

SUPPORTED LIVING SERVICES SERVICE SPECIFICATION

PURCHASE UNIT CODE: DSSL2620

PURCHASE UNIT NAME: SUPPORTED LIVING

1. Introduction

New Zealand is a signatory to the United Nations Convention on the Rights of Persons with Disabilities. The Ministry of Health (“the Ministry”) supports the objectives of the Convention.

Disability Support Services (“DSS”) is a group within the National Services Purchasing Unit, National Health Board of the Ministry. Its aim is to build on the vision contained in the New Zealand Disability Strategy of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in. ‘A society that highly values our lives and continually enhances our full participation.’

With this vision in mind, DSS aims to enhance disabled people’s quality of life and enable their community participation and maximum independence. This is achieved by creating linkages that allow disabled people’s needs to be addressed holistically, in an environment most appropriate to them.

DSS seeks to ensure that people with impairments experience autonomy on an equal basis to others. Support options are required to be flexible, responsive and needs based. They must focus on the person and, where relevant, their family and whanau, and enable people to make informed decisions about their own lives.

(NOTE: Subsequent references in this document to “the Person” or “people” should be understood as referring to a person/people with impairment(s). There are circumstances where this may include chosen significant others, but for clarity if there is any dispute between the person with an impairment and his/her significant other(s), the person’s views take precedent unless the person is shown to have diminished responsibility.)

2. THE SERVICES

2.1 Why the service is purchased

The Ministry purchases Supported Living Services for people who are eligible for Ministry-funded Disability Support Services and have been referred by a contracted Needs Assessment Service Coordination (NASC) organisation. The Service supports achievement of individual goals that are consistent with the long term life aspirations of eligible people. The overarching intent is that the person is at all times central to the development and control of all aspects of assessment and service delivery. It is expected that the Service will lead to people making greater use of natural supports, thus reducing the need for Government funded support as people are more engaged with their community.

2.2 Definition¹

Supported Living Services:

- are a range of flexible and individually responsive service approaches for eligible people that are based on an individual support plan;
- encourage and support people to think about how they might want to live and how self defined supports can be provided to foster opportunities for people to access their choices;
- are based on a collaborative approach and are contingent on the development of strong partnering between disabled people, families and/or whanau, service providers, generic community support and wider communities;
- provided under this Specification may be additional to other funded services provided for the person as part of a wider support package. (see 7 - Exclusions);
- are provided to people living in their own home, except when supporting a person to move from their current living arrangement (which may be the family home or a residential service) to a more independent living situation - such transitions are expected to be supported for no longer than 3 months, other than exceptional circumstances as agreed with the NASC organisation;
- are not provided in living arrangements where the Person leases the house from the Provider.

2.3 Principles of Supported Living

- (a) Inclusiveness¹: Barriers to inclusion should be minimised, supporting disabled people to make informed choices and decisions. Supported Living builds links and opportunities which may increase levels of inclusiveness of disabled people in the community.
- (b) Individualised and flexible support¹: Supports must focus exclusively on the individual within and across any chosen community environment. The services/supports that a person receives should reflect changing needs.
- (c) Relationships¹: A commitment to building community and meaningful networks. People's family and/or whanau, friends, other important people in their lives and their community are central to the person. An emphasis should be placed on identifying, developing and supporting these natural supports.
- (d) Choice and control¹: Individuals should be able to exercise choice over where and with whom they live, take a central role in deciding what they do, and the types of services, supports and activities they participate in.
- (e) Life building¹: the focus of support is long term and services need to be committed to the ongoing pursuit of autonomy and life long personal fulfilment for the person.

¹ Adapted from the Constitution of Supported Living New Zealand

- (f) Eligibility: Supported Living is an option for all people who meet the eligibility criteria for Ministry of Health disability services, if this is their preferred support arrangement and support can be provided within available resources. However, for the purpose of this Agreement, the Ministry's funding is available only in respect of a NASC organisation referral to the Ministry-funded Supported Living Provider.
- (g) Separation of accommodation and support: there must be separation between the ownership of the place where the person lives and the provider delivering Supported Living to ensure the person can have security of tenure if they choose to change Provider.
- (h) Cost: Supported Living funding should not be used to pay for services which should be funded by other agencies or the service user. The service user should not be required to pay, in part or full, for any Supported Living supports allocated by the NASC organisation.

2.4 Supported Living Operational Guide

In carrying out responsibilities under this service specification, the provider shall have regard to the Supported Living Operational Guide ("the Guide") issued by the Ministry of Health, as updated from time to time. The Guide sets out the Ministry's advice and further guidance about how providers and NASC's should carry out their responsibilities under this specification.

