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He Whakaora.
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SERVICE SCHEDULE FOR SPECIALIST PAEDIATRIC & ADOLESCENT REHABILITATION SERVICE

CONTRACT NO: _____

A. QUICK REFERENCE INFORMATION

1. TERM FOR PROVIDING SPECIALIST PAEDIATRIC & ADOLESCENT REHABILITATION SERVICE

1.1 The Term for the provision of the Specialist Paediatric & Adolescent Rehabilitation Service is the period from 1 December 2021 ("Start Date") until the close of 30 November 2025 (the "End Date") or such earlier date upon which the period is lawfully terminated or cancelled.

2. SPECIFIED AREA AND SERVICE LOCATION (PART B, CLAUSE 4)

Nationwide service based at: _____

3. SERVICE ITEMS AND PRICES (CLAUSE 23)

Table 1 - Service Items and Prices

Service Item Code	Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
PAR01	Paediatric & Adolescent Rehab - bed day rate	Delivery of nursing and Hotel services not otherwise covered by Programme Funding.	$357.91	Per client inpatient rehabilitation day

Table 2 – Programme Funding

Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
Paediatric & Adolescent Rehab - Programme Funding	Payment in addition to the inpatient rehabilitation bed day rate for delivery of all other	$415,168.68	Fixed fee paid quarterly in advance

Service Item Description	Service Item Definition	Price (excl. GST)	Pricing Unit
	aspects of the Service (including any staff disbursements for travel)		

Price Review

ACC will review pricing when, at ACC's sole discretion, we consider a review necessary. The factors ACC may take into account during a review include, but are not limited to:

- general inflation;
- changes in service component costs;
- substantial changes in the market.

If ACC finds that the factors we take into account have not had a significant impact on price, the prices will remain unchanged.

If ACC provides a price increase, the supplier must agree any adjustment in writing. The price increase will take effect from a date specified by ACC.

4. RELATIONSHIP MANAGEMENT (PART B, CLAUSE 22)

Table 3 - Relationship Management

Level	ACC	Supplier
Client	Recovery Team / Recovery Team Member	Individual staff or operational contact
Relationship and performance management	Engagement and Performance Manager	Operational contact/ National Manager
Service management	Portfolio Team or equivalent	National Manager

5. ADDRESSES FOR NOTICES (STANDARD TERMS AND CONDITIONS, CLAUSE 23)

NOTICES FOR ACC TO:

ACC Health Procurement (for delivery)
Justice Centre
19 Aitken Street
Wellington 6011
P O Box 242 (for mail)
Wellington 6140
Marked: "Attention: Procurement Specialist"
Phone: 0800 400 503
Email: health.procurement@acc.co.nz

NOTICES FOR SUPPLIER TO:

_____
_____
_____ (for deliveries)
_____
_____
_____ (for mail)
_____
_____ _____
Marked: Attention: _____ _____, _____
Phone: _____
Mobile: _____
Email: _____

TABLE OF CONTENTS

B. SERVICE SPECIFICATIONS FOR A SPECIALIST PAEDIATRIC & ADOLESCENT REHABILITATION SERVICE

1. PURPOSE

1.2 ACC wishes to purchase a Specialist Paediatric & Adolescent Rehabilitation Service (the "Service").

1.3 The purpose of the Service is to:

1.3.1 Provide goal focused non-acute rehabilitation and Reassessment services that have a strong interdisciplinary approach to support Clients, who as a result of injury, require a specialist rehabilitation service to ensure they return to active participation in their home, education, leisure and community in a planned and timely manner;

1.3.2 Ensure onward services required to support community based rehabilitation, community participation and wellness are coordinated by the Service in conjunction with the ACC Client Service staff; and

1.3.3 Provide national leadership in child and adolescent rehabilitation using a shared care model that builds capability across health and disability services in New Zealand.

1.4 The Service aims to ensure each Client:

1.4.1 Receives evidenced based and family centred Services;

1.4.2 Achieves maximum independence;

1.4.3 Can actively participate in education and their community; and

1.4.4 Receives on-going information and education to maintain their wellbeing.

2. SERVICE OBJECTIVES

2.1 ACC will determine the success of this service based on the following objectives:

2.1.1 Clients, their family and whānau have ready access to advice from the Service.

2.1.2 This Service makes an active contribution to the early rehabilitation of Clients who as a result of injury require a specialist rehabilitation service to ensure they return to active participation in their home, work, leisure and community in a planned and timely manner.

