

Community Health Transitional and Support Services

Community Activity Programmes

Tier 2 Service Specification

September 2024

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1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☒ **RECOMMENDED** ☐

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
First Published on NSFL	April 2012
Review: Age Related Day Care Services service specification S-1110 (South Island Districts). Amendments: updated formatting, content, new purchase units, retired purchase unit HOP1011. Integrated Chronic Health Conditions Service purchase units CHC0017, CHC0018 and service specifications.	November 2011
Amendments: Minor corrections made to the reporting tables for clarity.	June 2012
Amendments: Minor corrections made to the CHC0018 narrative reporting table for clarity.	November 2012
Amendment: replaced references to Tier One Rehabilitation and Support Services (now retired) with Tier One Community Health Transitional and Support Services.	April 2013
Amendment: clarified frequency of reporting requirements for narrative report detailing the number of rejected referrals during the reporting period and the reasons for rejecting them.	June 2013
Amendment: simplification of reporting requirements	May 2016
Content moved to updated Health New Zealand format	September 2024
Consideration for next Service Specification Review	Within five years

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

3. Introduction

This tier level two service specification for Community Activity Programmes (the Service) held in community or residential facility settings, is intended for both Health of Older People Service Users and Chronic Health Conditions Service Users of all ages. It is linked to the overarching tier one, Community Health, Transitional and Support Services service specification, which must be used in conjunction with this service specification.

This service specification is also linked to the tier two DHB-funded Needs Assessment and Coordination Service specification.

3.1 Background

Community Activity Programmes (Services) are designed to provide ongoing support for eligible people to enable them to live in their home for longer. These Services can improve their health and well-being by providing activities, assistance, support and social interaction within a group setting of any size.

If the eligible person has a main carer¹, the service is designed to provide the main carer with ongoing short breaks from their caring role, and can improve their health and well-being, enabling the main carer to continue in the caring role.

The Service is delivered by organisations referred to in this document as Service Providers (the Provider), and these organisations are accountable for the quality of the services delivered.

The Provider will have a philosophy and care delivery system that promotes and maintains Service Users' independence to support their ability to remain living in their home.

The Provider will:

- have age-appropriate expertise in working with people with health and support needs
- have expertise in working with people with chronic health related support needs
- be informed about and understand the requirements of a Service User who wishes to remain living in their own home
- if providing services to people with dementia, have expertise in working with people who have dementia specific needs.²

¹ The term 'main carer(s)' is a reference to the person(s) spouse, parent/guardian, family, whānau or friend providing informal support and care for more than four hours a day. The main carer does not have to live with the person supported, as long as the main carer is responsible for supporting their ongoing care and wellbeing – A Guide for Carers: He Aratohu mā ngā Kaitiaki. <https://www.msd.govt.nz/documents/what-we-can-do/community/carers/carers-a4-booklet-v8.pdf>

² Refer Appendix 1. Pg 20

4. Service Definition

The Service provides activity programmes that are orientated to the interests and abilities of individual Service Users. Community Activity Programmes are seen as an essential part of support for ensuring Service Users can remain as independent as possible.

The Service is provided to a group of Service Users in a community setting or facility such as residential care. The emphasis is on each Service User's social participation and maintenance of strength, balance and mobility through activities relevant to their support needs and abilities, with a focus on building resilience.

Where appropriate the Service may include community participation activities (eg. shopping trips, involvement in community events, and intergenerational activities).

5. Service Objectives

5.1 General

The Service will:

- support the Service User to remain living in their own home, wherever possible
- assist each Service User to maintain their level of functioning and the ability to remain as independent as possible
- ensure staff understand the holistic needs of the Service User
- support the wellbeing of the Service User's main carer, where relevant, to enable them to continue in their caring role and reduce carer stress
- assist Service Users to adapt to ongoing health or support needs
- reduce risk of social isolation
- provide culturally appropriate services
- provide a meaningful individual activity programme
- provide an opportunity for contact with health and community services
- ensure that a Service User focused approach is central to decision making.

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

5.2 Māori Health

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 and provision of appropriate pathways of care, which may include, but not be limited to:

- processes such as referrals and discharge planning

- ensuring that Services are culturally competent
- ensuring 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.