3. SERVICE OUTCOMES

3.1 Outcomes

The primary outcome for a Supported Living Service is the support for an individual to have a greater opportunity for an ordinary life.

Service outcomes include but are not limited to:

- A person has increased personal knowledge and self determination;
- A person holds the central role in all planning and decisions about their life;
- A person is satisfied with the service;
- Sustainable natural supports, relationships and networks are fostered and sustained over time so that people can be part of their community;
- A person expresses satisfaction with their quality of life;
- Meaningful connections with local iwi and hapu, as desired, are fostered and developed;
- Formal supports respond to varying levels of need which may reduce over time;
- There is enough and the right information so the person can make informed choices and decisions (self determination);
- The person's sense of being respected and valued is enhanced;
- The home environment is safe and meets the person's preferences;
- There is a collaborative and equal relationship between the three parties (the person, the NASC organisation and the service provider);

- Supports are provided in a timely manner to meet the person's needs, and may be at any time during a 24 hour period.

3.2 Māori

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service

4. WHO THE SERVICES ARE FOR

DSS funded Supported Living Services are for those people who are 17 years of age or older with a disability who meet eligibility criteria and have been referred to the Provider by a Ministry-contracted NASC organisation.

NASC organisations will apply DSS eligibility criteria. There may be circumstances where it is appropriate that DSS is not the only funder of supports received by the person.

5. HOW A PERSON GETS SUPPORT

5.1 Entry

The process for entry to Supported Living services is:

- A person will be referred to the relevant NASC organisation - this can be through self-referral or other means
- The NASC organisation will complete a Needs Assessment
- The NASC organisation will confirm that the Person is eligible for services funded via DSS
- Following the Needs Assessment, the NASC organisation will work with the Person to determine the best way to meet the identified needs
- When Supported Living is the identified service to be provided, the NASC organisation will provide the Person with information about Supported Living providers in their locality
- The Person may meet with a number of Supported Living providers before deciding which Provider they wish to be referred to
- Once the Person has chosen a Provider, the NASC organisation will make a referral to that Provider, if the Provider is able to provide the service
- The Provider will accept the referral and begin working with the Person on the Plan (see 6.1)

The Supported Living support package will be agreed between the Person, the NASC organisation and the Provider, is to be based on the person's needs,

existing natural supports and desired outcomes, and available Government funding.

5.2 Exit

The Person may choose to exit Supported Living, or ask to be supported by another Provider. There may also be circumstances where the Provider is unable to meet the Person's needs. The Provider will notify the NASC organisation within 2 working days of becoming aware that a person no longer wishes to receive support from the Provider.

The NASC organisation will work with the person, the Provider and significant others where appropriate to ensure the safe and appropriate transfer of supports and records that relate to the person.

6. WHAT THE SERVICE INCLUDES

Supported Living provides eligible disabled people with a creative, responsive and flexible person-centred approach to support. Support is provided consistent with the individual support plan (see 6.1)

Supported Living Services are designed to enable disabled people to live in their own homes, to develop relevant skills, to develop and access community resources, to actively participate in their community, to define and achieve their goals, and ultimately experience autonomy on an equal basis to others.

The support that a person receives changes as the Person's needs and aspirations change – this means that support is adjusted in response to the disabled Person's changing needs for support and assistance.

As people are more connected with their communities and natural support networks it is generally expected there will be less reliance on formal supports.

Support is available to assist people to transition from an existing living arrangement; this may include the family home or a residential service. The transition is expected to be complete in three months, other than exceptional circumstances as agreed with the NASC organisation.

Where sleepover/night support is required, this will be provided through the Home and Community Support Service contract. This will respond to an exceptional situation, where it represents the least restrictive option for a transitional period not exceeding one month. Examples of this include leaving home or a residential service through a crisis, or as an Intentional Safeguard.

The Supported Living Service must be provided in ways that are consistent with the Ministry policy regarding paid family caregivers.

6.1 Individual Support Plan

Each person will have an Individual Support Plan ("Plan") prepared by the Provider in conjunction with the Person, based on the goals and support needs as identified by the Person. The Provider's staff will support individuals to have

as much input as possible into their plans and the Plan will be completed within four weeks of the Person accessing Supported Living funding. The Plan will capture the goals and aspirations of the Person, and it will be Informally Reviewed by the Provider on a regular basis.

The Plan will be written in such a way that the Person understands and agrees with the content, the Provider's staff are clear about the outcomes required, and it ensures that the NASC organisation can see how referral needs will be met. The plan will be reviewed by the NASC organisation twelve monthly, or more frequently if there is significant progress with goals, life changes, or if requested by the person.

