

SERVICE SPECIFICATION

Description: Child Development Services Purchase Unit Code DSS1012

DSD Philosophy

The aim of Disability Services Directorate (DSD) is to build on the vision contained in the New Zealand Disability Strategy (NZDS) 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, disability support services aim to promote a person's quality of life and enable community participation and maximum independence. Services should create linkages that allow a person's needs to be addressed holistically, in an environment most appropriate to the person with a disability.

Disability support services should ensure that people with impairments have control over their own lives. Support options must be flexible, responsive and needs based. They must focus on the person and where relevant, their family and whanau, and enable people to make real 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).

1. Definition

Child Development services are non-medical, multidisciplinary allied health and community based. Whilst a significant component of the service is early intervention for pre-school children who have disabilities or who are not achieving developmental milestones, the service is intended to promote and facilitate each child's developmental pathway so that their maximal potential is attained throughout their development and growth.

It is envisaged that Child Development services may provide a centre of excellence to meet the needs of children who have disabilities, in some localities this is up to school leaving age.

The service will forge strong links with all other services and agencies involved in the delivery of services to children to ensure that the Child Development Service is integrated and readily accessible and that service links and boundaries are clear.

2. Service objectives

2.1 General

The service will provide a specialist assessment, intervention and management services to promote rehabilitation / habilitation outcomes for children who have an intellectual, sensory or physical disability.

In doing so, the service provider will ensure;

- That appropriate supports and information are available to the child's family/whanau/hapu/iwi and other support networks
- That the services offered are appropriately linked with and integrated into all other services that the child may be accessing. (eg;. service from CYFS, Ministry of Education, Well Child initiatives etc.).
- The service will be provided in the most suitable setting for the child and the family, e.g. home, school, clinic, swimming pool etc. in the most cost-effective manner possible.

2.2 Maori Disability

The Ministry Maori Health Policy and the requirement to develop a Maori Health Policy and Plan are outlined in the Standard Conditions (clauses A2 and B1) and the Provider Quality Specifications. In addition you will develop and implement an annual plan that outlines how that plan will contribute to Maori Health Gain for the services contained in this service description.

The plan should include the following objectives (as a minimum):

- how the provider will ensure that Maori utilisation is targeted to meet need
- how links with primary care – general practice, community providers, Maori providers - will be established and enhanced for Maori health gain
- how the links with the DHB Quality Plan and other contractual quality specifications, especially consultation with Maori, will be established
- And how these objectives will be monitored and measured for Maori health gain.

The service will encourage Maori participation, and will improve and protect the health of Maori so that Maori have the opportunity to enjoy the same level of health as non-Maori. Services will be delivered in a supportive manner that respects the dignity, rights, needs, abilities and cultural values of the client, and their family/whanau.

3. Service users

3.1 Inclusions

Client Type

- Children and young people who have been identified as having a physical, sensory or intellectual disability or a combination of these, which is likely to continue for a minimum of six months.

- Children who are at risk of developing such a disability or have developmental delay.
- Children who have Autistic Spectrum Disorder.
- Whanau, families, caregivers and advocates associated with the above children.

NB: Currently different DHB's are operating under different age criteria for access to this service. For some DHB's only children aged 0-5 years who live in the DHB area can access the Child Development service. For other DHB's the service is open to children of school age who are in mainstream education or attend special units that do not have specific Ministry of Education funding for therapy services. This should be clarified in the Provider Specific Terms and Conditions.

For 2000/2001 existing age-based access criteria in place in individual DHBs will continue to apply until such time as service boundary issues with the Ministry of Education are resolved and nationally consistent access criteria are developed and applied.

Service Type

The types of services that are included in this service specification are;

- Specialised Allied Health Assessment of status and need for intervention by multidisciplinary team
- Provision of appropriate Therapies to facilitate and enhance the development of;
 - neurological and motor skills and function
 - swallowing and feeding skills
 - respiratory skills and function
 - speech, language and communication
- Specialised assessment (by accredited assessor) for equipment needs and housing modifications. In some areas where there is not a dedicated service this will also include specialised wheelchair and seating assessment.
- Therapy follow-up after surgical intervention or a medical episode related to the child's disability
- Support and education for families / whanau / hapu / iwi.
- Education for all other support persons directly involved in services delivered to the child.
- Liaison with the school and relevant fund-holders for the Ministry of Education as the child begins the transition from early child hood services into school based services and ongoing liaison as relevant thereafter.