Providers must recognise Māori realities. The importance of Whānau, Hapu and Iwi structures, and the role the Service User, particularly of Koroua and Kuia, plays within these structures.

Positive intervention for Māori Service Users can help to introduce healthier lifestyles, change habits and enhance positive social and functional activities.

6. Service Users

People who have been assessed as eligible by the District approved needs assessment and service coordination service as requiring ongoing support with maintaining their independence, and who qualify for age appropriate services, such as people:

- aged 65 years of age or older, or
- aged 50 to 64 with age related needs, or
- requiring long term support for chronic health conditions, or
- fulfilling the criteria (as specified by individual Districts) to enable access to a specific District initiative.

People with mental health or addiction needs should have their specific mental health and addiction needs met through mental health services, but are not excluded from having their age related or chronic health conditions needs funded through these specifications.

7. Access

7.1 General

Access to the District funded Service is through referral from a District approved needs assessment and service coordination service. The referrer will have approved a maximum number of sessions per week that the Service User can attend the Service.

The Provider will have protocols developed and implemented that identify time frames and criteria for responding to referrals of an eligible Service User.

The Provider will use assessment information available from any current assessment (eg. InterRAI-HC) to inform care planning and prevent duplication of assessment.

A Service User may attend more sessions per week than they have been allocated, however they will be charged a daily fee, as agreed in advance with the Provider, for the full cost of care for any extra sessions.

7.2 Exit Criteria

Service Users will exit the Service by planned discharge, death, or if the services are no longer required. The District approved needs assessment and coordination service must be notified of discharge.

If a Service User's needs are no longer able to be met by the Service for any reason, the Provider must discuss and agree discharge with the District approved needs assessment service.

A Service User may choose to not attend the Service. In this situation, the Provider will make every effort to inform the District approved needs assessment and coordination service.

8. Service Components

8.1 Settings

The Provider will ensure the internal and external environment is comfortable, stimulating, and supportive of the Service Users' age and support needs. The environment must be physically safe and accessible for all Service Users and all possible risks should be identified and managed.

8.2 Optimal Numbers of Service Users

The Provider will have a protocol identifying the maximum number of Service Users that can be safely cared for in the Service setting.

8.3 Transport

The Provider will assist Service Users to identify appropriate transport options to and from the programme. Unless otherwise indicated through specific agreement with the funder, the Service cost does not include transport. Where the Provider does provide transport it will be provided by a person who is familiar with the Service User's support needs and where appropriate will include such things as ensuring their home is locked, assisting with outdoor clothing and assisting with transfer in and out of a vehicle. The driver must hold an appropriate driver's license and the vehicle must be safe and appropriate for the Service User's needs.

8.4 Meals and Fluids

The Provider will provide adequate and nutritious meals, refreshments and snacks at morning / afternoon tea and lunch times, that reflect the nutritional requirements of the Service User (refer to age-appropriate food and nutrition guidelines³), and as much as possible, considers the personal likes/dislikes of the Service User, addresses medical, cultural and religious restrictions, and is served at times that reflect community norms.

The Provider must ensure snacks and drinks are available to Service Users at all times.

³ <http://www.moh.govt.nz/foodandnutrition>

8.5 Processes

8.5.1 First Contact

The Provider will ensure the following information is provided to the Service User on or before their first visit to the Service:

- service information (eg. times, days, location, meals, transport if applicable etc.)
- Health and Disability Code of Rights
- complaints procedure
- Attendance Agreement details of additional costs (eg. option of attending extra sessions, costs for outings).

8.5.2 Attendance Agreement

The Provider must ensure that the Service User, or their main carer or nominated representative (for example, the person with enduring power of attorney for care and welfare), signs an Attendance Agreement. The Provider must not charge the Service User or any other person for preparing or providing an Attendance Agreement.