2.1.3 Clients and their families receive coordinated, competent multidisciplinary services which are appropriate to their agreed rehabilitation goals.

2.1.4 Clients transition from acute care services to Inpatient Non-Acute Rehabilitation and Community Integration Services as soon as it is safe to do so.

2.1.5 Clients receive active rehabilitation as part of Inpatient Non-Acute Rehabilitation and Community Integration Services which results in their safe and appropriate discharge to the community as soon as it is safe to do so.

2.1.6 Clients continue to maximise their rehabilitation potential as they develop.

2.1.7 Clients avoid preventable secondary complications through a regular comprehensive Reassessment programme.

2.1.8 Adolescents transitioning to adulthood have their specific on-going health and independence needs identified through a Reassessment which triggers referral and transition to appropriate adult services.

2.1.9 Clients are discharged to their own community and local paediatrician as soon as possible and can then receive community based rehabilitation delivered as onward services by others.

2.1.10 Supplier performance targets are met.

3. SERVICE COMMENCEMENT

3.1 Eligibility for Service

3.1.1 All Clients who are aged 15 years or under, or are attending secondary school, or have an equivalent developmental age at the time of injury, who have sustained an injury requiring Specialist Rehabilitation are eligible to receive:

3.1.1.1 Advisory Services.

3.1.1.2 In-reach Services to public hospitals in the Auckland region whilst receiving acute inpatient care.

3.1.1.3 Inpatient Non-acute Rehabilitation and Community Integration Services:

3.1.1.3.1 following an acute injury;

3.1.1.3.2 after elective surgery; or

3.1.1.3.3 when living in the community and require a period of inpatient rehabilitation.

All Clients require confirmation by a Specialist or Specialist Registrar of the acute service that the Client is medically stable having met criteria of Appendix One to participate in inpatient non-acute rehabilitation.

3.1.1.4 Reassessment services delivered as non-inpatient services.

3.1.1.5 Transition services.

3.1.2 Any existing Client (who meets the criteria in clause 3.1.1) or their family or whānau may use Advisory Services.

3.1.3 Any health professional may use Advisory Services in respect of a Client who is a child or adolescent with probable specialist rehabilitation needs.

3.2 Prior approval

3.2.1 The Supplier must obtain prior approval from ACC before admission to Inpatient Non-acute Rehabilitation and Community Integration Services where:

3.2.1.1 A Client is living in the community and requires Services.

3.2.1.2 A Client is referred by the National Burns Service for rehabilitation outside of a shared care arrangement.

3.2.2 The Supplier must obtain prior approval from ACC before:

3.2.2.1 Trial Home Leave.

3.2.2.2 Private caregiver training is undertaken prior to a Client's discharge where ACC is required to meet the costs of this training.

3.2.2.3 Extension of Inpatient Non-acute Rehabilitation and Community Integration Services beyond 40 inpatient days.

3.3 Referral process

3.3.1 The Supplier will actively seek referrals from public hospitals for acute inpatient Clients who are highly likely to require Inpatient Non-acute Rehabilitation and Community Integration Services.

3.3.2 Clients can be referred for Inpatient Non-acute Rehabilitation and Community Integration Services by a:

3.3.2.1 Specialist of an acute care service who determines the Client has completed acute care and confirms the Client is clinically stable (refer Appendix One) and ready for transfer to this Service;

3.3.2.2 Specialist if the Client requires a period of active specialist rehabilitation following elective surgery; or

3.3.2.3 Medical practitioner (e.g. GP or Paediatrician) if the Client requires a period of active rehabilitation following a change in their condition whilst living in the community.

3.3.3 The Supplier will have clinically based referral criteria which it applies to ensure appropriateness of referrals.

3.3.4 Prior to a Client entering the Service, a Paediatric Rehabilitation Medicine Specialist must accept the referral and agree to be responsible for directing the rehabilitation programme.

3.3.5 The Supplier will ensure all Clients who have received Inpatient Non-acute Rehabilitation and Community Integration Services are referred to receive Reassessment services as part of discharge planning.

3.3.6 Clients who meet eligibility criteria and have not received Inpatient Non-acute Rehabilitation and Community Integration Services may be referred to Reassessment services by a Specialist.

