY SUPPORT SERVICES
(DISTRICT HEALTH BOARD FUNDED)
COMMUNITY HEALTH, TRANSITIONAL AND SUPPORT SERVICES
TIER TWO SERVICE SPECIFICATION
HOP1009, HOP1010

The Tier Two service specification for Home and Community Support Services (HCSS) is used for purchasing services for older people who have support needs because of an age-related condition.

So that the total service requirements are explicit, this service specification is also to be used in conjunction with the Tier One Community Health, Transitional and Support Services service specification[1] that contains generic principles and content common to all the tiers of specifications below it.

Background

HCSS services are required to work cooperatively with representatives of bodies such as contracted providers, allied health, primary health care, needs assessment and service coordination (NASC) and district health board (DHB) Health of Older People portfolio managers. These bodies will work within an integrated management framework consisting of a strategic steering group and an operational integrated management group established at the commencement of the contracted service period and meet regularly.

The integrated management groups are responsible for ensuring integrated, coordinated and responsive HCSS service delivery with a focus on continuous improvements within a 'best for person, best for system' framework. The HCSS Operations Manual has been developed to support the integrated management groups throughout implementation strategic direction and operational delivery of this service.

1 Key Documents

The Tier Two HCSS service specification is supported by the National Framework for Home and Community Support Services[2] that provides the overarching guidance for publicly funded home and community support services to ensure national consistency of the commissioning, delivery and evaluation.

The strategic links for HCSS are New Zealand Health Strategy[3], the Healthy Ageing Strategy[4], He Korowai Oranga Māori Health Strategy[5], the New Zealand Framework for

[1] www://nsfl.health.govt.nz/service-specifications/current-service-specifications/community-health-transitional-and-support
[2] National Framework for Home and Community Support Services (HCSS) Ministry of Health August 2020. www.health.govt.nz/publication/national-framework-home-and-community-support-services-hcss
[3] www.health.govt.nz/publication/new-zealand-health-strategy-2016
[4] www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update
[5] www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Dementia Care[6], the New Zealand Carers' Strategy[7] and Te Ara Whakapiri[8] and the New Zealand Disability Strategy.

HCSS are a key component of achieving the long-term vision of the Healthy Aging Strategy by supporting older people to live well, age well and have a respectful end of life in age-friendly communities.

2 Service Users

Service Users are defined as clients for the purposes of this service specification.

Most clients will be over 65 or aged 50 to 64 years with age related needs. Clients are people who are eligible for long term publicly funded healthcare and that have been assessed using an appropriate interRAI assessment tool and:

a. have support needs because of an age-related condition aged over 65 years

b. are aged 50 to 64 years, and like in age and interest

c. are people receiving services for ACC funded short term services or

d. are receiving Mental Health and Disability Support Services (DSS)[9], and who also require Health of Older People Home Support services for age related needs to continue concurrently

e. have support needs that are likely to last greater than 6 months.

3 Service Exclusions

The following people will be excluded from this service where there are duplicate services that are already funded by the DHBs under other service specifications, by other government agencies or the Ministry of Health who:

- are funded for Home Support Services by Accident Compensation Corporation (ACC) (except for 2c. Service Users, above)
- receive Mental Health and Disability Support Services (except for 2d. Service Users, above)
- are funded for Long Term Supports – Chronic Health Conditions services
- in DHB funded aged residential care facilities
- reside outside the DHB's region, including those on holiday

[6] www.health.govt.nz/publication/new-zealand-framework-dementia-care
[7] www.msd.govt.nz/about-msd-and-our-work/work-programmes/policy-development/carers-strategy/index.html
[8] www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life
[9] Disability: The Ministry of Health's definition of 'person with a disability' for the purpose of accessing funded disability support services Service Coverage Schedule www/nsfl.health.govt.nz/accountability/service-coverage-schedule is 'a reduction in independent function to the extent that a person has been assessed as requiring support services due to an age related or a personal health condition'. These responsibilities are split between DHBs and the Ministry of Health. Funders also have specific criteria that determine eligibility for specific supports.

- receive household only assistance for people who do not have a current community services card
- have an individualised funding allocation of home and community support services.

4 Service Objective

4.1 General

The purpose of HCSS is to provide older people with restorative client-centred, culturally appropriate and responsive support that maintains or enhances the functional ability, health and social connectivity or to provide support at end of life for existing clients in the community.

4.2 Māori Health objectives

These requirements are in addition to the generic requirements for Māori Health in the Tier One Community Health, Transitional and Support Services service specification.

The Provider will work within the Pae Ora framework of He Korowai Oranga Māori Health Strategy, and seek to provide care and support that promotes:

Whānau ora – healthy families

Mauri ora – healthy individuals

Wai ora – health environments

Pae Ora provides a platform for Māori to live with good health and well-being in an environment that supports a good quality of life. It encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide a high-quality and effective service.

The Provider's policies and practices will demonstrate measurable benefit to Māori, including demonstration of:

- services that will equitably and directly deliver on Māori health priorities
- workforce training focused on the delivery of services to Māori including the service's understanding of Māori principles/tikanga
- client and whānau feedback on how they believe the Provider has delivered in relation to Māori values and beliefs
- linkages with the local Māori community and how these are enhanced; and
- processes to include engagement and input from Māori into service delivery management and ongoing improvement and development of the service.

5 Service Description

5.1 Hours of service provision

The Service will be accessible 24 hours, seven days a week, as appropriate to meet client needs. In usual circumstances, inside service hours are between 7.00 am and 10.00 pm or by negotiation, seven days a week. It is not expected that support services will be delivered by support workers between 10.00 pm and 7.00 am. Service times (eg, between

7am and 9am) will be determined in response to the client's current and evolving needs in consultation between the Provider, the client, their carer, and whānau.

Inside service hours the client, referrers and support workers will be able to make direct contact with a Provider representative. Responses to queries will be available Monday to Sunday between the hours of 7.00 am and 10.00 pm. The Provider is expected to have a process to screen and allocate urgency to messages. This expectation includes all forms of message including but not exclusive to; phone, text and email.

5.2 Restorative casemix model overview

The National HCSS restorative model uses a casemix methodology to group people with similar levels of assessed need together to support equitable resource allocation. The eligible population is initially screened by a NASC coordinator using a Service Allocation Tool (SAT) to determine level of complexity. There are two complexity groups: Non-Complex and Complex.

The interRAI assessment outcomes scores are used to determine and allocate client casemix. The clinical decision tree algorithms (with descriptors for both non-complex and complex population groups) are provided in Appendix 1. The casemix algorithms enable Providers to identify clients that can be reabled/restored, or alternatively supported to maintain or extend their level of functional ability and wellness.

Using a restorative approach, the Provider will work in partnership with the clients to develop and agree SMART[10] goals and document these in the clients' individual support plan. To facilitate achievement of the client's SMART goals, Providers will continuously deliver services that include activities of interRAI assessment, reassessment, client centred individual support planning, resource allocation, clinical oversight, case management, service review, personal care and support, and household management.

The Provider will review the individual support plans regularly, based on complexity as described by case-mix level. Where clients experience a change in wellbeing and/or functional ability, services are adjusted to the new level of need and the client's SMART goals amended. If the support needs of the client have changed significantly requiring an on-going change to resource allocation a re-assessment is completed to identify the casemix level. Alternatively, the reassessment may determine that the client cannot be safely supported in the community and requires an alternative arrangement. The Provider will continue providing support as outlined in the client's individual support plan until discharge, which occurs when the client is no longer at home.

5.3 Service delivery requirements

The Provider will actively collaborate with NASC, primary care, secondary care, community providers and aged-related residential care to deliver services to achieve the strategic objectives of the service as outlined below:

[10] SMART GOALS S- specific, M - measurable, A - agreed upon, R - realistic, T - time-bound.

- Engage and work with both formal and natural supports to facilitate client goal attainment and where appropriate discharge clients who can manage independently with appropriate community and/or family support in place.
- Work with a proactive restorative/reablement focus using flexible service delivery to optimise client independence taking a 'doing with' as opposed to 'doing for' approach where appropriate
- Deliver responsive and flexible services that meet fluctuation in client health and support needs from service entry to service exit. This may require working more closely with whānau, hospice, community health specialist nurses and primary care during times of unstable need or at end of life.
- Provide services that facilitate 'falls prevention' through support activities that improve strength and balance consistent with current evidence or as advised by an allied health professional.
- Promote and improve health literacy and knowledge for older people, their informal carers, whānau, and for the HCSS workforce; including sharing of informational resources such as advanced care plans (ACP)[11], Live Stronger for Longer leaflets[12], Dementia NZ fact sheet: Information for Friends and Family[13].
- Liaise with the NASC coordinator if end of life, respite care, carer support, day activity, palliative care or residential care is required.
- Complete case management as required to ensure clients access the supports they need from, natural supports, other providers and the wider community as required.
- Deliver services to facilitate integration across the health system, including, but not limited to integration with primary and secondary health services.
- Services are provided at the client's place of residence and at other community-based sites, as appropriate.

6 Service Processes

6.1 Service access

Access to this service is by referral to the DHB NASC from an appropriate DHB specialist service, general or nurse practitioners, practice nurses, iwi providers or specialist community health team nurses. Self-referral for assessment may also occur.

Initial screening of referrals by the NASC uses a SAT to determine level of complexity. The SAT can be found in Appendix 3.

Clients choose, or are referred to, their preferred Provider based on the contractual arrangements with the funder. The Provider is responsible for completing interRAI Contact Assessments for the non-complex population, Home Care assessments are generally

[11] www.hqsc.govt.nz/assets/ACP/PR/ACP_Plan_print_.pdf
[12] www.livestronger.org.nz/
[13] www.dementia.nz/files/infosheet/about_dementia_3_info_for_family_nz.pdf

completed by the NASC coordinator. To avoid duplication of effort the Provider may complete some complex assessments in agreement with the NASC coordinator.

Within the described access framework, people requiring 'household only' management services can only access this service if they hold a current community service card (CSC) and have no available able-bodied natural support. Non-CSC holders may be required to contribute to partial or full costs of care or choose an alternative provider. More detailed guidance is provided in the HCSS Operations Manual.

6.2 Provider management of referrals

The Provider will establish and maintain effective communication links with primary and secondary health services, and the NASC cordinator, to achieve a responsive and informed referral management processes. This may be inclusive of involvement in discharge planning for existing clients referred during an inpatient episode of care.

In adherence with legislative requirements the Provider will ensure an occupational safety and health risk assessment is undertaken and documented at the earliest opportunity in relation to the specific services to be delivered. See the Tier One Community Health, Transitional and Support Services service specification for the client Risk Assessment Framework.

6.3 Service response times for described activities

The response time for each referral will be based on the client's level of contextual risk (Appendix 4) assessed from the information given with the referral. It is intended that the response times enable clients' needs to be met with the best use of available resource.

Service Process	Response time and description of activities to be completed
Referrals confirmation and processing	The Provider will provide the referrer electronic confirmation of the receipt of referrals within one working day. Referrals will be processed by the Provider within one working day.
Initial contact/service Implementation – Non-Complex Clients (Low Risk)	Initial contact and appointment booked with client within three working days of acceptance of referral. Contact assessment and service implementation within five working days of acceptance of referral.
Initial contact/service implementation Complex Clients (Moderate Risk)	Initial contact and appointment booked with client within two working days of acceptance of referral. Service implementation within two working days of acceptance of referral or 3 working days if natural supports in can provide necessary interim support.
Initial contact/service implementation Complex Clients (High Risk)	Initial contact and service implementation within 24 hours of acceptance of referral.