The Attendance Agreement must contain:

- a list of items that are excluded from the Service as set out in 7.2
- an itemised list of each optional additional service offered by the Provider which is not part of this service agreement, and the charge for each optional additional service
- a statement of the right of the Service User to:
 - attend the Service without being required to receive and pay for any additional service
 - decide whether to receive any individual additional service
 - at any time decide to receive or cease to receive any individual additional service
- contact details for the Service
- emergency contacts for the Service User
- service information (eg. times, days, location, meals etc)
- information on optional outings (eg. what will happen if they choose not to attend the outing)
- the extent of the Provider's liability for damage or loss of the Service User's personal belongings, including clothing
- provisions relating to the following topics:
 - staffing the facility
 - safety and personal security of Service Users
 - fire protection and emergency management
 - communication with Service Users for whom English is a second language, are deaf, or whose ability to communicate is limited
- the complaints procedure a Service User should follow if they wish to make a complaint about the provider or any of the services received by the Service User, and how to access the Health and Disability Commissioner's Advocacy service.

8.5.3 Costs

The Provider must not directly charge the Service User for allocated sessions. The Provider may only charge the Service User for extra sessions, and the cost must be agreed with the Service User in advance.

A Service User may be requested to pay a small contribution towards some outings (e.g. a show) when they have:

- had prior notice of such a cost associated with that activity
- a choice as to whether they participate in the activity (if they choose not to participate they should still be able to attend the regular service).

8.5.4 Activities Programme

The Provider will develop an age appropriate activities programme. The Provider will ensure that when planning social and recreational activities, Service Users' preferred levels of participation and support needs are taken into account.

The activities programme will offer a range of motivational, diversional and social activities in a stimulating and supportive atmosphere to assist in meeting the physical, emotional and social support needs of Service Users.

The activities programme will be reviewed and updated on a regular basis, and orientated to both group and individual activities and will include:

- a range of recreational exercise activities
- a range of recreational pursuits and hobbies
- education and awareness programmes, including those related to health (such as asthma, diabetes, nutrition, cognitive function)
- volunteer involvement and, where required, links with relevant voluntary support groups
- communication with Service Users for whom English is a second language, are deaf, or whose ability to communicate is limited
- links with the community.

If the Service User group has behavioural support needs (eg. Dementia) a specialist activities programme will be provided. This programme should be led by a person who has had specialist training relevant to this Service User group. (See specific standards for Specialist Behavioural Support needs in 5.8).

8.5.5 Care Plan for each Service User

The Provider will ensure that each Service User has a written and implemented care plan, and that each Service User has had the opportunity to participate in developing the care plan. The care plan is agreed with the Service User, and is written in a way that is understood by the Service User. Where a Service User has a main carer, they will also be involved in the development of the care plan. Where possible a shared care plan can be used to ensure continuity between community and community activity programme services.

It is essential that the Service User's support needs are met appropriately both within the Community Activity Programme and at home. Therefore, the Provider must inform the needs assessment and service coordination service if a Service User's support needs change at any time so a reassessment of their needs can be arranged.

Where a Service User is unable to participate in discussions, their main carer or nominated representative will identify who can provide information about the Service User's preferences in relation to activities of daily living.

The care plan will:

- identify how the Service User's assessed support needs will be met
- include contact details for the Service User's emergency contacts (eg. main carer, family and whānau), referring service coordinator and General Practitioner / Nurse Practitioner (GP / NP)
- reflect pre-existing and/or new directives by the Service User's GP / NP
- include strategies and actions to safeguard the Service User
- where appropriate, include communication and behavioural support
- include dietary needs, allergies (eg. medication, food etc)
- agree administration of provided prescribed medication (eg. antibiotics)
- include baseline information regarding the Service User's health status, abilities and support needs, which is updated on a regular basis.

8.5.6 Risk Management

The Provider must, as a minimum, document and implement policies, processes and procedures for:

- identifying key risks to health and safety
- evaluating and prioritising those risks based on their severity, the effectiveness of any controls the Provider has and the probability of occurrence
- dealing with those risks and where possible reducing them
- staff recruitment to ensure the safety of Service Users (eg. Police vetting)
- minimising the adverse impact of any internal emergencies or external environmental disasters on the Service Users, visitors and staff
- working with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services
- accident and hazard management that safeguard Service Users, visitors and staff from avoidable incidents, accidents and hazards
- requirements of staff if abuse of Service Users is evident or suspected, following the appropriate Family Violence Intervention Guidelines (Child and Partner Abuse or Elder Abuse and Neglect)
- dealing with challenging behaviours – when and how to access support services and when to access reassessment
- development and maintenance of positive relationships with the immediate neighbouring community.