NB: The level of involvement the service will have with each child once they begin attending school will be dependent on the level of support they are eligible to receive from Ministry of Education. However the service will retain responsibility for the child's needs as defined in the Equipment and therapies protocols between the Ministry of Health and the Ministry of Education. (See Appendix I).

The respective responsibilities and relationships between the Ministry of Health and Ministry of Education are under ongoing review and evaluation and will be clarified as work progresses, by way of correspondence to Service providers.

3.2 Exclusions

Client type

The following children are specifically excluded from this service. Any child;

- Whose disability is as a result of an accident, trauma or injury and/or who has entitlement for payment under the Accident Insurance Act 1998.
- Who has a short-term acute illness and is expected to rapidly return to their former level of function and wellness.
- Who has had surgical intervention for an acute need and is expected to rapidly return to their former level of function and wellness.
- Who is terminally ill where it is unlikely that there will be an improvement in the level of the child's function
- Who requires maintenance services only and not a multidisciplinary developmental programme.
- Whose service needs are covered under another service specification

Service type

The following services are specifically excluded from this Service Specification;

- Support needs assessment for children, which be undertaken by the relevant local Needs Assessment and Service Co-ordination Services (NASC) provider.
- Medical Specialist assessment and review, which are covered by other contracts with the Ministry.
- Services designed to provide day care or respite to family members.
- Acute Medical or Surgical Management services not related to the child's disability.
- Rehabilitation following acute medical or surgical admission.
- Palliative care for children who are terminally ill.

4. Service Access

4.1 Entry and Exit

A child and their family may be referred to the service via a number of routes. The primary source of referrals will be from the relevant NASC provider. Referrals will also be accepted from Medical Practitioners and Allied Health Professionals in the following services;

- General Practitioners
- Neonatal services and Paediatric Medical and Surgical services
- Community Health Services
- Other Ministry contracted Health and Disability Services
- Education Funded Allied Health Services

- Children Youth and Family Services

On receipt of referral from any of these sources, the team co-ordinator will ensure that families are referred to the relevant Needs Assessment and Service Co-ordination Service as soon as practicable.

Exit from the service will be by way of planned discharge to ensure that the child and family have appropriate supports in place. This may occur for a variety of reasons including;

- The child's disability changes or improves such that they no longer require the services.
- The family chooses to exit the service and declines further services.
- The family leaves the geographic catchment area for which the service provider is responsible. In this situation the provider must facilitate referral to another appropriate and similar service in the region to which the family is moving.
- The child is of an age where referral to more age appropriate services should be made available to the family or turns 16 years old.

4.2 Access

The provider will deliver services in a location convenient to the child and their family /whanau. Services will be delivered as close to the families' residential setting as is practical and every effort will be made to minimise the need for families to have to travel extensive distances to access services.

This may at times be at a central facility, particularly for group situations but should more frequently be in the family home, on a marae, at a pre-school or school setting, or other community based setting depending on the circumstances. This should be negotiated with the family/whanau and other support services such that no one should be disadvantaged in their access to services.

The provider should work towards ensuring that there are no barriers to access through cultural beliefs and practices (where 'cultural' denotes gender, ethnicity or disability).

The service will operate during normal business hours from 8.30am till 5.00pm from Monday to Friday. Some flexibility should be applied in the availability of staff to accommodate the needs families and their support networks outside their normal work hours. It is the responsibility of the provider to negotiate this with employees and families using the service.

5. Service Components and Processes

The following service components are included in the price of this contracted service.