Service Process	Response time and description of activities to be completed
Existing Client returning home from hospital/ED/Hospital Avoidance Service (eg, CREST, START, etc)	Services to the existing client to recommence within 48 hours of acceptance of referral unless the client is High Risk whereby services must recommence within 24 hours. The DHB is to ensure the Provider Registered Health Professional (RHP) is involved in discharge planning to determine Provider service allocations meet new temporary needs on discharge.
Client's individual support plan	The individual support plan is fully developed at time of service implementation except for High Risk clients who require interdisciplinary input where it is completed and agreed prior to service implementation. The service plan is reviewed and amended as clinically indicated (change of medications, deterioration in health status) or due to a change in personal circumstances (primary carer no longer able) or as a result of a review.
Client's service review	Reviews are scheduled from date of service implementation and must occur as scheduled (Appendix 2) or clinically indicated. The review section (HCSS Operations Manual) details the minimum activity Providers must undertake to complete a review.
Significant change of client ability or condition requires reassessment	For complex clients the Provider may request the NASC coordinator to reassess the client if there has been a significant change to their abilities, which may result in a new casemix allocation.
Client discharge	When a client is transferred or discharged from the service, and accesses other appropriate services, the Provider will transfer or discharge without avoidable delay or interruption

6.4 Individual support plan

Client centred goal-based service planning informs the Individual support plan. The Provider will work with the client and their whānau to:

- understand the living situation including natural supports
- explore what is important to them
- understand what is meaningful to them
- understand the interRAI assessed support needs of the client.

A SMART goal format is used, where the Provider and client and family whānau agree goals that are focused towards maintaining or increasing independence where possible and that are aligned with their restorative or reablement potential. Goals will also support clients to be involved in normal social activity.

Where clients are frail and/or require end of life support the goals of the individual support plan will reflect this transition of need and focus on support activities that promote clinical

safety, dignity and comfort to align where possible to the clients advanced care plan/wishes. End of life care will be delivered in line with Te Ara Whakapiri.

The Provider will ensure the individual support plan documents how the service will be delivered flexibly to ensure clients use natural supports, whānau, or technological aids to meet their agreed goals.

Individual support plans provide sufficient detail for support workers to understand the support interventions required for clients to be able to achieve their goals.

A clear escalation pathway is documented within the individual support plan to manage situations where arrangements for support are uncertain or do not occur as planned. This may include processes for support to be provided by their carer or whānau and will ensure information on how to contact emergency services if required. The 'Stop and Watch tool' (HCSS Operations Manual) provides a framework that supports workers and whānau to identify what must be escalated to a service coordinator.

6.5 Client Consent, Assessment and Review

6.5.1 Consent

The Provider will seek written informed consent from clients at service commencement in adherence to the Code of Health and Disability Services Consumers' Rights 1996 and other relevant legislation (see link to section 12 Legislation). Consent will be regularly revisited at times while the client is in contact with the service.

If the client's enduring power of attorney for health and welfare has been activated, then this is documented, and this person provides consent on behalf of the client.

6.5.2 Monitoring and review of client progress

The Provider is responsible for on-going monitoring and review of client progress towards achieving the goals established in the individual support plan and for ensuring the services are responsive and flexible enough to meet current and evolving needs as they occur. A full assessment and review schedule to support this process is attached in Appendix 2 and must be adhered to.

Reviews (refer to the HCSS Operations Manual) are scheduled when the individual support plan is developed. The purpose of the review is to measure client progress against SMART goals, observe if there are any clinical indications for a change in support provision, further assessment or greater transdisciplinary team input. The outcome of a review may require the individual support plan to be modified or redeveloped or the client may be ready for discharge. The risk assessment[14] will be revised during the scheduled client review/reassessment and/or repeated as services change.

6.5.3 Assessments and reassessments

The Provider will complete assessments and reassessments for all non-complex clients who are referred to the service.

The Provider may also complete some assessments for complex clients. This will be agreed with the DHB Funder and NASC coordinator and include specified parameters indicating when these are undertaken (eg, rurality). Provider and NASC services will

[14] Refer to relevant service specifications nsfl.health.govt.nz/service-specifications/current-service-specifications/community-health-transitional-and-support

ensure access to sufficient complex client assessments for Provider RHPs to maintain interRAI HC assessment competency (See HCSS Operations Manual).

The Provider RHP may complete or facilitate a clinical assessment by a primary care clinician to establish any reversible cause where there:

- is an unexplained or gradual decrease in function (eg, mobility/transfer skills to a degree that places significant pressure/distress on the carer/whānau)
- is an unplanned episode of acute care
- is an unexplained and/or sudden increased need for home and/or carer support
- are clear risks in the client's ability to stay at home and socially involved in their community.

Where reversibility is unlikely the Provider may refer clients to the NASC for assessment. For non complex clients where the Contact Assessment shows an Assessment Urgency Score of 5 or 6 clients will be referred to NASC. The RHP will exercise clinical judgement to determine if clients require a referral to NASC where contact assessments show an urgency score of 4.

6.6 Process for outside of service hours

Outside of service hours (after 10.00 pm and before 7.00 am) clients, health professionals and workers must be able to leave messages for the service which will be responded to as appropriate on an urgent or non-urgent basis. The urgency of call is defined by immediate safety and need of the client. The Provider has a system in place to retrieve, process and act on urgent messages early the next day.

6.7 Clients requiring high and very high intensive support

There is a group of clients that present with complexities requiring significantly more resources than the casemix allocation methodology allows for. Providers will continue to deliver services to clients with intensive support needs that:

- may be short term as part of an intensive rehabilitation programme, or
- longer term to prevent further decline, admission to aged residential care or to support clients who require end of life care and support.

This client group has a broad range of intensive support needs that require case management to bridge multiple interconnected needs across health, disability and /or social and whānau groups. Their high and complex needs may be stable or non-stable, and this will determine the frequency of review by the NASC: monthly for unstable and three- monthly for those who are stable. To identify clients with intensive support a robust process of assessment and review with trans-disciplinary team input is provided by the Decision Framework: Clients with high needs requiring intensive supports (see the HCSS Operations Manual).

Some clients with high and very high support needs may be eligible to have a member empoloyed to deliver their allocated package of care. When this is required the Provider will employ the family carer on merit using usual employment practices.

6.8 Case Management and Flexible Service Provision

Through mutual agreement by the clients wider integrated healthcare team (which may include primary care, social sector agencies, DHB based community health specialists, NASC and HCSS Providers), the most appropriate person will be nominated to undertaken case management activities as described in appendix 5. This may include the Providers RHP.

6.9 Client Discharge Processes

6.9.1 Planned discharge

Some clients will successfully regain their functional ability and independence. Where this occurs, the Provider will use safe consistent practices drawing on a combination of assessment and clinical support tools to flexibly deliver services, reducing service allocations as clients regain independence and eventually discharging them from the service.

For these clients the Provider will have on-going and early discussions with NASC, the client and their whānau to ensure reduction in service provision leading up to discharge and the discharge itself is well planned and expected.

Providers are required to have a formal process for discharging clients. As a minimum this will include discussion with clients to confirm the last date of service, a documented discharge letter outlining referrals made to other services and how these can be accessed, activities to be continued in the home, and what to do if they feel they are not coping and need the service restarted.

Unless there are exceptional circumstances (see disputed discharges) the Provider will give 14 days' notice of the intent to discharge and discharge the client five days after the end of service.

6.9.2 Discharge Criteria

The Provider will initiate and continue discussions with client and their whānau and NASC to ensure a safe and timely discharge.

Clients will be discharged from the service when they:

- no longer wish to receive the service
- cease to meet the service access criteria
- choose to transfer to another service Provider
- transfer to age residential care
- transfer to another DHB region
- are deceased
- changing domicile
- have new natural supports in home
- have met service goals and restored to independence
- cannot safely remain at home.

6.9.3 Disputed Discharges

The contracted Provider may withdraw services for an existing client because the service is no longer necessary or due to inappropriate client or whānau behaviour, non-compliance or for health and safety concerns that pose a risk to staff. Should this be necessary, and the family dispute the discharge decision, the Provider and NASC coordinator will peer review the client case and rationale for the decision. If service provision cannot be continued while resolution is sought, the DHB Funder must be notified immediately to be able to manage any risks to the client.

The Provider and the NASC Manager will work with the client and whānau to agree the way forward. If the situation cannot be resolved at this level it will be referred to the DHB Funder who will act as an arbitrator if an appeal is requested.

7 Workforce Development

7.1 General

The Provider develops and maintains a capable, diverse, experienced, culturally aware and well-trained workforce to deliver this service to clients with diverse levels of assessed clinical complexity and support needs.

The Provider workforce will be developed and deployed so that support staff knowledge and competency level can be matched to client complexity needs across the service area. The Provider will have a casemix/caseload mechanism in place to ensure fair and safe allocation of clients at a safe staffing level.

7.2 Support workers

All support workers will have attained NZQA New Zealand Certificate in Health and Wellbeing – Level 2, within 12 months of commencement.

Support workers will have access to and be supported to complete further professional development, including training to attain the New Zealand Certificate in Health and Wellbeing level 3 and 4 in accordance with the Care and Support Workers Pay Equity Settlement Act.[15]

7.3 Registered health professionals

Registered Health Professionals (RHP) will have a current practicing certificate as required under the Health Practitioners' Competence Assurance Act 2003 and the Health Social Workers Registration Act (2003) and relevant professional authorities for self-regulated professions. RHPs will work within their scope of practice and may provide an outline of delegated duties for the support workers.

RHP will receive training to understand the HCSS service model, with a particular focus on understanding casemix and service allocation methodology.

Client assessments must be completed by trained RHP interRAI assessors who meet the 'Criteria for Training and Workforce Requirements' as listed in the Ministry of Health's interRAI National DHB Project Implementation Plan (2008-2012). The Provider RHP will

[15] www.legislation.govt.nz/act/public/2017/0024/28.0/DLM7269154.html

meet competency requirements to complete interRAI Home Care (if requirement is agreed by NASC) and Contact assessments and write and review individual support plans using the interRAI assessment information (refer to the HCSS Operations Manual).

7.4 Workforce diversity

The Provider ensures services are provided by a workforce that is reflective of the communities in which they provide services and has active strategies to attract more Māori and Pacific staff and staff of other ethnicities and minority groups (eg Lesbian, Gay, Transitioning, Questioning or intersex) to health roles as reflected by the community service area. Where possible the client will be matched with support staff of the same culture who can speak in the same language as the client as required. Clients are supported to access interpreter services as required including New Zealand Sign Language for the Deaf.

8 Service Linkages

See Tier One Community Health, Transitional and Support Services service specification Section 8, Service Linkages.