Each risk management policy, process, or procedure developed must include definitions of all incidents and accidents, and must clearly outline the responsibilities of staff, including:

- taking immediate action
- reporting, monitoring and taking corrective action to minimise incidents, accidents and hazards, and improve safety; and
- debriefing and staff support as necessary.

Key risks include, but are not limited to:

- theft / burglary
- fire
- accidents / incidents
- disposal of waste, and
- natural disasters.

A record of any accidents or incidents must be maintained, and crises and major incidents must be notified immediately to Service User's main carer, family or whānau, needs assessment and service coordination service, and GP / NP.

8.6 Key Inputs

8.6.1 Staff

The Provider will ensure sufficient staffing is available to safely meet the needs of Service Users.

Staff can be volunteers. Volunteers must meet the same recruitment requirements as paid employees, for example police vetting, and have opportunities to access training.

The following roles and responsibilities will be required to be undertaken by staff in the Service:

- a Programme Co-ordinator who can manage the daily routine of the Service and the referral system
- an Activities Co-ordinator who designs the individualised activity programmes and is skilled in facilitating an activities programme for Service Users and identifying the interests and preferred levels of participation of a diverse group of people
- activities assistants who work under the direction of the Activities Co-ordinator
- support workers who provide support with daily living activities as needed by Service Users
- these roles may be combined.

8.7 Equipment and Facilities

The facilities will be clean, warm, safe, well-maintained, comfortable, user friendly for Service Users, meet their support needs, and will include the following:

8.7.1 Resting Area

There must be a comfortable and quiet area where Service Users can rest when tired or ill. The Provider will ensure that Service Users who are resting are either monitored closely or can attract the attention of a staff member.

8.7.2 Food Preparation

If food preparation is required a suitable safe kitchen area must be used.

8.7.3 Toilets and Hand Washing Facilities

The toilets and hand washing facilities will be accessible for Service Users and meet their support needs.

8.7.4 Storage Space

If applicable, the Provider will ensure that there is sufficient storage space for hobby activities, craft equipment and general supplies. Storage of solvents and cleaning agents should be safe and secure. Equipment that belongs to individual Service Users should be kept safely out of the general traffic areas when not in use.

8.7.5 Entry

A sheltered entry area which can be used as a reception and waiting area for those awaiting transport is desirable. If a sheltered entry is provided, then comfortable seating and safe storage of personal belongings (eg. space to hang coats and umbrellas) would also be desirable.

8.7.6 Clean Up Area

If activities which involve the use of materials are anticipated, it is desirable to have an area separate to hand washing and kitchen areas, where equipment can be cleaned.

8.7.7 Security for Service Users

The Service is designed so that Service Users who are likely to wander (eg. dementia) are able to be closely supervised or cannot leave the premises without attracting the attention of a staff member.

8.8 Specialised Behavioural Support Community Activity Programmes

Where the Service is designed specifically for Service Users with behavioural support needs (eg. dementia), the Provider will:

- ensure at least one staff member has advanced specialist training in behavioural support (eg. dementia specific)
- ensure that key staff providing Specialist Behavioural Support services to Service Users have completed (or can demonstrate that they are working towards completing) a specialised care training course (eg. dementia care training)
- ensure that communication and behavioural support needs are addressed in each Service User's care plan
- operate a non-aversive policy for managing challenging behaviour which adopts the principle that a person's freedom should be restricted only for safety reasons
- utilise restraint procedures based on the Restraint Minimisation and Safe Practice Standards NZS8134.2.2008
- ensure the internal and external environment meets the following requirements:
 - is homelike and assists with the management of difficult behaviours
 - supports the Service Users' needs, especially minimising the risks related to confusional states
 - the premises are secure and do not allow Service Users unsupervised exit from the centre. Within the centre, maximum freedom of movement is facilitated while at the same time the safety of Service Users likely to wander is ensured
 - there is a safe and secure outside area that is easily accessible.

8.9 Information for Service Co-ordinators

The Provider will inform the needs assessment and service co-ordination service about the number of vacant places in the programme on a regular basis.

9. Service Linkages

Where relevant and appropriate the Provider should be able to inform Service Users, and if appropriate their carers, on how to access general information about other related support services and how they can access those services.