Service Component	Description
<p>Referral management</p>	<p>The Service provider will: Operate an effective and efficient system to receive, identify eligibility and prioritise all referrals into the service. This system will be operated by staff who are knowledgeable of the scope and nature of Child Development services.</p>
<p>Assessment</p>	<p>The Service provider will:</p> <ul style="list-style-type: none"> • On referral, identify the most appropriate Allied Health professional/s to carry out the assessment/s. • Ensure that thorough assessment/s is conducted which determines for each child; <ul style="list-style-type: none"> • the developmental and/or disability needs • the risk of deterioration of developmental milestones or of functional skills • the suitability of the services offered for each child, including their need for hands-on programmes, involvement in group therapy programmes and need for environmental support services. (i.e. Housing modifications, mobility and postural / seating support and /or other long term loan equipment). • (by direct liaison with the relevant NASC provider) the utilisation of other services (e.g. personal care hours, day care, respite care etc.) that will have impact on the family's ability to cope with the child's needs and situation and /or refer for needs assessment as appropriate. • Developmental goals and desired outcomes • Refer children and their families on to other services as their clinical or support needs require (notifying the referring health professional and/or other support services as appropriate). • Conduct assessments in the environment most appropriate to the individual child and family, ie; in the family home, or other community setting. The choice of environment will be determined taking account of the child's and family's needs and choice, the specialist equipment required, the cost of service delivery. • Ensure that the family / whanau understand the assessment process • Take account of Maori cultural requirements and

Service Component	Description
	<p>include Maori whanau, advocacy and support services as required by the Maori family</p> <ul style="list-style-type: none"> • Where appropriate, use Pacific assessors or Pacific assistance in assessment, taking account of Pacific people's cultural needs, and include Pacific advocacy and support services as required • Take account of the impact and implications of the child's disability in the family's life and lifestyle options and include advocacy and support services as requested / required by the family. • Conduct ongoing assessment of each child's developmental and / or functional level to monitor the effectiveness, acceptability, and appropriateness of continuing the provision of specialist Child Development Services. • Have a process for resolution of disputes re the quality and level of service delivery
<p>Specialised Assessments</p> <p>NB: Specialised Assessors are defined in the context of DSS NASC as follows; Specialised Assessor / Service</p> <p>An individual or a team with a specific range of expertise, who work alongside the client to assess their particular needs (cognisant of causation and implications) then develop options that respond to those particular needs.</p> <p>The child may require one or many specialised assessments to adequately assess a diverse range of needs. The collective feedback from these will inform the needs assessment summary and process of Service Co-ordination.</p>	<p>This includes the assessments carried out by Physiotherapists, Occupational Therapists, Visiting Neurodevelopmental Therapists and Speech and Language Therapists in their roles as Specialised Assessors (Accredited and or Registered Assessors) for DSS funded environmental support services accessed through Enable NZ or "accessible" (Auckland only).</p> <p>Environmental Support Services includes housing modifications and long term loan equipment for mobility (wheelchairs, walking frames, walkers etc.), personal care, pain management, household management, seating and postural support, communication etc.</p> <p>The provider will ensure that in undertaking the provision of specialised assessments for environmental support services the Allied Health Professionals;</p> <ul style="list-style-type: none"> - are suitably qualified and competent to complete specific types of specialised assessment * - will comply with all requirements laid out in the relevant Manuals for provision of environmental support services (Enable NZ / "accessible" Equipment Manual and Housing Manual) - have sufficient administrative support to facilitate the completion of all relevant paperwork and the co-ordination of all