Key linkages between the Provider and other entities are critical to the effective delivery of seamless and integrated HCSS and to maintain social connections for clients. Key linkages will be established with:

- **The client's primary health care provider** – the Provider will ensure they develop specific protocols and policies to strengthen communication directly with client's general practitioner (GP) or nurse practitioner (NP) and practice nurse. The Provider will communicate with the GP/NP or practice nurse about clients with high and complex needs in regard to any service risks or deterioration in the client's well-being.
- **NASC/Care manager** – the Provider will establish an effective and collaborative working relationship with the NASC service to facilitate timely responses and access to other services and to ensure continuing two-way communication regarding service requests/referrals and client support needs.
- **Secondary health care** – the Provider will develop and nurture relationships that promote integrated client pathways with DHB services, district/community nursing and allied health services, older people's health specialist services including specialist nurses who work in mental health.
- **Community agencies/voluntary sector** – the Provider will establish and sustain effective relationships with other organisations and individuals involved in assisting clients and their carer/whānau to address their goals, needs and risks. This may include:
- local Māori networks, kaumātua groups, marae, whānau groups and Māori health providers
- Alzheimer's New Zealand and/or Dementia New Zealand
- support groups and consumer advocacy groups
- cultural and disability networks
- accredited community providers of strength and balance classes

- interpreter services including New Zealand Sign Language
- meals on wheels or equivalent, and support with supermarket orders/deliveries
- community based Non Government Organisaitons (NGOs) including those providing mental health services.
- **Emergency response coordinators** – the Provider will establish relationships with district wide emergency planning/coordination entities (for example WREMO[16]) for a coordinated emergency response to emergencies such as flooding and earthquakes, in addition to developing individual emergency response plans; and ensure contact information is updated regularly.

The Provider will also need to supply evidence when required (for example in the event of an external audit) of effective linkages to support clients link to the wider community, involving Māori, Pacific, disability groups, providers of strength and balance classes and other support networks and advocacy groups.

9. Quality Requirements

Refer to the Tier One Community Health, Transitional and Support Services service specification for Quality Requirements for General, Access and Acceptability.

9.1 Legislative requirements

The Provider's services are governed by NZ Regulations and Legislation, including:

- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- New Zealand Public Health and Disability Act 2000
- 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 Competence Assurance Act 2003
- Health and Disability Services (Safety) Act 2001
- Health Information Privacy Code 1994
- Home and Community Support (Payment for Travel between Clients) Settlement Act 2016
- Support and care workers (Pay Equity) settlement Act 2017
- Crimes Act 1961 (duty of care Section 151).

[16] Wellington Region Emergency Management Office (WREMO) www://wremo.nz/

9.2 Audit

The Provider must hold and maintain current certification against Home and Community Sector Standard 8158:2012. The Provider must also be compliant with NZS 4121:2001 for accessibility. Certification audits will be completed by a designated audit agency. All certification audit reports and associated progress reports will be provided to the DHB Funder as soon as finalised.

9.3 Quality improvement and risk management systems

The Provider must have a documented quality improvement and risk management system in place that reflect continuous quality improvement principles.

The quality of the Provider's services will be measured as the extent to which they are:

- delivered safely
- are highly effective
- client and whānau centred
- delivered in timely way
- delivered flexibly and efficiently.

The Provider must deliver the service in accordance with the outputs to achieve the expected outcomes as set out in the table below.

Quality Indicators	Service output	Expected qualitative and quantitative outcomes:
Quality and safety	Complaints management system that aligns with the agreed Complaints Categorisation (2015)[17] Sector standard compliance maintained. Adverse and sentinel events are measured. Professional Body standard requirements are met.	• as per the Health and Disability Requirements. • proactive management of complaints, including providing an update to those involved in making the complaint when the complaint is resolved. • interRAI assessment competency achieved and retained. • continued certification against sector standards. • all professional staff are supported to meet professional body requirements for practice and maintain an annual practicing certificate.
Client experience	Restorative and maintenance HCSS for	• reduced duplication of assessment for people with non-complex needs.

[17] www.hcha.org.nz/news/complaints-categorisation-guidance-available.

Quality Indicators	Service output	Expected qualitative and quantitative outcomes:
	complex and non-complex clients. interRAI assessments completed. Adherence to Medication Management guidelines[18]. Communication management systems. Measurement of client experience.	• same Provider where possible when dual care arrangements exist (eg Accident Compensation Corporation). • positive changes in casemix over time for some reversible non-complex clients. • client satisfied with ability to communicate with you in a timely way. • service delivery responsive and appropriate for client need. • where specific times requested by the client cannot be staffed, the nearest possible service time is agreed with the client. • client experience survey.
Referrer experience	Communication systems that enable effective and direct communication. Proactive collaboration in health system integration and Non-Government Organisation forums.	• referrers satisfaction with communication and responsiveness of contact with the Provider. • escalation of issues to the Provider is be transparent, with documented outcomes. • communication occurs regularly and as required with referrers, primary care and consumer advocacy groups.
Best value from resources	Clients are supported to remain in their own home with HCSS targeted to meet need.	• utilisation patterns reflect client complexity. • delivery of HCSS results in people staying in their own homes longer. • interRAI CAPs show improvements over time (see HCSS Operations Manual).
Equity	Service is appropriate for all ethnicity groups.	• client diversity reflects population diversity. • workforce reflects population diversity. • outcomes for clients are fair and equitable across ethnic groups.

[18] www.health.govt.nz/publication/medication-guidelines-home-and-community-support-services-sector

Quality Indicators	Service output	Expected qualitative and quantitative outcomes:
Integration	Service Provider actively participates in health system integration management. Active collaboration and problem-solving regarding IT integration.	• HCSS participation in discharge planning. • engagement in health system integration development. • client information appropriately shared and available for primary care Providers to access.
Workforce sustainability	Staff training in Career Force Level 2, 3 and 4. Workforce planning anticipates and responds to risk of insufficient workforce to deliver as HCSS requirements demand.	• training levels are achieved to required standard. • staff turnover is monitored and reduced where possible. • RHPs are engaged in peer review.
Natural supports	Presence in community facilitates client participation in local activities and interest groups.	• individual support plans detail how the client uses available natural supports to achieve goals and social connectivity.

Further to this above, the Providers continuous quality improvement strategy 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.

10 Purchase Unit Codes

Purchase Unit (PU) codes are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following PUs codes apply to this Service.

PU Code	PU Description	PU Definition	PU Unit of Measure
HOP1009	Household Support Services for People with Age Related Disability	The service provides assistance with tasks normally performed in and around the home to enable eligible people with age related disability to remain in or to return to their own home / private accommodation in the community.	Hour
HOP1010	Personal Care Services for People with Age Related Disability	Provides assistance with personal hygiene and the range of tasks required to support daily living to enable eligible people with age related disability to remain in or return to their own home / private accommodation in the community.	Hour

Unit of Measure	Unit of Measure Definitions
Hour	Number of hours provided.

NOTE: The above PUs will be replaced by a new PU code(s) when all DHBs have transitioned to the casemix funded HCSS model described in Appendix One. This casemix model does not require that services be purchased in hourly units of measure.

11 Reporting and Monitoring

11.1 Reporting to the Ministry of Health

The Provider is required to report detail about workforce for pay equity and paid family carers to the Ministry of Health until July 2022.

11.2 Reporting to the DHB Funder

All certification audit reports and associated progress reports will be provided to the DHB Funder as soon as finalised.

The Provider is to complete monitoring, analysis and benchmarking activities working collaboratively with the DHB Funder to evaluate the service programme against whole of system measures as described in the National Framework for HCSS. The detail of these arrangements will be agreed at a local level within the HCSS Integrated Strategic Steering Group. Guidance is provided in the HCSS Operations Manual about the reporting required to support a continuous quality improvement approach.

The table below provides the reporting required by DHB Funders to monitor and measure the performance of the service. The Provider will provide the set of reporting information as requested by the DHB's Contract Manager (a reporting template and guidance is provided in the HCSS Operations Manual).

Outcomes indicator definitions and counting rules

Missed Visit: The service cannot respond 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. Exclude: if Client is out at time of visit, client initiates or is comfortable with rescheduling agreed time in advance.

Proportion (%) of support workers trained: Number and percentage of staff by qualification level at end of quarter Support workers highest qualification should be included and counted only once

Objective	Method	Outcome indicator specification	Report type	Frequency
Clients maintain or improve their independence	Service responsiveness meets requirements	Total number of clients discharged to Aged Residential Care	Excel	Monthly
		Number and percentage of reviews completed of total due by casemix level	Excel	Monthly
		Number and percentage by type of assessment and reassessments completed	Excel	Monthly

Objective	Method	Outcome indicator specification	Report type	Frequency
		(Ca or HC) of total due by casemix group		
		Total number of clients discharged to independence	Excel	Monthly
		Total number of clients discharged because deceased	Excel	Monthly
		Total number of clients discharged because changing domicile	Excel	Monthly
		Total number of clients discharged because have new natural supports in the home	Excel	Monthly
		Total number and percentage of high risk clients have services implemented within 24-hour from acceptance of referral	Excel	Monthly
Clients have a positive experience and satisfied with service	Client satisfaction survey	Number of surveys completed as proportion of total clients. Narrative of feedback received (positive and negative), and corrective actions taken where negative	Excel Narrative	Quarterly
Services are delivered when agreed and expected	Service responsiveness meets requirements of 6.3 of the service specification	Number of missed visits	Excel	Monthly
		Percentage of missed visits as proportion of total visits	Excel	Monthly
		Number and percentage of visits incurring exceptional travel funding	Excel	Monthly
		Number of new staff by designation within the quarter	Excel	Quarterly
		Number and percentage of staff by ethnicity as a proportion of total staff (if small numbers consider identifiability of data)	Excel	Quarterly
		Number and percentage of total support worker staff on guaranteed hours	Excel	Quarterly
		Number and percentage of staff by qualification level at end of quarter	Excel	Quarterly

12. Technology and Data Requirements

12.1 General

The Service Provider's Information Technology Systems will comply with the system requirements described in national and HISO Ethnicity Data Protocols (2017)[19], including the Health Records NZS 8153:2002. The Home and Community Support Sector Standard NZS 8158:2012[20], the Health Act 1956, the Health (Retention of Health Information) Regulations 1996 and the Health Information Privacy Code 1994. The Service Provider's IT Systems will support electronic information processing, interfaces and workflows specifically interRAI software.

12.2 Data sharing

To support the objectives of service the DHB and Providers will work together with Primary Health Organisations and General Practices and other community-based providers towards identification and exploration of data sharing opportunities that will benefit the care and outcome of their clients. In undertaking any such data sharing arrangements, they must be cognisant of the confidential nature of client data and obligations to appropriately protect clients' rights to confidentiality.

12.3 Data collection

The Provider will use electronic information systems to collect information as set out in the table below to demonstrate access and ability, recording, reporting and facilitate sharing of demographic information, referral management, service review and service delivery data per client.