The planning process includes all natural supports and other agencies involved in providing support to the person, including the referring NASC organisation.

The Plan identifies those supports provided by the Supported Living Services, alongside those provided by other agencies and natural supports.

Where required, the Plan will include strategies or actions to safeguard the person in various individual circumstances, and be clearly linked to any risk management documents that relate to the person or the Service (where applicable).

The Plan belongs to the disabled person. This means that the disabled person has final say in the content of the Plan with agreement indicated by signing it, unless he/she is shown to have diminished responsibility. In this situation the Plan should be signed by a Welfare Guardian on his/her behalf.

6.2 Staffing

The Provider will ensure that it has sufficient staff who are suitably qualified to provide the Supported Living Services as described in this Specification. This will include Coordination and Support functions. The Provider will also ensure that Support Workers have access to appropriate training. The Coordination function may include providing training.

6.2.1 Coordination

The Provider will ensure that every person for whom services are provided has an identified person who knows the person well and takes responsibility for the co-ordination, development, oversight of implementation and review of the person's plan.

The Coordination function is integral to the design, development, and delivery of individualised Supported Living Services and ensures that regular and effective communication happens between all those involved in the planning process; particularly as needs change or issues arise.

6.2.2 Community Support

The Provider will be responsible for employing skilled staff to meet individual client needs and to provide continuity of support. Staff will be appropriately matched to each person based on the person's preferences and needs. This may include consideration of preference, gender, age and culture.

It is expected that the primary skills required to provide effective support will include general competency and attributes to provide support according to each person's needs. Support workers will be supervised by a person who ensures that training is provided. The supervisor will also oversee service delivery to ensure quality services are being provided.

Some of the things support staff may be required to do include, but are not limited to:

- Responding to the changing needs and aspirations of the individual in a creative and flexible manner;
- Understanding how to assist a disabled person to define, work towards, and achieve goals;
- Understanding the learning style of the disabled person and the course of action that needs to be taken to enable the person to achieve the outcomes and goals identified in the Plan;
- Creating opportunities for disabled people and educating others;
- Working with, learning with, and supporting the disabled person;
- Fostering and developing links to a wide range of people, organisations and community based supports and services;
- Developing strategies and resources to ensure that people are able to develop new skills;
- Ensuring that any Intentional Safeguards are in place and regularly reviewed so that they do not restrict the person's life and/or choices but do enable the person to live as safely as possible in their home and in their community.

7. EXCLUSIONS

Excluded from services under this specification will be any individual or individuals entitled to the support under the Injury Prevention, Rehabilitation and Compensation Act (2001) or where this service is not considered appropriate to meet the individuals identified support needs as identified by NASC.

The Supported Living Service is not to deliver services that are separately purchased, such as:

- Household Management - The Ministry contracts for this type of support through Home and Community Support Services, and a Community Services Card is required before this service can be received.
- Personal Care - The Ministry contracts for this type of support through Home and Community Support Services.
- Day Services and Vocational Services - These services are funded and contracted through the Ministry of Social Development, other than a

limited group of people who meet strict eligibility criteria for Ministry of Health funded Day Services.

- Rehabilitation Services - These services are funded through separate contracts by District Health Boards and in limited circumstances by DSS.

8. LINKAGES

The Provider is required to facilitate access and information for service users to make and sustain links with other services and supports in the community. This includes but is not limited to:

- needs assessment and service co-ordination services
- family / whanau and other networks the person may have
- local communities
- independent advocates
- person/carer community support services
- disability consumer groups
- appropriate ethnic, spiritual and cultural groups
- services linking Maori service users with whanau, hapu and Marae
- mental health services
- specialist support team
- primary health services
- day activity, vocational or education services
- employers
- equipment and modification services
- rehabilitation services
- Government departments

9. QUALITY REQUIREMENTS

9.1 General

All providers contracting with the Ministry of Health are expected to ensure that services are delivered in an efficient and cost-effective manner.

A Supported Living provider can charge for any activity within the hours approved by the NASC organisation that progress the Individual Plan. Specifically this means:

- Initial set-up
- Direct support
- Monitoring of the achievement of the Person's plan, recognising this should be done face to face
- Formal review of the plan at agreed intervals
- Meetings or activities that support achievement of the Person's plan, e.g. with family, advocates or other agencies; court proceedings, community liaison, finding places to live; or activities that respond to an incident or unexpected event relating to the person
- Researching options for the Person
- Any activities must be directly linked to the Person's individual support plan as agreed by the NASC organisation. All hours associated with

these individual activities must be documented in a way that they can be validated against the support hours provided

- The hourly rate paid for Supported Living includes an overhead component from which the provider is responsible for administration, monitoring of staff and the overall service, service and staff development and research.