Service Component	Description
	<p>associated individuals and agencies involved in the assessment, trial and supply of environmental support services (i.e. equipment suppliers, draftspeople and/or architects, builders, Enable NZ or "accessible". etc.).</p> <p>*(The development of a competency framework for Specialised Assessors sponsored by DSS, is currently in progress. It is anticipated that the implementation of a new framework will commence from July 2001. Whilst the details and scope of this framework is not yet confirmed it will replace or upgrade the Accredited and Registered Assessors framework).</p>
<p>Planning and Provision</p>	<p>The Service provider ensure the effectiveness of their service by:</p> <ul style="list-style-type: none"> • Ascertaining the safety, practical viability and the cost effectiveness of using home based Child Development services to manage the child's developmental or disability need. • Working co-operatively with all other community, disability support and paediatric services to provide appropriate allied health support as required. • Working co-operatively with NASC providers to ensure that planning and recommendations for the provision of services for children are understood, are consistent with other services which they may be receiving and are appropriately incorporated into the process of Service Co-ordination. <p>The provision of services will include;</p> <ul style="list-style-type: none"> • Identification and planning of the anticipated level and frequency of intervention and support for each child. • A multidisciplinary allied health team approach that will facilitate each child's achievement of developmental milestones, minimise the long term impact of their disability, optimise their functional skills and / or reduce the barriers to the child's participation in activities appropriate to their age and stage of development. • Adjustment of the intervention and/or treatment programme according to the child's and family's response and the need to achieve developmental or functional benefit. • Ensure that the child and / or their family / whanau understand the manner in which the intervention, support and/or treatment plan will be delivered. • Ensure that the services provided and the manner in which it will be delivered (eg by whom, when etc) are understood by

Service Component	Description
	<ul style="list-style-type: none"> · the Maori client/whanau, advocate and support service as required by the Maori whanau · the Pacific Islands client, advocate and support service as required by the Pacific Islands family
Education	<p>The Service will be a source of:</p> <ul style="list-style-type: none"> • Education about the principals of developmental support and enhancement. • Training on the use and application of therapy and other equipment. This will include training family and caregivers (paid and unpaid) on the appropriate use of feeding and respiratory support equipment, therapy equipment and long term loan equipment (consistent with the expectations outlined in the Enable NZ / “accessible” Equipment Manual) • Family and carer education to optimise functional level, prevent deterioration and maximise developmental and functional gains. This will include training caregivers (paid and unpaid) on how to incorporate exercises, reinforce appropriate movement patterns and facilitate functional skills into all daily living activities. • educational activities that will recognise the culturally sensitive issues relating to these services and focus on <ul style="list-style-type: none"> · the holistic taha Maori perspective of health · the holistic community approach to health for Pacific Islands cultures
Specialist Professional Skills	<p>The Service may include, but not be limited to, the following mix of skills:</p> <ul style="list-style-type: none"> • physiotherapists • occupational therapists • visiting neuro-developmental therapists • social workers • speech language therapists • psychologists • cultural advisors • dieticians
Discharge Planning	<p>The Service will:</p> <ul style="list-style-type: none"> • discharge the child and family from the service when, on formal assessment, the child has obtained identified goals and outcomes or • has reached the age limit for which the service is contracted • refer the child to other services as required • plan discharge in consultation with the family and

Service Component	Description
	<p>agencies as appropriate. You will ensure that when planning discharge:</p> <ul style="list-style-type: none"> * Maori clients/whanau have access to a Maori advocate/ support worker * Pacific Islands clients have access to a Pacific Islands advocate/ support worker • ensure appropriate linkages with and make referrals to Maori and Pacific Island providers as required • make a written discharge report available to the family / whanau the referrer and/or GP and to the relevant NASC provider. • ensure that transition of responsibility for the child's and family's management to other providers has occurred
<p>Key worker</p>	<p>The Service will:</p> <ul style="list-style-type: none"> • identify a key worker as defined below. The decision as to who is an appropriate key worker and which disciplines will be involved in each assessment rests with the team and the family/whanau. . • The key worker will: <ul style="list-style-type: none"> • act as the co-ordinator of Child Development service delivery to establish and review the service to ensure it is goal oriented and effectively and efficiently provided, from the perspective of both the family and the provider and • liaise directly with the NASC service to ensure that Child Development Services are consistent with all other services that the child / family is receiving. • be the principal contact for the family / whanau and/or carer and the referring health professional, NASC provider and/or GP. • ensure there is full appreciation of the child's and family's cultural needs and that these are met. • ensure that there is full understanding of the child's developmental and disability needs and the implications / impact that these will have on all aspects of their life.