4. SERVICE LOCATION (PART A CLAUSE 2)

4.1 This is a national service.

4.2 The Service will be provided in the locations specified in Part A Quick Reference Information.

4.3 The Advisory and Reassessment Services may be provided in other appropriate community location(s).

5. SERVICE REQUIREMENTS

5.1 The Service has five components:

5.1.1 Advisory Services where the Supplier provides specialist advice, usually by telephone to other health professionals or current Clients, their family or whānau of the Service.

5.1.2 In-reach Services where Clients, their family or whānau and the treating team are visited in the acute inpatient setting where early rehabilitation advice is provided, a plan developed and preparation is made by the Supplier to receive the Client as soon as they are medically stable.

5.1.3 Inpatient Non-acute Rehabilitation and Community Reintegration Services delivered in an inpatient setting where Clients receive rehabilitation from a specialist multidisciplinary team that also coordinate community-based rehabilitation programmes the Client can participate in on discharge.

5.1.4 Reassessment Services where Clients, their family or whānau attend day-stay, outpatient or outreach clinics on a regular basis for a routine review which assists the Client to maintain their wellbeing; and local clinicians to build capability.

5.1.5 Transition Services where adolescent Clients transition from this Service to equivalent adult services, for example non-acute specialist spinal cord injury rehabilitation services.

6. ADVISORY SERVICES REQUIREMENTS

6.1 Advisory services aim to provide specialist rehabilitation advice which may reduce the need for Inpatient Non-acute Rehabilitation and Community Reintegration Services.

6.2 The Supplier will provide telephone or other methods of advice such as video conference or tele-health to:

6.2.1 Clients and/or their family/whānau;

6.2.2 Hospital personnel (e.g. surgical or medical ward of a DHB) providing care for a Client;

6.2.3 GPs providing care for a Client;

6.2.4 Personnel of another service where the Client has competing injuries (e.g. burns) which have resulted in the Client being managed by another service.

6.3 Advice may include arranging a Reassessment in accordance with this Service Schedule.

6.4 The Supplier will keep a brief record of the contact including adding this to the Client's hospital record where possible.

6.5 Where a Client has a shared care plan and this includes a messaging portal, the Supplier may provide advice through this portal without adding an additional record to the Client's hospital record.

7. IN-REACH SERVICES REQUIREMENTS

7.1 The Supplier will respond to referrals from acute inpatient services at Starship Children's Hospital (and where practicable to the National Burns Service located in the Auckland region) for Clients requiring specialist rehabilitation.

7.2 The Supplier will arrange to visit the Client, their family or whānau and the acute care team to:

7.2.1 Discuss the Client's early rehabilitation needs which can be delivered within the acute setting.

7.2.2 Participate in decision making leading to development of a plan for the safe, appropriate and early transfer of the Client to Inpatient Non-acute Rehabilitation and Community Reintegration Services.

7.3 The Supplier will record the consultation with the Client and the advice provided to the acute inpatient service in the Client's medical record.

8. INPATIENT NON-ACUTE REHABILITATION AND COMMUNITY REINTEGRATION SERVICES REQUIREMENTS

8.1 Inpatient Non-acute Rehabilitation and Community Reintegration Services include:

8.1.1 Delivering an individually tailored outcome focused active rehabilitation programme.

8.1.2 Coordinating community and school reintegration and discharge planning.

8.1.3 Providing diagnostic and specialised services that support the Client's rehabilitation.

8.2 The Supplier will allocate a key worker to a Client on admission. The key worker is responsible for:

8.2.1 The coordination of the multidisciplinary team and rehabilitation programme in conjunction with the paediatrician responsible for the rehabilitation programme.

8.2.2 Communication with the Client, family and whānau, ACC Client Service staff, GP, home care and community based rehabilitation providers and any other parties necessary to the Client's rehabilitation (e.g. school, peer support).

8.2.3 Ensuring the ACC Client Service staff receives a copy of a completed ACC1377 Active Rehabilitation Goal Setting Form and any ancillary reports.

8.3 Multidisciplinary teams work with the Client, their family and whānau to develop an individually tailored, culturally appropriate and outcome focused rehabilitation programme.

8.4 The Client's rehabilitation programme includes but is not limited to:

8.4.1 Identifying short and long term goals for functional improvement, psychosocial wellbeing, educational participation, discharge and participation in the community.