The invoice for hours will reflect the hours delivered against the support plan developed with the Person and/or NASC organisation. It is also subject to any allocation of support hours made by the NASC organisation as part of the service coordination process.

The Provider is required to comply with the General Contract Terms and the Provider Quality Specifications of the Agreement in addition to this service specification. A companion document to this Specification is being developed and will provide additional detail about Supported Living.

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

9.2 Staff Management and Training

The Provider will provide its staff with a planned orientation to their role and responsibilities, and the service, which covers areas of service philosophy and values, knowledge and skills required, service and organisational procedures. Note also sections 6.2.1 and 6.2.2.

9.3 Acceptability

People who are supported will have opportunities to indicate their level of satisfaction with the service they have received, and the Provider must be able to produce evidence of the information gathered. This may be in the form of surveys or similar. The Provider should use information gathered from people who are supported as part of the Provider's continuous quality improvement process.

9.4 Safety

The Provider will have a set of documented policies/ protocols as part of its Risk and Quality Management framework including, but not limited to:

- Code of Conduct, including professional boundaries
- Conflict of interest
- Complaints policy and processes
- An abuse policy that covers recognising and reporting physical or sexual abuse from others and preventing abuse (physical, sexual, financial and psychological) from staff
- Confidentiality
- Positive behavioural approaches

- A process to identify vulnerabilities in relation to specific people supported by the service, and intentional safeguards that respond.

9.5 Reporting

The Ministry will work with the sector to develop a reporting framework that will measure outcomes. The Reporting section of the specification will be altered by way of a contract variation when the framework is implemented.

PU Code	PU Short Name	PU Measure	Reporting Requirements	
			Frequency	Information
DSSL2620	Community Supported Living	As requested	<p>Six monthly</p> <p>Annually</p>	<p>Quality Measure</p> <p>1.1 Number of people with written individual plans</p> <p>1.2 Number of individual plan reviews completed</p> <p>1.3 Percentage of Individual Plans goals met for those people reviewed</p> <p>1.4 Total number of complaints received in the reporting period, and the number resolved</p> <p>1.5 Total number of compliments received in the reporting period</p> <p>1.6 Total number and description of critical incidents that occurred in the reporting period</p> <p><u>A written narrative</u></p> <p>2. The outcome of person and family satisfaction survey</p> <p>3. Organisational strategic plan for Maori including:</p> <ul style="list-style-type: none"> • strategies to recruit and train Maori staff • Maori consumer satisfaction • Services meet the needs of Maori • Maori participation • Quality plan • Support for Maori • Number of FTEs • By type (Maori, total) <p>4. Report on service delivery issues (for example staff turnover, staff training, undelivered services), contingencies, emerging trends or innovative approaches taken.</p>

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

You shall forward your completed Performance Monitoring Returns to:

The Monitoring Team
 Ministry of Health – Dunedin
 Private Bag 1942
 Dunedin

GLOSSARY OF TERMS

Intentional Safeguard

Planned and deliberate interventions that are designed to minimise any potential impact from known risks. E.g. ensuring that a person who is known to have limited understanding of time or place to always carry a cell-phone on their person.

Needs Assessment Service Co-ordination Organisations (NASC):

These organisations are funded by the Ministry. Their roles are first to assess service user's needs, and then to co-ordinate other services to meet those needs within available funding.

Needs Assessment:

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

Person

The recipient of DSS funded services.

Plan

The Individual Support Plan prepared by the Provider in conjunction with the person.

Provider

The Supported Living Service Provider.

Review

Informal Review - This is the ongoing review of progress towards achieving goals, and identification of new goals that occurs as part of the regular communication between the person receiving services and the Supported Living Provider. This informal review is expected to occur as part of normal business.

Formal Review - the Individual Plan should be formally reviewed at intervals agreed between the person, the Provider and the referring NASC organisation, but at least annually. The formal review is to consider the goals in the Individual Plan, the need for new goals and to determine what further support will be needed. It is expected to include other people significant to the person. The cost of formal review is met through the identified set-up and review allocation.

Service Coordination:

Service co-ordination is the process of identifying, planning and reviewing the package of services required to meet the prioritised assessed needs and goals

of the client and, where appropriate, their family/whanau and carers. Service co-ordination will also determine which of those needs can be met by government funded and other services, and will explore all options and linkages for addressing prioritised needs and goals.