Client Information	Service Information	Provider Information
Client NHI **Client Name** **Client Date of Birth** **Client Gender** **Client Ethnicity** **Contact Details** **Emergency Contact Details** **Next of Kin/Carer** **Date of referral to service** **Known previous medical history/ diagnosis** **Accepted/rejected (case made active)**	Assessor/reviewer name(s) and contact details by client Assessment/review information generated from NASC Date referral accepted Date of first visit Date of client's service(s) implemented Date client service(s) stopped (discharge) and reason (page 13) Review dates by casemix Reassessment dates by casemix	Hours of service delivered by NHI

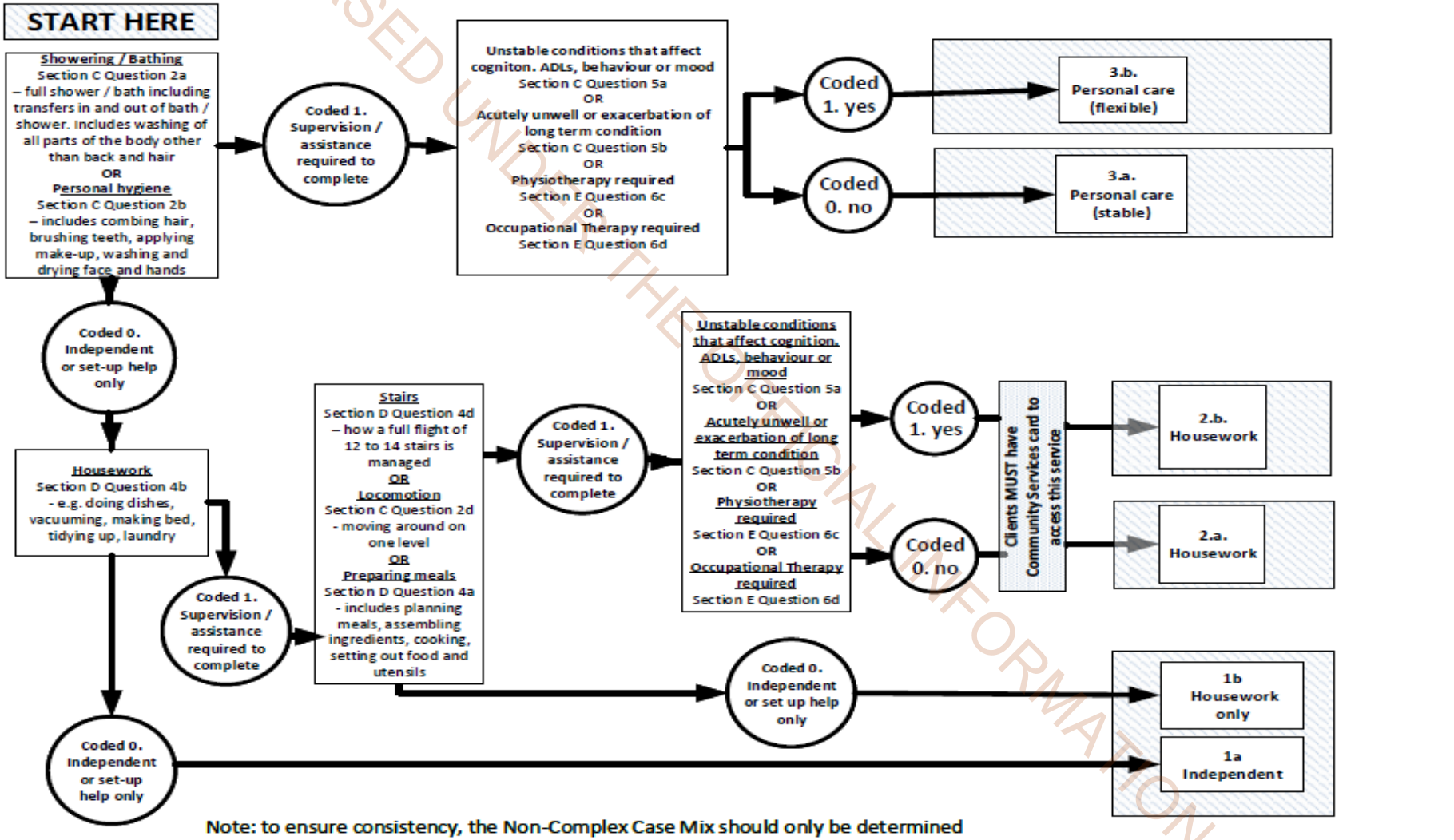
[19] www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols
[20] www.health.govt.nz/publication/auditing-requirements-home-and-community-support-sector-standard-nzs-81582012

Client Information	Service Information	Provider Information
Client by allocated casemix level **Details including contact details** **Residence Type Known Access/Safety Issues** **Preferred Language** **Iwi Affiliation** **Clients' GP name, practice address, phone number.** **GPs' PHO name and address.** **Client's Pharmacy name and address**	Date of discharge, reason and where to Date of death Workforce training information. Contact with other agencies. Missed visits (definition in footnote)	

ENDS

Appendix 1: Casemix Algorithms

Non-Complex Algorithm Utilising the InterRAI Contact Assessment Tool



Note: to ensure consistency, the Non-Complex Case Mix should only be determined from coded responses in the most recent interRAI Contact Assessment

Last Updated 24/09/2019

Complex Algorithm Utilising the InterRAI Home Care Assessment Tool

COMPLEX CASEMIX QUICK REFERENCE CHART

VERSION 5.1
26/03/2014

A. LEAD CATEGORY

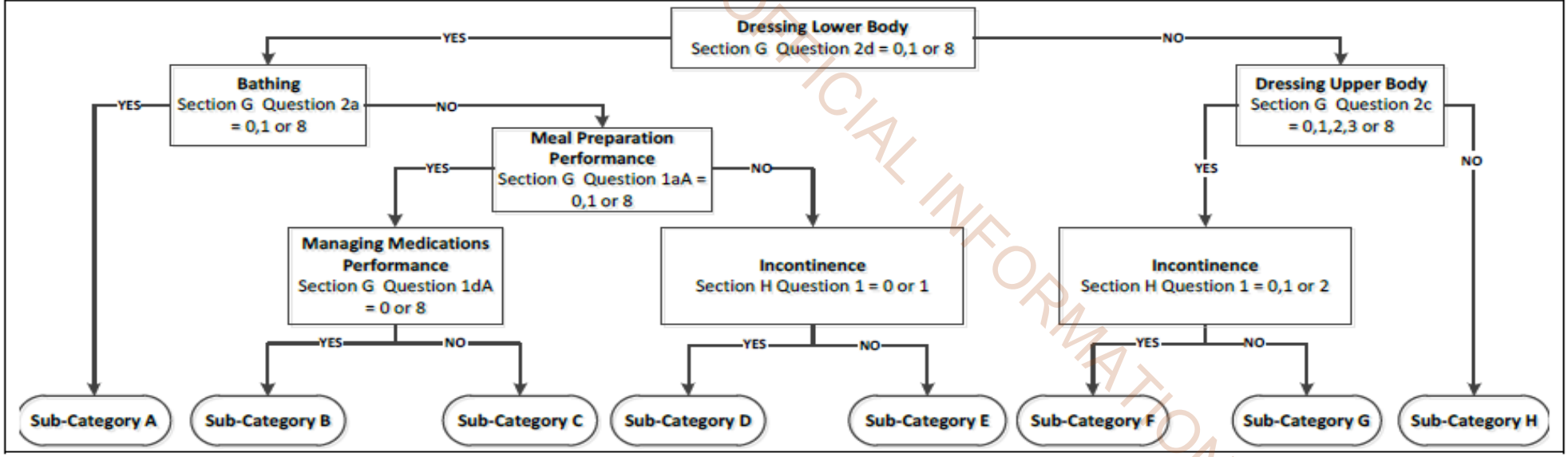
TO DETERMINE LEAD CATEGORY
Check the questions indicated in the most recent interRAI Home Care assessment to determine if Brittle Social Support and/or Cognitive Impairment issues are present. Then use the table determine the Lead Category.

COGNITIVE IMPAIRMENT
Section C – Question 1 – Cognitive Skills for Daily Decision Making
- If you have coded 2,3,4 or 5, then YES
Section C – Question 5 – Change in Decision Making
- If you have coded 2 Declined, then YES

BRITTLE SOCIAL SUPPORT		NO	YES
Section F – Question 3 – Change in Social Activities in Last 90 Days - If you have coded 2 Decline, Distressed, then YES	NO	Lead Category 4	Lead Category 6
Section P – Question 2 – Informal Helper Status - If you have coded any of A,B or C as Yes, then YES	YES	Lead Category 5	Lead Category 7
Check Section N3 - If any single PT/OT/SLT input greater than 60 minutes ***(No Sub Category - Sig Rehabilitation Potential/CREST)***		Lead Category 8	

B. SUB CATEGORY

TO DETERMINE SUBCATEGORY - start at **Dressing Lower Body** and work down flow chart using scores coded on the most recent interRAI Home Care assessment.



Note: To ensure consistency Complex Case Mix should only be determined from coded responses in the interRAI Home Case Assessment.

Appendix 2: Review and Assessment Regime

KEY: HBS=Home Based Support; RHPA=RHP Assessor; RHP=Health Professional; InterRAI-CA= Contact Assessment; InterRAI =HC, Contact, palliative or Other InterRAI Tool

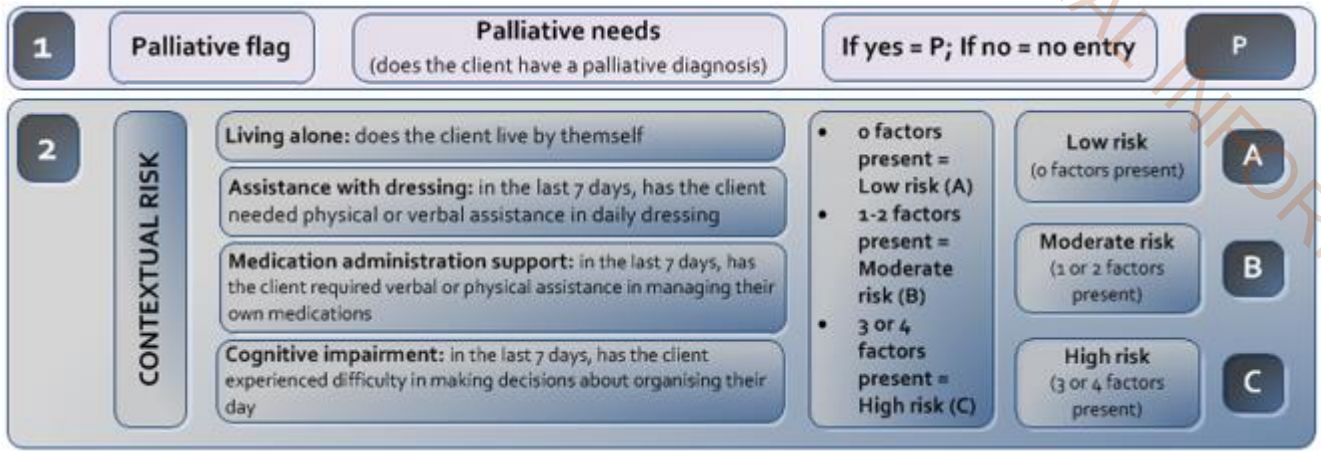
		Non-Complex Clients			Disability only	Brittle Social Support & Disability	Cognitive Impairment & Disability		Brittle Social Support & Cognitive Impairment & Disability	Significant Rehabilitation
		Lead Category 2	Lead Category 3	COMPLEX	Lead Category 4	Lead Category 5	Lead Category 6		Lead Category 7	Category 8
Low disability	A	Review and Re-assess 12/12 by RHP (InterRAI-CA)	Review and Re-assess 12/12 by RHP (InterRAI- CA)	Refer to DHB NASC for an InterRAI HC Assessment	HBS: 12/12 review by RHP; 3yr re-assess by RHPA using interRAI	Review / Re-assessment inputs scheduled as per Lead Category 4. In addition, depending on initial interRAI HC, additional reviews may be organised using RHP and telephone assessments. **Goal ladder to include specific actions relating to carer, as a minimum, reviews against carer stress**	HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	Support workers trained with Dementia module (or equivalent) Nutritional screening undertaken regularly	HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	Early Supported Discharge (ESD) or equivalent response from Specialist Services if ESD not available in geographical location
	B	Review 6/12 by RHP, Re-assess 12/12 by RHP (InterRAI-CA)	Review 6/12 by RHP, Re-assess 12/12 by RHP (InterRAI-CA)		HBS: 12/12 review by RHP; 3yr re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	
Moderate disability	C				HBS: 6/12 review by RHP; 2yr re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	
	D				HBS: 6/12 review by RHP; 2yr re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	
	E				HBS: 6/12 review by RHP; 2yr re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	
High disability	F				HBS: 6/12 review by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	
	G				HBS: 6/12 review by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	
	H				HBS: 6/12 review by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI		HBS: 4/12, 8/12 by RHP; Annual re-assess by RHPA using interRAI	

High Cost Intensive Support packages: clients in any casemix group that require intensive support packages over 21 hours will have an interdisciplinary review arranged by the NASC. Review will occur monthly for unstable and three monthly for stable.