8.4.2 Completing regular WeeFIM scores including within three days of admission to the Service and prior to discharge.

8.4.3 Completing other outcome measures based on international best practice in complex injury rehabilitation practice, for example PEDI, PEDI-CAT, COPM.

8.4.4 Involving the ACC Client Service staff as an active member of the multidisciplinary team ensuring they can participate in goal setting and discharge planning meetings.

8.4.5 Holding weekly multidisciplinary team meetings to review progress against goals, discuss changes required to the rehabilitation plan and ensure the interdisciplinary team are working towards a discharge target date.

8.4.6 Regularly inviting the Client, family and whānau to participate in multidisciplinary team meetings.

8.4.7 Providing ongoing education to Clients, family and whānau that will support and prepare the Client to participate in meaningful activities and develop self-management skills.

8.5 Discharge planning will commence on admission of the Client to the Service and be coordinated by the key worker assigned to the Client.

8.6 The Supplier will ensure that the Client, family and whānau, and multidisciplinary team will work together to identify any barriers to a safe, planned discharge. This includes:

8.6.1 Working with ACC and Health New Zealand - Te Whatu Ora to determine whether the Client should be transferred to a Health New Zealand - Te Whatu Ora inpatient service and how hand-over of care should be achieved under a shared care model.

8.6.2 Working with ACC and suppliers contracted by ACC to undertake housing modification assessments including discussing short term options for alternative accommodation or temporary equipment which may facilitate discharge.

8.6.3 Completing an assessment that considers onward equipment needs including wheelchairs and seating as temporary solutions for the safe discharge of the Client. Note that the wheelchair and seating requirements are considered an intermediate (i.e. suitable for the six to twelve months following discharge) and not a long term permanent solution as an assessment for a permanent solution will be undertaken by an ACC assessor once the Client is living in the community having been discharged from inpatient services.

8.7 Prior to discharge, the Supplier will:

8.7.1 Case conference with the Health New Zealand - Te Whatu Ora paediatric team.

8.7.2 Complete a home visit by the multidisciplinary team where the Client lives within the Auckland region.

8.7.3 Facilitate trial home leave where this is part of the rehabilitation plan.

8.7.4 Provide any caregiver, family or whānau training required for the safe discharge of a Client.

8.7.5 Ensure the Client's GP and Health New Zealand - Te Whatu Ora are:

8.7.5.1 Involved in the discharge planning process and transfer of care discharge information is available to them.

8.7.5.2 Aware of the Advisory Service available to them from the Supplier.

8.7.6 Identify options for Clients to access transport to health appointments on discharge and inform the ACC Client Service staff accordingly.

8.7.7 Ensure the Client has a crisis plan and information on predicting what to do if an issue emerges that is not part of a shared care plan.

8.7.8 Coordinate the development of a shared care plan or similar (e.g. health passport) unless the Client (or their family or whānau as legal guardians) has declined.

8.7.9 Notify the ACC Client Service staff at least 10 days before the planned discharge date to ensure ACC understands the Client's support needs on discharge.

8.7.10 Follow-up with the ACC Client Service staff to ensure any referrals to services required on discharge have been actioned, for example tertiary level pain services, or psychological support services not provided as part of the Reassessment Service.

8.7.11 Ensure all onward services required by the Client are in place prior to discharging the Client. Note the Service shall not discharge the Client without confirmation of onward services or acceptable temporary solutions.

8.7.12 Make arrangements for regular Reassessments by the Supplier, making best endeavours to avoid the Client being lost to follow-up.

8.7.13 On discharge, provide the ACC Client Service staff with a copy of the Client's discharge report.

8.7.14 Provide immediate post-discharge follow-up within five working days of discharge. This may include:

8.7.14.1 A home visit if the Client lives locally to the Service.

8.7.14.2 Telephone contact with the Client, family and whānau to ensure there are no issues which need input from this Service.

8.7.14.3 Liaison with Health New Zealand - Te Whatu Ora and/or Home and Community Support Provider (if in place) to ensure they have all necessary information and do not require any additional support or training from this Service.

8.7.14.4 Liaison with the GP, ACC Client Service staff and other ACC contracted suppliers that have been part of the multidisciplinary team leading up to discharge to ensure transition to the community and handover of responsibilities has been successful.

9. REASSESSMENT SERVICES REQUIREMENTS

9.1 Reassessment services comprise non-inpatient services in the form of Day-stay, Outpatient and Outreach services.

9.2 Reassessment services include the regular review of Clients requiring a specialist rehabilitation service to ensure they return to active participation in their home, education, leisure and community in a planned and timely manner.