Service Provider	Nature of Linkage	Accountabilities
Advocacy services	Liaison, consultation, coordination of services	Improve or maintain the Service User's access, and support seamless delivery and continuity of care
District approved needs assessment and service coordination services	Referral and consultation	Service Users needing reassessment of their support needs have timely access to individual needs assessment and service coordination services
Equipment and Modification Services (eg. long-term equipment, including specialist assessment services, home modifications) to assist with daily activities	Referral and consultation	Eligible Service Users needing environmental support services receive appropriate equipment and environmental modifications
Information and advisory services (eg. on available services and how to access these including Disability Information and Advisory Service, Age Concern, and Alzheimers New Zealand)	Referral and consultation	Service Users have timely access to appropriately presented information and relevant advice
Major incident management including Civil Defence	Liaison and coordination of services	Ensure appropriate and timely response in the event of an emergency
Occupational Therapy, Physiotherapy, Social workers, Podiatry services	Referral and consultation	Clinical consultation and referral services that support continuity of care
Other specialist services	Referral and consultation	Expert clinical consultation and referral services that support continuity of care
Primary care services eg. GP/NP	Referral and consultation	Clinical consultation and referral services that support continuity of care
Public health service communicable disease programmes and the Medical Officer of Health	Referral and consultation	Clinical consultation and referral services that support continuity of care

Service Provider	Nature of Linkage	Accountabilities
Social services, counselling, home based support, meals on wheels, community services, new migrant Community Health Workers, Accredited Visiting Services	Referral and consultation	Ongoing support and service coordination that supports continuity of care
Voluntary organisations, eg Age Concern, Alzheimers New Zealand, Cancer Society, National Heart Foundation	Liaison, consultation and coordination of services	Ensure relevant and accurate information is available to support service delivery
If Applicable:		
Specialist behavioral support teams	Referral and consultation	Clinical consultation and referral services that support continuity of care
Other day and/or recreational activities	Liaison, consultation and coordination of services	Maintain Service User's access, support seamless service delivery and continuity of care
Disability Support Services (Health New Zealand funded)	Liaison, consultation and coordination of services	Maintain Service Users access, support seamless service delivery and continuity of care
Ethnic and cultural services	Liaison, consultation and coordination of services	Ensure culturally appropriate support is provided
Mental health services	Referral and consultation	Clinical consultation and referral services that support continuity of care
Palliative care services – Hospice	Liaison, consultation and coordination of services	Support seamless service delivery and maintain continuity of care
Transport services, including Total Mobility, to recreational and/or day activities, National Travel Assistance to specialist services	Liaison, consultation and coordination of services	Maintain the Service Users' access.

10. Exclusions

10.1 General

The District funded Service is not for Service Users who:

- are receiving Services under other public funding arrangements such as ACC (unless formal agreements have been made for joint funding for individuals with complex needs).
- have specific needs that cannot be met by the Service
- have behaviours that will adversely affect the safety of, and benefits to, other Service Users in the programme.

10.2 Exclusions from Service

Unless otherwise indicated through specific agreement with the funder, the Service cost does not include:

- prescribed pharmaceuticals, including pharmacy dispensing fees or co-payments (note that if emergency supplies are required consideration should be given to achieving this at the least cost to the Service User – local Primary Health Organisation arrangements apply)
- doctors visits (note that if an emergency visit is required, consideration should be given to achieving this at the least cost to the Service User – local Primary Health Organisation arrangements apply)
- services provided by community nursing and allied health services eg. Community Oxygen Therapy
- continence consumables
- dressings for wound care
- any transport.

The Provider must ensure the Service User has access to these items, and may supply them to the Service User if they choose to obtain the items from the Provider. The Provider is allowed to charge for these items if the Service User chooses to obtain them in this way, but the Provider must inform the Service User (and if applicable, their main carer) of the cost of items before purchasing them. The Provider must not charge the Service User for any items that are otherwise publicly funded.

The Service User is responsible for the safety, security and insurance cover of their own personal belongings, but the Provider must exercise due care and comply with relevant laws.

11. Quality Requirements

11.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework, as applicable, Crown Funding Agreement variations, or service level agreements.

11.2 Acceptability

The Service will be acceptable to Service Users, and as appropriate their main carer, families, and whānau. This will be supported by Service User participation in on-going evaluation of the Service and by feedback contained in annual Service User satisfaction surveys which, where appropriate, include input from main carers, family, and whānau.