Appendix 3: Service Allocation Tool

Lead Issue	Screening Question
1. Cognitive impairment	Does the client have a cognitive impairment that affects their everyday life through a decreased ability to think, concentrate, remember ideas and make safe decisions?
2. Progressive neurological condition	Does the client have a progressive neurological condition such as Parkinson's Disease, Multiple Sclerosis or Huntington's Disease that requires daily support?
3. Carer stress	Is the client's carer unable to continue caring for the client or feeling overwhelmed or distressed and/or there is abuse and neglect concerns?
4. Dressing	Does the client require ongoing/long-term physical assistance with daily dressing of their lower body? (does not include application or removal of compression hosiery).
5. Medication Management	Does the client require ongoing/long-term verbal or physical assistance in managing their own medications?
6. Mood	Does the client have fluctuating anxiety, low mood, other mental illness or experience chronic pain that significantly impacts on daily living?

Appendix 4: Contextual Risk Rating for Response Time



Appendix 5: Key Terms and Processes

Service Term or Process	Definition or process description
Person	The use of the term "People" or "Person" refers to people living in the community who are referred to the NASC to receive the services described in this specification.
Client	The term client refers to a person who has been screened and is eligible to receive the services described in this specification. i.e. The Service User.
Referral	A formal request to the NASC to determine if a person is eligible for the services described in this specification.
Initial Client Visit	The first face to face visit where assessment / plan of service discussed, and individual support plan agreed
Clinical Assessor	A registered health professional employed by either the Provider or the Needs Assessment Service Co-ordination Service organisation (NASC) that is responsible for completing the interRAI Contact or Homecare or other interRAI assessment.
SMART Goals	An aspiration or target, or objective or future condition that the client wishes to achieve to improve, maintain or prevent decline in functional ability, to improve social connectivity or achieve specific health outcomes (for example confidence in self-management of long-term conditions). Goals should be: **S** – specific, **M** – measurable, **A** – agreed upon, **R** – realistic, **T** – time-based
Service Allocation Tool	Also abbreviated to 'SAT'. It is a screening tool that comprises five questions to determine client complexity and service level access.
Casemix	This is a system that classifies people into groups with similar levels of assessed need and resource utilisation.
Casemix allocation	The process by which clinical assessors determine which case mix group a client belongs to, based on the outcomes of either the Contact or Home Care Assessment.
interRAI Assessment	A comprehensive clinical assessment, which focuses on a person's level of functional ability. It is specifically designed to show the assessor opportunities for improvement and/or any risks to the person's health, which then forms the basis of a care plan. The interRAI assessment tools used within this service are the Contact and Home Care assessments.
Re-assessment	Provider and NASC assessors are required to complete repeat assessments of clients as clinically indicated or as set out in the Review and Reassessment regime (pg. 25)
Care plan	This is the process that responds to the completed assessment findings (such as 'CAPs' 'CHESS' and 'MAPle' 'Outcome Scores') by developing an appropriate plan of care. The Care Plan is generated using the interRAI software at the completion of an InterRAI and the information in the care plan is used by the Provider to develop a service plan.

Service Term or Process	Definition or process description
Service Implementation	The first day that the support service is delivered into the home of a client by a support worker implementing the requirements of the individual support plan.
Natural Supports	the resources inherent in the community, including personal associations and relationships, that enhance the wellbeing and security of clients. Natural supports usually involve family members, friends, neighbours and acquaintances. Some clients have few natural supports and may need support to develop these connections.
Individual Support Plan	The Providers develop client centred goal-based individual support plans in partnership with clients. The purpose of the Individual support plan is to provide clear guidance to support staff about: • activities they need to complete to support clients to achieve set goals • what needs to be escalated to the attention of the RHP • the estimated time it should take for them to complete the activities of the individual support plan and expected time between reviews. • hazards are identified and describe how they are mitigated • the contingency plan in the case of emergencies The support plan is owned by the client, can be made available to be shared with the wider support team.
Household management	The activities required to maintain the living environment as 'safe and sanitary'. This could include but not limited to vacuuming, cleaning of bathroom and kitchen areas, changing of bed linen and support with laundry. This does not include, cleaning of windows, high cleaning, outdoor maintenance, cleaning of any additional rooms, dusting, cleaning of ornaments and additional cleaning considered beyond that required to maintain 'safe and sanitary' living conditions.
Personal Care	Activities of Personal Care include: • support with bathing or showering • support with personal grooming, for example shaving, brushing teeth • support with toilet access and use • support with transfers, in accordance with manual handling guidelines • support with dressing and undressing • support with application of creams and lotions, following guidelines where applicable.
Stop and Watch	An early warning communication tool that support workers and/or whānau can use to alert the service co-ordinator if they notice something different in a resident's daily care routine.

Service Term or Process	Definition or process description
Flexible service delivery	Services are planned in such a way that enables flexible service delivery. Support can be increased if the client is temporarily unwell or reduced if they regain functional ability. A client does not need to be reassessed or have a change in Casemix allocation because of the short-term nature of the flex.
Client service review	Reviews are scheduled when the individual support plan is developed. The purpose of the review is to evaluate and measure client progress against SMART goals, observe if there are any clinical indications for a further assessment or greater Interdisciplinary team input. The outcome of a review may require the individual support plan to be modified or redeveloped. Following a review, the service allocation may: • remain the same with same service allocation • remain the same but with a change to the mix of services • be decreased with a decrease in service time and support activities provided • be increased with an increase in resource allocation • be discontinued with Provider initiating a formal discharge process • be insufficient, indicating there is a need for a re-assessment. The Provider will flex the service as appropriate to ensure the client is safe and supported until the reassessment occurs.
Needs Assessment and Service Co-ordination (DHB NASC)	These organisations are funded by DHBs. Their roles are to determine service eligibility, assess the person's support needs, make service allocations and co-ordinate support services to meet those needs. NASC co-ordinate such services, but do not themselves provide the services. They manage referrals to Providers, other Interdisciplinary team members including primary care.
Case management	Case management is a client and whānau centred collaborative process of assessment, planning, coordination, evaluation and advocacy that sees the client's wider health and social sector team take an integrated approach to service delivery. A designated lead RHP who understands the client's wider health and social needs is nominated by the clients integrated healthcare team and acts as the key point of contact to facilitate the client/whānau to navigate the wider healthcare team. The lead RHP may be, but is not limited to, a Provider RHP, NASC assessor, primary care nurse or dementia navigator.

Service Term or Process	Definition or process description
Service coordination (NASC)	Service coordination is about planning a person's care based on their goals and support needs and sharing information with everyone who helps to care for the person. It is performed collaboratively with a person and their whānau and likely includes all of the following: • educating and supporting the person and their carer • helping the person access community care and support services • talking with health and community care providers • planning what services might be needed in the future
Service co-ordinator (Provider)	Service co-ordination activities carried out by Provider staff including • matching support staff with required competency and level of training to meet the complexity needs of the client; • Acting as a conduit between clients, support staff, registered health professionals and external agencies; • Completing activities of client case management; • Assisting in the recruitment, employment, management and training of support workers, • rostering and scheduling staff; • developing and maintaining relationships with referring agencies, and • monitoring and reviewing the quality of service provision including completion of some client reviews. These activities are incorporated into staff roles so that services can be delivered efficiently to optimise resource utilisation and to ensure enough service flexibility to address regional needs (for example. rurality)
Registered Health Professional	The Health Practitioners Competence Assurance Act 2003 (the Act) provides a framework for the regulation of health practitioners to protect the public where there is a risk of harm from professional practice. Registered health professionals (RHP) may include, physiotherapists, occupational therapists, registered nurses and social workers. In this service the RHP is responsible for delivering services on behalf of a service Provider. This includes the provision of direct care or support services to the client and covers all staff who are employed or contracted. Activities completed by the provider RHP may include: • interRAI assessments, • case management including facilitating an integrated approach to client support from primary and secondary care. • writing and review of support services and individual support plans, • direction, delegation and supervision of non-regulated staff.
Support Worker	Provider staff who help patients at home with tasks such as showering and dressing, housework such as cleaning, ironing, meal preparation and assistance, medication oversight and supporting clients with rehabilitation in areas supporting strength and balance and walking exercises, and attendance at social groups.

Service Term or Process	Definition or process description
Interdisciplinary Team (IDT)	A team of health professionals from different disciplines and work places work together with the client, to undertake assessments, diagnosis, and plan interventions through goal-setting and the creation of an individual support plan. The client and their whānau and carers are involved in discussions as appropriate.
Medication Support	Provider support worker staff assist and/or prompt a client to self-administer medicines as prescribed and as documented in the individual support plan.
Medication Administration	The Provider has determined that the client is unable to safely administer their own medication and does not have reliable whānau support to assist them. The support staff physically assists the client to safely administer medication as per the individual support plan developed by the Registered Nurse[21].
Risk assessment	Process undertake to determine the level of risk associated with support provision. A Risk Assessment Framework supports DHB NASC and contracted Providers with this process. The risk framework can be found in the Tier One Community Health, Transitional and Support Services (DHB funded) service specification.
Integrated Management Framework	HCSS services are required to operate integrated management framework composing of strategic and operational integrated management groups consisting or representatives from contracted providers, allied health, primary health care NASC and DHB HCSS contract managers. More detail is provided in the HCSS Operations Manual.

[21] Draft Medication Guidelines for the HCSS Sector 2017

MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

Appendix 2

National Framework for Home and Community Support Services (HCSS)

Released 2020

Citation: Ministry of Health. 2020. *National Framework for Home and Community Support Services (HCSS)*. Wellington: Ministry of Health.

Published in August 2020 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-98-859793-5 (online)
HP 7403

MINISTRY OF HEALTH
MANATŪ HAUORA

This document is available at health.govt.nz

Contents

Section one: National Framework for Home and Community Support Services

Introduction

The New Zealand Healthy Ageing Strategy (2016)[1] (the Strategy) and the Director-General's Reference Group (DGRG) report on in-between travel[2] (2015) have called for new ways of working in home and community support services (HCSS) to respond to the multiple and growing demands on HCSS. The DGRG report identified the following as key issues facing HCSS in New Zealand:

- increasing demand in terms of both the number of people needing care and the complexity of that care
- inconsistent, fragmented service delivery with no national approach
- a lack of focus on the person at the centre, including funding arrangements that create inefficiencies in the system and negatively impact on the older person
- a lack of regularisation of the HCSS workforce, resulting in high turnover
- increasing skill and competency levels required for support workers, including in relation to health and safety
- inconsistent quality improvement processes
- wide variation in contract agreements and insufficient funding to increase supply to a level that will meet the growing demand.