9.3 The frequency of the Reassessments will depend on the needs of individual Clients but will include:

9.3.1 A minimum of one Reassessment to be undertaken within the first 12 months post-discharge from Inpatient Non-acute Rehabilitation Services and Community Reintegration Services.

9.3.2 An annual Reassessment unless there is a clinical decision to reduce the frequency to every two years or as clinical need determines. Where an annual Reassessment is not planned, the Service will:

9.3.2.1 Contact the Client's paediatrician and/or general practitioner to determine whether there is a need for an annual Reassessment.

9.3.2.2 Schedule a Reassessment in response to a request from the Client (or their family or whānau as legal guardians) or ACC.

9.3.3 A Reassessment is undertaken as clinically indicated:

9.3.3.1 Following a Client's discharge from a general hospital inpatient service.

9.3.3.2 At appropriate stages of recovery and developmental stages.

9.3.4 All Reassessments will be undertaken by one or more appropriately skilled and qualified health professionals from the Service. Together, the paediatrician and either the inpatient key worker or referrer will decide the composition of the health professionals undertaking the Reassessment. Reassessments will include, as applicable:

9.3.4.1 Clinical review of functional status and developmental progress.

9.3.4.2 Psychological review.

9.3.4.3 Appropriateness of any equipment and environmental supports.

9.3.4.4 A general medical examination, diagnostic investigations, radiology procedures, functional or psychological assessment.

9.3.4.5 Ongoing education to the Client, their family and whānau.

9.3.4.6 Communication with other health professionals (e.g. GP, Pain Specialist, general paediatrician) and services the Client has interaction with regarding their rehabilitation and support to participate in the community (e.g. Educational Service).

9.3.4.7 Completion of a follow-up monitoring report and any relevant Ancillary Report(s) such as recommendations for referrals to other services.

9.3.4.8 Providing a copy of the report and any recommended referrals to the ACC Client Service staff and the Client's GP.

9.3.4.9 Providing the results of any investigations undertaken as part of the Reassessment and discussing suitable treatment options with the Client.

9.4 The Client, together with their family or whānau may be recalled by a multidisciplinary team member for a follow-up Reassessment where:

9.4.1 It is not possible to provide results of any investigations on the day of the Reassessment; and/or

9.4.2 Rehabilitation or treatment options need to be discussed following completion of a Reassessment.

9.5 The Supplier will ensure local community teams are involved in the delivery of Outreach Clinics to ensure alignment of any community based rehabilitation or services with the recommendations which arise from the Reassessment.

9.6 Outreach Clinic teams will provide formal and informal education to local clinicians, to build capability as appropriate.

10. TRANSITION SERVICES REQUIREMENTS

10.1 The Supplier will identify the need for Transition Services through a Reassessment when the Client is approximately 15 years old.

10.2 Transition Services include initial liaison (by phone or email) with the equivalent adult service to agree and document a specialist to specialist handover where clinical responsibility shifts from the paediatric service to another service.

10.3 The Service will meet with the Client, their family and whānau, and their receiving Specialist as part of the handover process. This may be in-person or by tele-health where the Client is remote to this Service.

10.4 The Service will be available in the form of Advisory Services to the receiving adult service as appropriate.

11. TRANSPORT REQUIREMENTS

11.1 The Supplier will provide transport including:

11.1.1 Any necessary In-reach visits with a Client receiving acute in-patient care.

11.1.2 Return transport of the Client from the Service to another facility for tests, assessments or rehabilitation or recreational activities where they form part of the Client's rehabilitation plan including Trial Home Visits where the Client lives locally.

11.1.3 Pre-discharge home visits by members of the Multidisciplinary team where the Client lives locally.

12. DIAGNOSTIC AND SPECIALISED SERVICES

12.1 The Supplier will provide diagnostic investigations relevant to the Client's medical management provided in Inpatient Non-Acute Rehabilitation and Community Integration Services including:

12.1.1 Any routine laboratory tests.

12.1.2 Any routine medical procedures including lung function testing, angiography, gait analysis, audiology, video cystogram, cystometry, urodynamic studies, optometry and podiatry.