The Provider will ensure that the Services are culturally appropriate. That is, staff should be able to demonstrate an appropriate level of cultural competence.

11.3 Staff Training

The Provider will ensure that all staff:

- will be able to access professional advice and information, and will be able to recognise when this information and advice is required
- are trained in the identification and management of abuse to Service Users. Where elder abuse or neglect is observed or suspected, the Family Violence Intervention Guidelines 'Elder Abuse and Neglect' should be followed
- are trained to be able to provide assistance with activities of daily living such as assisting the Service User with food and fluids, assistance with toileting, managing continence aids, assistance with transferring from rest bed to chair and assistance with mobility
- will have an appropriate orientation programme
- will receive appropriate ongoing training and development.

Providers of Services for Service Users with specialist behavioural support needs (eg. Dementia) will ensure specialist training is provided to staff (refer 6.8).

12. Purchase Units

Purchase Units are defined in the Nationwide Service Framework Purchase Unit Data Dictionary. The Service must comply with the requirements of national data collections where applicable. The following Purchase Unit codes (PU) apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure
HOP241	Community Activity Programme for Older People - Non-Residential Care Facility	Programmes delivered in a community setting (non-residential care facility) to enable older people to have regular meaningful social contact, and main carers (if applicable) regular short breaks	Attendance
HOP242	Community Activity Programme for Older People - Residential Care Facility	Programmes delivered in a residential care facility to enable older people to have regular meaningful social contact, and the main carer (if applicable) regular short breaks	Attendance
HOP243	Dementia Community Activity Programme for Older People - Community/Residential Care Setting	Specifically designed dementia programmes for older people, delivered in a community or residential care setting, to enable people with dementia to have regular meaningful social contact, and the main carer (if applicable) regular short breaks	Attendance
CHC0017	Community Activity Programme for people with CHC - Non-Residential Care Facility	Programmes delivered in a community setting (non-residential care facility) to enable people with Chronic Health Conditions (CHC) to have regular meaningful social contact, and main carers (if applicable) regular short breaks	Attendance
CHC0018	Community Activity Programme for People with CHC- Residential Care Facility	Programmes delivered in a residential care facility to enable people with Chronic Health Conditions (CHC) to have regular meaningful social contact, and the main carer (if applicable) regular short breaks	Attendance

Unit of Measure	Unit of Measure Definition
Attendance	Number of Attendances to a clinic/department/ acute assessment unit/domiciliary.

13. Reporting Requirements

The reporting information is used by the Provider and Funder to monitor the scope and quality of service delivery. Other local specific reporting requirements for the Service may be specified by the Funder in the agreement Provider Specific Terms and Conditions.

Unless otherwise specified in the agreement, the following reporting information will be emailed to: performance_reporting@health.govt.nz

The following information is to be reported as per the Information and Reporting Requirements.

PU Code	Frequency	Reporting Requirements
HOP241 HOP242 HOP243 CHC0017 CHC0018	Quarterly	<ol style="list-style-type: none">1. number of sessions that have been provided during the reporting period2. number of attendances3. number of individual Service Users4. number of Service Users new to the Service5. number of people on your waiting list6. number of rejected referrals <p>Narrative Report</p> <ul style="list-style-type: none">• Feedback from Service Users on their experience.• Summary of complaints (verbal and written) and action taken.• Reason for any rejected referrals.• Update on any service issues, including design development and delivery of new initiatives.• Describe any issues including risk management issues.• Identify gaps in service delivery.

13.1 Reporting Definitions

Term	Explanation
Service Users new to the Service	Service Users who have not ever used this Service before, in this District.
Session	A community activity that is recognised as part of the Community Activity Programme that is provided during the reporting period.

14. Glossary

Not Required

15. Appendices

15.1 Appendix 1: Guidelines Community Activity Programmes

This guideline document provides information to District Health Boards contracting for community activity programmes; it should be used as a guide only. It describes where Provider specific components can be added to contracts to further specify the Service, and provides examples.

15.1.1 Service User

This service specification is intended to be flexible and cover a range of service models, as well as the traditional day care model.