5.2 Key inputs

Staffing:

Staff must have experience in working with families and children and be cognisant of the need to respect the family's primary role in all decision making about their child and the programmes in which they are involved. The provider will employ sufficient numbers of staff to meet the requirements of

this Service Specification. Staff will include but are not restricted to the following;

- Managerial support
- Administrative support
- Physiotherapists
- Occupational therapists
- Visiting neuro-developmental therapists
- Social workers
- Speech language therapists
- Psychologists
- Cultural advisors
- Dieticians (or access to them)

Cultural Advice:

The provider will ensure that they have ready and appropriate access to cultural advisors at an individual and organisation level. This will include Maori and Pacific Advocates, Maori and Pacific support workers and other cultural support as identified by the person.

Staff Training:

Ongoing, regular and appropriate training for all allied health professionals employed by the provider.

5.3 Settings

The provider must ensure that any facilities used for service delivery are fully accessible and provide a suitable level of privacy for the child and their family/whanau and other support persons.

The facilities will be “child friendly” with appropriate furnishings, décor and decorations to provide a welcoming and non-threatening environment to children and their families.

6. Service linkages

The provider is required to establish close service relationships with the service providers listed below.

- Maori providers
- Needs Assessment and Service Co-ordination Services
- Strengthening Families Local Co-ordination Groups
- Strengthening Families initiatives
- Community and Home based support services
- Relevant Disability Support Services contracted services such as Conductive Education
- Enable New Zealand or “accessable” (Auckland only)
- Children and Young Persons & Their Families Service,

- W.I.N.Z.
- DHB neonatal and paediatric services
- ACC
- Ministry of Education fund-holders and therapy services

In some cases these links will be based on Memoranda of Understanding between the HFA and another service (e.g. CYPFS) or Ministry of Health Guidelines (e.g. Needs Assessment and Service Co-ordination).

Where children / young people are receiving services from other agencies, the Child Development Team will participate in interagency collaboration and co-ordination initiatives including Strengthening Families Local Co-ordination case Management.

7. Exclusions

Nil

8. Quality Requirements

The service is required to comply with the General Contract Terms & Conditions. In addition, the Provider Quality Specifications will apply to this service as determining quality standards. The following specific quality requirements also apply.

8.1 General

The provider is responsible for implementing a strategy for planning, implementing and reviewing service delivery to children and their families, from a family perspective. All families should be involved in the development of their child's service plan and personal outcome objectives. In addition, outcome measures should be developed for each child, their family and whanau.

8.2 Access

Services should be provided in an environment that is easily accessible to the child and the family. Access in this context refers to the entire spectrum from culturally accessible to geographically accessible and physically accessible (i.e. level access at entrances and to all facilities, to enable children who have limited mobility or are wheelchair users to move freely into and around facilities).

8.3 Acceptability

You should provide the service in a way that is sensitive to the needs of the community within which you operate and have effective working relationships based on co-operation with a range of relevant community and support link groups.

Client satisfaction surveys should explicitly measure satisfaction with the service and with the equipment supplied.

In addition, acceptability to Maori should be included in the review conducted by the provider in conjunction with Maori. Support services to Maori requiring your services should be proactively offered and available.

8.4 Safety and Efficiency

The provider will ensure that all persons who supply or provide or assist in the supply or provision of this service are competent, appropriately qualified and, where relevant, currently registered with or licensed by the appropriate statutory and/or professional body.

9. Purchase units and Reporting requirements

The following information is to be reported as per the Information Specifications in Standard Terms and Conditions

Purchase Unit Code	Purchase Unit	Frequency	Reporting Requirements
DSS1012	Child Development	Quarterly	<ol style="list-style-type: none"> 1. Number of "contacts" 2. Number of new referrals accepted by team. 3. Number of individual children seen / accessing the service by <ul style="list-style-type: none"> • Gender • ethnicity (Maori, PI, non Maori) • disability type (intellectual, sensory, autistic spectrum disorder, physical, multiple, or no specific diagnosis) • age (0-4, 5-16) • referral source 4. Number of children on current team caseload. 0-4 years; 5-16 years. 5. Number on waiting list (accepted, but no appt. made). 6. Number of clients accessing service by service type: <ul style="list-style-type: none"> • Physiotherapy • Occupational Therapy • Neurodevelopmental therapy • Speech and Language Therapy • Social Work • Other