12.1.3 Any routine radiology procedures including X-rays, CT, MRI.

12.1.4 Any special investigations such as flexible cystoscopy, flexible cystoscopy with Botulinum toxin, flexible cystoscopy with dilatation, supra pubic catheter insertion, supra public catheter change, trans anal irrigation.

12.2 The Supplier will provide other Specialist services and interventions including pain management (excludes specific tertiary or quaternary level pain services), psychiatry, psychology, counselling, visual impairment, hearing impairment, traumatic brain injury and spasticity management services for Clients receiving inpatient services.

12.3 The Supplier will provide play therapy and educational services not otherwise provided by the Ministry of Education.

12.4 The Supplier will provide access to 24 hour emergency medical cover for Clients receiving inpatient services provided by appropriately qualified medical staff.

12.5 The Supplier will provide Social Work, Cultural, Advocacy, Spiritual and Interpreter services as needed for Inpatient Non-Acute Rehabilitation and Community Integration Services and Reassessment Services.

12.6 The Supplier will arrange diagnostic pathology or radiology services from a Pathology provider or Radiology provider where the Supplier cannot provide these due to the Client's locality and the pathology or radiology results are required for a Client to attend a Reassessment. Although this Service arranges for another supplier to provide these services, payment for these services are to be invoiced directly to ACC by the Pathology provider or Radiology provider and not by this Service.

EQUIPMENT AND CONSUMABLES

12.7 The Supplier will provide:

12.7.1 Inpatient Non-Acute Rehabilitation and Community Integration Services and Reassessment medical consumables and inpatient pharmaceuticals.

12.7.2 Assessment for, and provision of a range of equipment that assists Clients achieve their rehabilitation outcome whilst in inpatient services.

12.7.3 Short Term Loan equipment for up to six weeks post-acute discharge (i.e. where the Client has had elective surgery or has been acutely admitted to a public hospital and has then been transferred to this Service for rehabilitation before their discharge).

13. FACILITIES

13.1 The Supplier will provide Hotel services including hydration, nutrition (includes dietetics and nutritional advice) and medical and non-medical equipment for Clients receiving Inpatient Non-Acute Rehabilitation and Community Integration Services.

13.2 The Supplier will book suitable venues (e.g. outpatient clinic at another DHB) for Outpatient and Outreach clinics and meet any associated costs.

14. ADMINISTRATIVE SERVICES

14.1 The Supplier will provide administrative services including those normally required to allow the Supplier to:

14.1.1 Provide Services.

14.1.2 Determine volumes of Advisory, In-reach Services, Reassessment and Transition Services provided.

14.1.3 Monitor treatment outcomes.

14.1.4 Record service outcomes.

14.1.5 Meet the requirements of the National Minimum Data Set.

14.1.6 Meet the requirements of Australasian Rehabilitation Outcomes Centre (AROC) data collection.

14.1.7 Evaluate Services.

14.2 The Supplier will manage the administration of Outreach clinics by:

14.2.1 Developing an annual plan of the regional locations of Reassessment Outreach clinics ensuring sufficient clinics are offered in regions to meet obligations to reassess Clients as per Reassessment requirements.

14.2.2 Scheduling Outreach clinics.

14.2.3 Scheduling up to four staff (Paediatrician, Psychiatrist, Allied Health and/or Registered Nurse) members to travel to Reassessment Outreach clinics.

15. SERVICE SPECIFIC QUALITY REQUIREMENTS

15.1 In addition to the requirements specified in the Standard Terms and Conditions, the Supplier will meet the following requirements:

15.1.1 The Supplier will complete actions of the New Zealand Spinal Cord Impairment Action Plan as applicable to paediatric services.

15.1.2 Standards

15.1.2.1 The Supplier's facility will comply with Standard New Zealand NZS 8134:2021, The Health and Disability Services Standards.

15.1.2.2 The Supplier will comply with Standard New Zealand NZS8171:2005, Allied Health Services Sector Standard.

15.1.2.3 Where a responsible authority or professional body sets out standards of practice for assessment or evaluations, the Supplier will comply with those standards.

15.1.2.4 The Supplier will voluntarily meet standards of good practice relevant to this Service such as the Australasian Faculty of Rehabilitation Medicine Standards for the Provision of Paediatric Rehabilitation Medicine Inpatient Services in Public and Private Hospitals 2015 or the CARF (Commission on Accreditation of Rehabilitation Facilities) International Medical Rehabilitation Standards or any NICE guidelines.