The Strategy identifies a vision to enable older people to live well, age well and have a respectful end of life in age-friendly communities. This vision will be achieved by ensuring our policies, funding, planning and service delivery:

- prioritise healthy ageing and resilience throughout people's older years
- enable high-quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events

[1] Associate Minister of Health. 2016. *Healthy Ageing Strategy*. Wellington: Ministry of Health.

[2] DGRG. 2015. *Towards Better Home and Community Support Services for all New Zealanders: Advice to the Director-General of Health from the Director-General's Reference Group for In-Between Travel*. Wellington: Director-General's Reference Group for In-Between Travel.

- ensure older people can live well with long-term conditions
- better support older people with high and complex needs
- provide respectful end-of-life care that caters to personal, cultural and spiritual needs.

The Strategy provides the framework to guide development and continued improvement in services and supports for older New Zealanders (see Figure 1). It outlines actions to change the system in ways that will achieve improved and more equitable outcomes for older New Zealanders through greater integration and smarter use of the workforce and technology.

One of the Strategy's identified priority actions is to 'identify and implement models of care that are person-centred, needs-based and equitable, and deliver high-value, high-quality and better outcomes through HCSS across New Zealand'.

Figure 1: Strategic framework for healthy ageing

In New Zealand, over 75,000 older people receive government-funded HCSS provided in their homes. In 2017/18 district health boards (DHBs) funded HCSS at a cost of over $478 million. Typical HCSS include help with personal care and household management as well as clinical coordination and support for older people to remain active and independent. Such services can be a critical way of supporting the continued health and wellbeing of older people, enabling them to stay in their own homes and to be more connected to their community. As the Controller and Auditor-General's report into HCSS for older people notes, 'Assurance about the quality and adequacy of those services is important for the older people receiving them and for those of us who care about people receiving the services'.[3]

Most people aged between 65 and 74 years live at home without any formal assistance. However, the proportion of people needing assistance increases with age. Older people

[3] Controller and Auditor-General. 2011. Home-based Support Services for Older People: Performance audit report. Wellington: Office of the Auditor-General.

receiving HCSS are generally aged over 75 years. Around half the population aged 85 years and over live at home with HCSS, while another 28 percent live in residential care. Other older people have informal support from family, whānau and friends, or pay for support services privately.

Older people, including those with considerable disability, generally prefer to live at home rather than in residential care. By staying at home, an older person can maintain their social networks and continue to be part of their community.

As well as having these social advantages for older people, providing support to people who cannot receive the care they need from their friends, whānau and family has clear financial advantages for the health system. Providing an older person with effective HCSS can delay their admission to aged residential care or avoid it altogether.

As with all health services, HCSS need to be effective and fiscally sustainable over time.

Overview of the National Framework for Home and Community Support Services

While all DHBs commission services and supports to meet local population needs, they vary significantly in what HCSS they fund and how. DHBs and the Ministry of Health (the Ministry) have identified that introducing a National Framework is the means to guide the sector to change in the ways desired and to improve the overall quality of services experienced by older people and their families and whānau. Therefore, the scope of the work was defined as to:

> Develop a national framework for sustainable future models of care for publicly funded home and community support services (HCSS) that support older people to live well, get well, and stay well closer to home.

This National Framework for Home and Community Support Services (National Framework) will guide DHBs for future commissioning, developing, delivering and evaluating home and community support services to improve national consistency. It includes:

- a vision and principles to guide service design
- core (essential) components of services that could be expected anywhere in the country
- an outcomes framework describing the outcomes sought from HCSS at individual, population and system levels.

The National Framework covers DHB-funded services for:

- people aged 65 years and over who have an assessed need in response to an interRAI assessment and meet criteria for funding

- people considered to be alike in age and interest – for example, Pacific peoples and Māori aged over 55 years, and others aged over 60 years, with age-related disabilities
- older people receiving HCSS who require increased support following an acute health episode who have required hospitalisation
- HCSS that may continue concurrently with short-term Accident Compensation Corporation (ACC) services.

Two other initiatives are linked with developing the National Framework, which will help to achieve consistent service commissioning and delivery and consistent resource allocation.

First, a National Service Specification for HCSS. This service specification will become the nationally mandated specification describing in detail the services and service approaches required of DHBs and providers. This National Service Specification will be implemented by July 2022, in line with DHB service commissioning timetables. This approach aims to achieve the best balance between national consistency and flexibility for DHBs in meeting the needs of their populations.

Second, a nationally consistent case-mix methodology will be developed for all DHBs to use as a way of improving targeting resources according to need. Some DHBs are already applying case-mix methods to resource allocation or use. However, they are using different versions of the methodology, resulting in some inconsistency in resource allocation and lack of transparency across DHBs. This indicates the need for a single, nationally consistent case-mix method that will also be implemented across all DHBs by July 2022.

Why we need a National Framework

National and international developments in HCSS models focus on:

- improving national consistency by better integrating services
- improving the capability of the workforce to support more complex needs as the population ages and becomes more ethnically diverse
- using new models of care – especially integrated and restorative approaches – to increase participation and self-determination of older people and their whānau, families and carers
- supporting older people to self-manage in their own homes
- using new and emerging technologies to improve efficiencies in coordination of care, monitoring and communications
- responding to new opportunities and new demands facing the HCSS workforce and providers
- making transformational change to ensure a robust future market for HCSS providers.

Below we look at each of these developments in more detail.

Addressing inconsistency of services across the country

Over the last 10 years, DHBs have been changing the way they provide HCSS to give a greater emphasis on flexibility and integration. Many DHBs are now using a case-mix model, with strong restorative or enabling models of care. Innovative models and frameworks such as the Calderdale Framework have also begun to influence models of HCSS in New Zealand. However, these innovations are not consistent nationally, as DHBs differ in their case-mix approaches, restorative approaches and requirements of HCSS providers. They also do not follow a nationally consistent approach in assessing the:

- quality of the services
- impact of those services on the outcomes of older people
- satisfaction of older people and their families and whānau with those services.

Responding to the more complex needs of an ageing and more diverse population

New Zealand's population is ageing: the number of older people will increase substantially over the next decade. This older population, and our communities, will also become more ethnically diverse. The Māori population aged 65 years and older is projected to increase by 79 percent from 2016 to 2026. The older Pacific population is expected to increase by 63 percent and the older Asian population by 125 percent in this same period.

As the older population grows, particularly among Māori, the need for care will increase substantially. The New Zealand cohort Life and Living in Advanced Age Study (LiLACS) estimates that the number of people needing care more than once a day may increase by more than 200 percent for Māori and by approximately 75 percent for non-Māori from 2016 to 2026.

Because people are also living longer, more people have care and support needs arising from a mix of physical and mental health conditions, including frailty and dementia in old age. Enhancing the ability of older people to age well and supporting them to live well with long-term conditions – no matter how complex those conditions are – is critical to enabling older people to continue to participate socially and feel valued.

Changing models of care

The health system has adapted over the last 10 years in significant ways. With changing models of care, services have:

- delivered more care in the community, with stronger relationships across services
- developed real or virtual interdisciplinary teams working together around the care of patients
- involved people in taking a more active role in assessment and care planning.

In recent years, the New Zealand health system has focused strongly on ensuring that people can remain independent for as long as possible, living within their own communities. Measures to achieve this outcome include increasing use of re-ablement models (supporting people to regain their independence after illness or injury), early supported discharge, hospital avoidance, integration and shifting care closer to home.

HCSS also have a key role to play in greater integration with primary and community teams to support older people, particularly people with complex health and wellbeing needs.

This new approach requires responsive, agile and collaborative services delivered by a well-trained and stable workforce to meet the changing and growing needs of older people. HCSS need to be flexible, responsive and of high quality to support these changing models of care.

Self-management

A sustainable health system needs to:

- support people to take a lead in managing their own health
- enable more integrated care for people who have complex needs
- expand the range of care provided in communities.

HCSS, alongside many other providers of health services, have an important role in supporting this move to greater self-management.

Technology

Digital technology has created the platform to support these changes. It has the capacity to place people, their families and whānau at the centre of the care by:

- supporting people to manage more of their health needs at home through self-monitoring and access to professional advice using remote diagnostics
- undertaking shared care planning that also supports the ability of older people, health care professionals, support workers and social service providers to share accurate and reliable information with each other.

Technology developments in the broader health system will influence the speed at which the HCSS sector can take up supporting technology. Where technology is available to help older people, then the sector should take advantage of these opportunities.

A changing workforce

The health system cannot implement system change, nor operate effectively, without a responsive and well-trained health workforce. The in-between travel and pay equity settlements support opportunities for new models of care. The improvements in carer conditions are expected to reduce staff turnover and increase skills in the care and support workforce.

Improving models of care will create new opportunities for, as well as new demands on, the HCSS workforce and providers. Examples are the opportunities and demands to:

- invest in and use technology to work more productively and engage more proactively with older people, so that the right thing to do is the easiest thing to do. Technology, along with good support to use it, can rapidly change workforce behaviour, including by encouraging staff to participate in interdisciplinary teams, share information and use the technological tools consistently
- create interdisciplinary team models that foster new ways of working and enable the workforce to adapt and take innovative approaches to services within communities
- support the workforce to achieve a work–life balance so that they can stay healthy, and invest in the education and training they will need to work differently
- ensure the workforce reflects the population it is serving and increasingly focus on the strategies already in place to attract more Māori and Pacific peoples to health roles
- enable health professionals and kaiāwhina to work to the full extent of their scope, including by expanding opportunities for care and support workers to contribute more to care planning and monitoring.

The HCSS market

Nationally, approximately 75 providers of HCSS are contracting to DHBs, ACC and disability support services. The variety of providers includes large, medium-sized and small private providers, iwi-based providers and charitable providers; some of these providers have contracts with several DHBs.

The provider market has consolidated in recent years and continues to do so in order to remain viable as the health and disability system has sought better-value services that are more responsive to the more complex needs of the older population. Some DHBs have also implemented re-ablement models, supporting more flexibility in how services are provided to better respond to changing needs.

Pay equity, guaranteed hours and in-between travel settlements have had impacts on providers. One result has been to further consolidate the market, as HCSS providers seek to strengthen the core business systems required to implement these requirements.

In some cases, the in-between travel and pay equity settlements have made the provision of HCSS more complex. This National Framework for future development of HCSS provides guidance on some of the changes needed to realise the benefits of the settlements, such as increased investment in the workforce.

As noted in the DGRG's report, a 'burning platform for change' supports models of care and growing demand:

> there is a view that the HCSS sector is at risk of becoming unsustainable within the next decade (Deloitte 2015), and there is a lack of confidence that HCSS are effective,

efficient or capable of meeting the expected future increase in demand (Office of the Auditor-General 2014).[4]

From our engagement across the sector, we identified the following factors as central to delivering high-quality HCSS and underpinning a robust future market for HCSS:

- being financially sustainable
- being innovative and flexible
- meeting the needs of individuals and populations in the ways they want
- recognising and providing for different levels of complexity and acuity
- measuring effectiveness
- showing evidence of continuous improvement strategies
- giving providers as much funding certainty as possible
- having the mechanisms to integrate with other services
- supporting workforce stability and sustainability.