It is essential that services and settings are age appropriate (eg. it is not appropriate for young adults to attend Community Activity Programmes in an aged residential facility). It is not the intention of the service specification to mix age groups together for services, but to provide one platform for contracting a range of services.

Adults with early onset dementia should be provided services appropriate to their age and needs wherever possible (eg. not within an aged residential care facility). However, there is an understanding that this may not be possible in smaller communities where a limited number of resources are available.

15.1.2 Setting

The service could be held in various settings (eg. Marae based, outing based, a small group of Service Users in a person's home) and held at various times (eg. evenings and weekends) and the length of the sessions can vary (eg. two hours to ten hours).

Provider specific component of the contract can be added by Districts if they would like to contract models that require further specification, for example Koroua and Kuia programmes.

15.1.3 Private Payers/Carers Support

Although Service Users accessing these services through the Carers Support Subsidy or by private payment are not covered by this service specification, the expectation is that service providers will not provide a lesser service. The Provider is able to take private paying clients as well as District funded Service Users and the District cannot influence the cost of the service between the Provider and private paying clients, as this is a private agreement. Some Providers may be able to source funding through other avenues for example, by fund raising, which they may choose to use to subsidise private paying clients.

15.1.4 Staff Expertise and Training

The service specification sets out general training requirements and deliberately does not stipulate qualifications. This enables Districts to ensure the **Provider specific component** of the contract contains the appropriate staff expertise and qualifications necessary for the particular service being contracted for, and that all Service Users needs are met. For example, Provision of Dementia Community Activity Programmes should require all staff to hold the Level 3 Dementia unit standard.

15.2 Transport

If Providers are required to provide transport, then details should be included in the **provider specific component** of the contract. The provision of transport should be consistent for all Service Users of the Community Activity Programme, and must be suitable to their support needs. The driver must have a suitable license and the vehicle must be safe.

15.2.1 Facilities

15.2.2 Showering facilities

It could be appropriate to ensure showering facilities are available and if required this should be included in the **Provider specific component** of the contract.

15.2.3 Rest areas

A comfortable and quiet area is required for Service Users in case they become unsettled, tired or ill during a session. A comfortable area could include a bed, sofa or chair away from the noise of the session but within close proximity to staff. It could also include a seat in a car if the group is on an excursion.

15.2.4 Non-attendance

Providers of Community Activity Programmes have on-going costs that have to be met even when Service Users are unexpectedly unable to attend (eg. due to illness). Funding for these circumstances is an issue that needs to be addressed in the **Provider specific component** of the contract.

15.2.5 Dementia Community Activity Programmes

If Services are designed specifically for Service Users with Dementia then the following should be added to the **Provider specific component** of the contract.

15.2.6 Service Definition

Community Activity Programme components for Service Users with dementia should be designed to provide activities that are appropriate and meet their needs and interests in a safe and stimulating environment.

These components may run concurrently with programmed activities for Service Users where dementia is not a predominant aspect; or the programme of activities may be offered separate to those of a general programme – either consecutively in the same environment, or at a separate time or location.

15.2.7 Staff Ratio and Training

There should be a higher staff ratio for activities for Service Users with dementia-related needs than other Service Users.

Staff orientation and training should ensure staff have experience in working with Service Users with dementia. Staff should have specialised training in providing activities for Service Users with dementia, having completed or working toward relevant unit standards.

15.2.8 Secure environment

Where Service Users are assessed as requiring care in a secure environment, the environment will be safe, and have appropriate stimulation factors that will not cause unnecessary stress.

If the Service being provided is always held within the same facility then it should have a safe fenced and secure outdoor area to ensure Service Users are not able to wander from the facility. If the Service is being provided away from a facility, all care must be taken to ensure Service Users are supervised and remain safe.

The Provider will ensure that any behavioural management needs are addressed in a Service User's individual plan and that staff are trained in how best to meet those needs.

15.2.9 Hours

Specific activities for Service Users with dementia can be run at times most suited to people with dementia for example, to allow for 'sundowning' (a state of increased agitation, confusion, disorientation, and anxiety that typically occurs in the late afternoon or evening for some individuals with dementia), or at weekends.

15.2.10 Specialised behavioural support

Community Activity Programmes specifically designed for Service Users with behavioural support needs (eg. Dementia) should have specialised behavioural support readily available to them.