The National Framework aims to bring these areas for improvement into the national context and provide further guidance on how to undertake more transformative changes.

How we developed the National Framework

In developing this National Framework, we drew on information from the latest literature, and recent local and international experiences of changes in these services. We also engaged with key stakeholders in the HCSS sector, which included engaging with older people and their families and whānau.

In June 2017, clinicians, providers, unions, funders and other stakeholders took part in a national workshop. This workshop helped to build relationships across the sector, build a common understanding of the concerns in the sector and shape the future direction of HCSS work.

Regional workshops were held in early to mid-2018, along with two further workshops to ensure that Māori and Pacific voices were heard. Contributions to this National Framework also came from discussions with clinical and community representative bodies. We tested the vision and principles of a proposed national framework and asked for stakeholders' thoughts about core components of good HCSS. Input from the workshops was rich and varied.

Section four summarises the key themes from the consultation.

[4] DGRG. 2015. *Towards Better Home and Community Support Services for all New Zealanders: Advice to the Director-General of Health from the Director-General's Reference Group for In-Between Travel*. Wellington: Director-General's Reference Group for In-Between Travel, p 8.

How we will implement the National Framework

Supporting the National Framework, a National Service Specification sets out the strategic direction and objectives, along with the care, quality and monitoring requirements that all DHBs are expected to meet by 2022 (see Table 1). The National Framework will be embedded into DHBs' Nationwide Service Framework, specifically the Operating Policy Framework and Service Coverage Schedule.

Table 1: Systems to implement the national framework

System	Detail
National requirements	Outlined in Service Coverage Schedule.
Contractual	Each DHB develops own contract/s.
Service specifications	National Services Framework Library holds the Tier One Community Health, Transitional and Support Services service specification and the Tier Two National Service Specification for Home and Community Support Services.
Regulatory	No legislative regulatory framework or requirements.
Standards	Home and Community Support Sector Standard NZS8158:2012. DHBs have agreed to include a requirement for audit against these in HCSS contracts. Audit reports are available to funders through HealthCERT.
Access to services	A needs assessment using an interRAI assessment.
Eligibility	Must have needs for HCSS identified through an interRAI needs assessment: • Personal care – services have no charge to the client. • Household management – services that have no charge to Community Services Card (CSC) holders. People who do not have a CSC may be required to contribute. May include support, clinical and coordination services on a DHB-by-DHB basis.

When we will implement the National Framework

When we introduce the National Framework will depend on when DHBs' and providers' contracts come up for renewal. Some districts will be able to begin implementing changes more quickly as contracts with their HCSS providers come up for renewal; others will have to wait longer for contracting rounds to come up.

For DHBs that are already delivering the core components, shifting to this framework will be relatively easy. For others, moving from a fee-for-service model to a case-mix model may be more costly and will require slower implementation. The National Framework sets the direction, but how it is implemented will be up to DHBs, as guided through the

National Service Specification. The pace of implementation will vary depending on what DHBs need to address locally and what needs and supports the wider system addresses. Other components of this framework rely on broader needs to be addressed across DHBs, such as the need to establish shared care platforms across the country.

Section two: Vision and key principles of the National Framework

Vision for home and community support services

High-quality services that flexibly meet the needs of individuals, are person-, family- and whānau-focused and culturally appropriate, are sustainable over time, and are delivered by a competent, skilled, well-trained workforce.

HCSS should focus on understanding the individual needs of each older person and their family and whānau, and on goals centred on the person, with the aim of maximising and maintaining the older person's independence for as long as possible. The older person must be an active participant in planning their care, setting their own goals and identifying a range of possible services that could support them. HCSS must be flexible, allowing the support worker to respond to the client's individual needs as these needs change.

The enabling approach underlying the National Framework aims to ensure that a comprehensive and flexible range of services is available for older people. Appropriately skilled organisations and support workers will support and deliver those services. The future approach to HCSS is expected to be proactive to focus on regaining or maintaining function, preventing or slowing down a decline in mental and physical function in older people and supporting their family, whānau and caregivers. If an older person enters a life stage where palliative care is necessary, the service delivery will adjust to meet palliative support needs.

Integrated HCSS are core to improving outcomes for older people. HCSS should be part of the wider primary and community care team, participating in interdisciplinary teams, particularly where older people have complex health and social needs, and involving their families and whānau. HCSS will ideally inform care plans for the older person through shared care platforms.

HCSS sit in complex environments and it is important that HCSS are well linked to the communities they work in. DHBs are increasingly arranging their services with a greater focus on integrating service with the broader community.

Key principles of the National Framework

1. Person-directed

The older person is actively involved in assessment and care planning to identify their strengths, values and life goals, and the support needed to overcome any barriers to achieving those goals. This will be achieved through consistent, comprehensive and timely assessment and individualised care planning.

2. Connected

The older person and their family and whānau have a seamless pathway through connected services, with HCSS working as part of a multidisciplinary team involving primary and community support. Care plans, where possible, are available on shared care platforms, and older people can see and engage with their own health information.

3. High quality and safe

The older person and their family and whānau have confidence in the services they receive, are guided through their care plans, and experience few cancellations and disruptions to their schedule. Services maintain continuous quality improvement and assurance. A well-trained, culturally competent workforce delivers the services, with the workforce skill mix matched to the complexity of the older person's assessed needs.

4. Flexible

HCSS respond to the changing needs of the older person and their family and whānau in a timely way. They put additional supports in place promptly to support the older person to avoid the need to go to hospital and allow for early supported discharge of people receiving HCSS.

5. Equitable

Older people and their families and whānau have equity of access to services. Services and supports are accessible, culturally appropriate, flexible, integrated and family-centred. They are responsive to diverse needs such as those of the lesbian, gay, transsexual, queer and intersex (LGBTQI) community.

6. Responsive to Māori

Māori health aspirations are understood and realised, and services explicitly act to improve Māori health outcomes and address inequities. Older Māori and their whānau, hapū and iwi are supported to improve their own health and wellbeing.

7. Cost effective and sustainable

Services are financially sustainable. Resources, including the workforce, are used in the most cost-effective way within the parameters of the other principles.

The vision and key principles outlined above are built on the foundation of He Korowai Oranga – the Māori Health Strategy.

He Korowai Oranga has an overall aim for Pae Ora to achieve wellbeing. Pae Ora includes three interconnected elements: Whānau Ora (healthy families), Mauri Ora (healthy individuals) and Wai Ora (healthy environments).

He Korowai Oranga recognises the special relationship between the Crown and Māori through the Treaty of Waitangi – te Tiriti o Waitangi. In particular, it recognises that services and supports are aligned with te Tiriti o Waitangi to enable participation at all levels; partnership in delivering support; and protection and improvement of Māori wellbeing. These outcomes can be achieved through understanding each other's aspirations and:

- recognising the health needs and aspirations of Māori, as individuals and as part of a whānau, hapū or iwi, to improve Māori health outcomes
- enabling whānau, hapū, iwi and Māori to exercise control over their own health and wellbeing (rangatiratanga and mana motuhake).

These key elements were developed following feedback and workshops with stakeholders from across the older people sector. We will seek to measure each of these elements.

Section three: Core components of national Home and Community Support Services

This section outlines the core components of what older people and their families and whānau can expect from HCSS nationally.

The core components of HCSS will incorporate an enabling model of care in which older people are supported to maintain independence, to care for themselves, to be connected with family and whānau and to participate in their communities for as long as possible. The enabling approach requires registered health professionals – including nursing, allied health and social workers – to coordinate HCSS in consultation with the older person.

HCSS focus on understanding the individual needs of older people, within the context of their family and whānau, and setting goals that are aimed at maximising and maintaining their independence for as long as possible. The older person is an active participant in planning their care, setting their own goals and identifying a range of possible services that could support them. Services are flexible, within the scope of support packages, allowing the support worker and carers to respond to the person's individual needs and to review them as needs change.

HCSS are not intended to replace natural support systems. There is an expectation that support is planned and provided within the context of natural supports, including family and whānau and other available community supports, such as volunteer services, and that these are integrated in a flexible and responsive way.

Part of ensuring that a range of responsive services is available for older people involves using an enabling HCSS model. The service approach is expected to be proactive in order to maintain function and, where possible, prevent a decline in function and coping mechanisms in both older people and their family, whānau and caregivers. If older people enter a life stage where palliative care is necessary, the service delivery will adjust to reflect the palliative support needs of the individual. The intent of this model is to ensure the service provided is delivered by appropriately skilled organisations and support workers.

HCSS may include:

- non-complex assessment and reassessment
- service (support) planning
- coordination of support workers to deliver the support plan.

The core components of how HCSS should be provided will be nationally monitored so that we can consistently measure our progress towards realising these. As discussed in Section one, a National Service Specification for HCSS will set out details of services to be commissioned from HCSS providers and will be implemented by July 2022 as DHBs enter new contracting rounds.

Nine core components

1. Nationally consistent assessments

The interRAI suite of tools provide comprehensive and consistent assessment of older people receiving support in the community. Older people are assessed by trained health professionals using the appropriate assessment tool.

Assessment involves stratification to work out a person's level of acuity and allocate appropriate resources, using tools such as case-mix methods and interRAI data. HCSS clients' acuity is matched to the ability and capability of the case worker. The health professionals use a nationally consistent case-mix method to allocate resources according to client need.

2. Support planning

Support plans are developed considering the goals and aspirations of the older person. Goals focus on achieving maximum independence and normalised socialisation. Support plans document how to reach goals and how to measure their achievement. Equipment is supplied in a timely manner.

3. Enabling focus

Support plans will focus on enabling the older person, aiming to enhance their functionality wherever possible. Older people are encouraged to participate in Functional Activities of Daily Living (ADL) and exercise through everyday activities. This outcome is achieved by giving support workers the training and supervision they need to encourage the older person to participate in household activities and exercise programmes.

4. Integrated

Care is delivered in a coordinated and connected way with a team-based approach. Teams include the person, family and whānau, informal networks, home and community support teams, primary health care, allied health, district nursing, non-governmental organisations, the wider health interdisciplinary team and the broader intersectoral team (such as Work and Income, and housing).

5. Competent and supported workforce

Support workers receive Career Force Level 2 training as a minimum. The workforce is further trained for the capability required to provide services that consistently meet the needs and mix of people receiving HCSS. This training will enable the support worker to identify an older person's functional decline if and when it happens and communicate this to relevant health professionals.

Employers support training opportunities for their workforce, to ensure the HCSS team has competent, qualified clinical staff enabled to work to the full extent of their scope. They will support robust care planning, provide clinical oversight and optimise the functional ability of the older person. The workforce is responsive to the needs of Māori, Pacific peoples and minority groups, including LGBTQI.

Employers meet all employment and training commitments to care and support workers established by the in-between travel and pay equity settlement agreements.

6. Clinical oversight

Registered health professionals are part of the team and are able to provide assessments and oversight to the HCSS team. Roles and duties may include: delegating and supervising non-regulated staff; conducting comprehensive assessments, writing and reviewing support plans, and managing care support; analysing goal activity; and helping to integrate services across primary, secondary and community care.

7. Optimum use of natural supports

HCSS provide one component of support, alongside a range of natural supports for an older person and their family and whānau. The public health system works within a capped envelope, and HCSS make one contribution to a package of care for an older person. Family, whānau, friends and communities, where possible, are a part of the care plan, alongside HCSS. Optimising the role of natural supports may also involve training and supporting family and whānau to fulfil this role.

8. Culturally competent

Staff with training in cultural competence provide support. Support is respectful and enhances dignity and mana. Programmes are targeted to particular groups, such as Māori, Pacific peoples and migrants. Family and whānau are trained to provide care where needed and appropriate. Where an older person would prefer carers from their own cultural background, this will be supported as much as possible.

9. Performance focused

HCSS collect data in a comprehensive and consistent way and use it to measure and improve services. Access to national shared data is available, where possible, to inform quality improvements and benchmarking – for example, through shared access to interRAI records. Ethnicity data is collected where possible and used to improve outcomes for Māori, Pacific and Asian populations.

Section four: Consultation with older people and the home and community support sector

In developing this National Framework, we undertook consultation with the aim of gaining the views and input of older people, their families and whānau and the wider HCSS sector on the future provision of HCSS.

In June 2017, PricewaterhouseCoopers (PwC), on behalf of the Ministry, held a workshop for clinicians, providers, unions, funders and other stakeholders. The workshop helped to build relationships across the sector, build a common understanding of the concerns in the sector and shape the work of future HCSS.

As part of a 'ground up' approach in March and April 2018, the Ministry and DHBs held a series of workshops around the country in five different locations (Auckland, Hamilton, Wellington, Christchurch and Palmerston North).

Two further workshops were held in May 2018 to ensure that Māori and Pacific voices were adequately heard. First, a hui in Hamilton at the Rauawaawa Kaumātua Charitable Trust had more than 20 participants, including representatives of several local iwi, kaumātua, DHB representatives and providers. Second, a Pacific fono at Counties Manukau DHB drew approximately 30 representatives from local Pacific providers, older people, practice nurses and DHB representatives who work with Pacific peoples.

The development of the National Framework also drew on feedback and information gathered from extensive consultation around the country for the Healthy Ageing Strategy.

Format of the 2018 workshops

The workshops outlined the background and approach to the work on future HCSS and provided a set of draft principles for discussion. The aim was to test whether the principles were what the participants wanted future HCSS to follow, as well as to establish what they thought were core components of HCSS.

To this end, the workshop asked participants four key questions.

1. How do I get into the system? (identification and referral)
2. How do my needs get assessed and plans made? (stratification, assessment and planning)
3. What are my options for getting support? (service delivery)
4. What if my needs change? (review, exit and changing levels of need)

To answer these questions and to encourage discussion, each workshop prompted participants to identify:

- core components of future, high-quality HCSS and how these link to the principles
- the systems and processes that need to change to achieve high-quality HCSS
- their priorities for change
- what innovation is needed
- their most radical ideas for change in the sector.

Input from the workshops was rich and varied. The many ideas from these were recorded, summarised and sent back to participants.

Results of consultation

During the development of the Healthy Ageing Strategy, older people identified opportunities to improve home support. These included the opportunity to:

- increase choice and control for older people (eg, around choice of carers)
- include family and whānau in assessment, planning and delivery
- expand the range of supports offered and improve flexibility around changing needs
- improve coordination or integration of services (eg, to reduce the number of assessments needed)
- simplify the process of raising concerns or complaints about care.

Sector representatives (including providers, non-governmental organisations, and iwi and fono providers) identified the above issues in the workshops as well. They also gave feedback about the need for older people and their families and whānau to:

- have their support needs identified in a timely and flexible way
- have support within, and connect to, their communities
- access a range of appropriate resources and information so they can make informed choices
- be supported and empowered to manage their own health care (self-management)
- participate in assessment and planning processes and settings that are culturally appropriate
- have plans that are developed flexibly and that provide choice and control

- have support from integrated services that have strong alliances across different sectors
- know who to speak to if their needs change, know how to speak to them, and feel supported to give feedback about how to improve their care
- have smooth processes for temporarily or permanently leaving services.

DHBs see that future improvements to HCSS should be financially and clinically sustainable in a system that is integrated (horizontally and vertically), with the aim of improving efficiency and ultimately achieving better outcomes for older people. DHBs also gave examples of what they have already achieved through existing models, service changes and improvements in HCSS. They expect providers to embrace new ways of working and take up new technologies.

DHBs recognised that growing numbers of older people have more complex needs and higher acuity. They also asked for:

- health services accessed by older people to be more integrated, such as between hospital, pharmacy and primary care services
- updated service delivery approaches
- clear communication to older people about support available – including time limits on that support as appropriate
- consistency in the number and frequency of assessments and reassessments, along with consistency in the eligibility for, allocation of, and type of services available across DHBs
- flexibility and a restorative approach (where appropriate)
- working across funding streams within DHBs, for example, between short-term and long-term HCSS, and between funders, ACC and disability support services).

HCSS providers would like to see consistency in contracting and pricing approaches, continuity of contractual arrangements and commercial relationships to give greater business sustainability.

Providers would also like future approaches to HCSS to balance older people's desire for flexibility with providers' obligations in terms of guaranteed hours and sufficient funding to invest in staff and service development.

Care workers and unions want to be a valued part of the health care support team. They would like to have access to appropriate training and skills development, a clear career path, appropriate and supportive supervision and safe rosters.

Hearing Māori and Pacific voices through targeted workshops

Some key points Māori participants raised were the need to:

- acknowledge the unique relationship that Māori have with the Crown through the Treaty of Waitangi
- link HCSS with Whānau Ora and the wider community
- increase support for whānau to care for their own
- use navigators to support people to access available services.

Some of the key points Pacific participants raised were the need to:

- support families adequately in a family-centred way
- use a variety of communication methods to inform older Pacific peoples about what services are available
- assess the needs of older Pacific peoples in flexible ways, including through self-assessments and by training other health professionals (eg, fono nurses and practice nurses) to carry out interRAI assessments
- provide timely assessments so older Pacific peoples are not waiting weeks for an assessment
- make translators available and use them when needed.

Appendix A: Continuous improvement – outcome measures and accountability

Note: These outcome measures and indicators are operative drafts to be refined and tested through the 2019/20 financial year. We include them here to demonstrate their current status and broad direction.

At a high level, HCSS aim to improve the quality of life, for all categories of people (equity aim) using resources in a manner that is value for money – that is, to achieve the 'triple aims'. Figure 2 sets out the way the Health Quality & Safety Commission (2011) describes the triple aims.

Figure 2: The triple aims

To improve quality of life for older people needing help at home, services:

- restore and maintain function
- support activities of daily living
- meet the needs and preferences of the older person in a timely way
- maintain independence and respect

- provide safety – that is, avoid injury to the older person, their caregiver and staff
- coordinate with other services
- continue to involve older people's families and whānau.

Measuring how well services meet these high-level outcomes is challenging, particularly because the cost involved could otherwise go to those services. DHBs can use measures to indicate the progress of the health of their older population compared with previous periods and also to monitor the quality of services funded via HCSS.

The following are key measures that a national standards framework should include. Appendix B sets out more specific measures.

Home support

interRAI prevalence indicators

To measure specific outcomes for HCSS, interRAI assessments are an excellent source of data. At present, DHBs differ widely in their proportion of older people receiving HCSS with interRAI *home care* or *contact* assessments and the frequency of their reassessments. For this reason, these indicators are useful for measuring trends over time within a DHB, but comparisons between DHBs should only be used with considerable caution.

Timeliness

Timeliness of assessments and service is an important aspect of meeting an older person's need and is easy to measure. Time between referral and assessment, and between assessment and a person receiving the first HCSS, is critical, as is understanding the level of missed and late carers.

Other factors

A number of measures are not indicators of outcomes but provide helpful information to interpret outcome indicators over time or between DHBs. Important measures in this area are the frequency of reassessments, percentage of contact assessments compared with home care assessments and the percentage of hospital assessments. Complaints received, number of emergency department visits, qualification levels of workers, and missed visits may also give some indication of outcomes.

Appendix B: List of outcome measures and indicators to monitor HCSS

Note: These outcome measures and indicators not confirmed are to be developed and refined throughout the 2020/21 financial year.

Indicator	Outcome indicator specification	By	Source
Aged residential care (ARC) bed days	ARC bed days per population by DHB of domicile with estimated maximum contribution of older people in rest home category added, age standardised	DHB	CCPS
Weight loss	Older people with unintended weight loss	DHB, ethnicity	interRAI
Falls	Number of older people who record a fall on follow-up assessment	DHB, ethnicity	interRAI
Social isolation with distress	Older people who are alone for long periods or always and also report feeling lonely, or older people who are distressed by declining social activity	DHB, ethnicity	interRAI
Disruptive/intense daily pain	Older people having daily pain and intense pain, or pain disrupts activities	DHB, ethnicity	interRAI
Inadequate pain control	Older people who have pain and are receiving inadequate pain control	DHB, ethnicity	interRAI
Any injuries	Older people with fractures or unexplained injuries	DHB, ethnicity	interRAI
No flu vaccination	Older people who have not received influenza vaccination within the last two years	DHB, ethnicity	interRAI
Hospitalisation	Older people who have been hospitalised, have visited a hospital emergency department, or have received emergent care since last assessment	DHB, ethnicity	interRAI
Caregiver distress	To be confirmed	DHB, ethnicity	interRAI

Indicator	Outcome indicator specification	By	Source
Timeliness	Percentage of notifications that do not have an interRAI assessment by the date indicated by its urgency	DHB	interRAI
Entry to residential care	Percentage of new entrants into ARC at each MAPLe and CHESS score from last home care assessment before entering ARC		interRAI
Frequency of reassessments	Average days between assessments of all home care assessments where the older person has had a previous home care or contact assessment	DHB	interRAI
Percentage of contact assessments	The percentage of assessments for people living at home that were contact assessments	DHB	interRAI
Assessments undertaken in hospital	The percentage of home care assessments undertaken in hospital	DHB	interRAI
Complaints received	Number of complaints about home support services received by providers or DHB as a percentage of home support older people	DHB	DHB data
Emergency department visits	Emergency department visits as a percentage of the number of older people receiving home support	DHB	DHB
Qualifications of workers	To be confirmed	DHB	Provider
Missed or late visits	To be confirmed	DHB	Provider
High-cost home support	The percentage of long-term home support for older people that costs the DHB more than the average DHB cost of the relevant aged residential care category	DHB	Provider
Complaint management	Proactive management of complaints, including providing an update to those involved in making the complaint on its resolution Trends in adverse/sentinel events monitored and remedial improvement actions undertaken	DHB	Provider
Assessment	Total registered nurse contact assessments Total assessments due Percentage completed of those due Average wait time by risk level Target: Low: 5 week days Med: 2 week days High: 1 day (Monday to Friday)	DHB	Provider

Indicator	Outcome indicator specification	By	Source
Review	Total reviews complete Total reviews due Percentage completed of those due	DHB	Provider
Support service commencement, service responsiveness	Number of new supports started Date of referral Date of first contact Date of service start Average wait time from referral to start by risk level Target: Low: 10 week days Med: 7 week days High: 1 day (Monday to Friday)	DHB	Provider

Note: CCPS = Clients Claims Processing System; SLM = System Level Measures