15.1.3 Service Provider Requirements

15.1.3.1 The Supplier will have a Multidisciplinary team who have appropriate specialty, experience and qualifications to deliver outcome focused, client centred, rehabilitation and assessment services. The team will be made up of core members, extended members and Specialist members.

15.1.3.2 All team members will have a shared philosophy based on rehabilitation principles.

15.1.3.3 Core staffing requirements include:

15.1.3.3.1 A Clinical Medical Specialist(s) with a Vocational Scope in Paediatrics, a current annual practicing certificate and a Fellow of the Royal Australasian College of Physicians (paediatrics) or equivalent and preferably a Fellow of the Australasian Faculty of Rehabilitation Medicine.

15.1.3.3.2 Nursing, Allied Health (including psychology, physiotherapy, occupational therapy, speech language therapy) and Social Worker staff who are registered health professionals and hold a current annual practising certificate.

15.1.3.3.3 A play therapist and/or early education teacher where one is not otherwise provided by the Ministry of Education.

15.1.3.4 Extended members of the Multidisciplinary team will include other medical specialities including a Psychiatrist.

15.1.3.5 The Supplier will ensure that all staff receive ongoing education and training in specialist injury rehabilitation service delivery.

15.1.3.6 The Supplier will ensure all services are adequately and appropriately resourced.

15.1.3.7 The Supplier will utilise information technology to ensure effective communication between all health providers.

15.1.4 Quality initiatives

15.1.4.1 The Supplier will contribute to the collection of AROC data as directed by ACC.

15.1.4.2 The Supplier will participate in a quality forum with ACC to discuss AROC and Service results with the intention of focusing on value based health services.

16. SERVICE EXIT

16.1 The Service is complete for a Client when all relevant Service requirements have been completed (i.e. the Client no longer requires Specialist Rehabilitation). In most cases this will be when the Client has reached their agreed outcome/rehabilitation goals to enable them to return to living in the community and the Discharge Report or other relevant document specified in clause 20 (containing all the information required by ACC) is received and accepted by ACC.

16.2 The Service is considered complete:

16.2.1 When the Client is transferred to another rehabilitation Supplier and an independent medical or social rehabilitation assessment confirms that the Client no longer needs Reassessment Services or that these services would be more appropriately provided by another Supplier;

16.2.2 The need for rehabilitation is no longer related to a personal injury for which the Client has cover under the AC Act (in these cases the cost will be transferred to the Ministry of Health funding);

16.2.3 A significant complication occurs requiring a Transfer of Care to acute inpatient services;

16.2.4 The Client is transferred to a Health New Zealand – Te Whatu Ora Health Service which does not hold a contract for this Service and ACC has agreed to the transfer the Client;

16.2.5 The Client is transitioned to equivalent adult services;

16.2.6 The Client goes absent without leave;

16.2.7 The Client (or their legal guardian) discharges him/herself from the facility;

16.2.8 The Client leaves New Zealand permanently; or

16.2.9 The Client dies.

17. EXCLUSIONS

17.1 The following services are not purchased under this Service:

17.1.1 Acute secondary care services funded under the Public Health Acute Services Agreement.

17.1.2 Rehabilitation following burns (without prior approval by ACC) unless this is part of a shared care arrangement.

17.1.3 Dentistry.

17.1.4 ACC pre-approved escort or transport costs.

17.1.5 ACC pre-approved accommodation costs for a caregiver.

17.1.6 Vocational rehabilitation services.

17.1.7 Long term equipment required for independence.

17.1.8 Surgical services including implants and prostheses and the immediate post-operative stay.

17.1.9 Fixed wing air travel for the transfer of Clients on mechanical ventilation to another facility or the Client's home during delivery of this Service.

17.1.10 Serious Injury Support Needs Assessment.

17.1.11 Social Rehabilitation Assessments, including but not limited to: Wheelchair and Seating, Single Discipline, Housing, Integrated Rehabilitation, Assistive Technology, Education Support and Transport for Independence Assessments (including Highly Specialised Transport for Independence assessments).

17.1.12 High and Low Tech Radiology provided by a Radiology provider for Reassessment services where these services cannot be provided by this Service.

17.1.13 Pathology services provided by a Pathology provider for Reassessment services where these services cannot be provided by this Service.

17.1.14 Tertiary and quaternary level pain services.

18. LINKAGES

18.1 The Supplier will ensure that linkages are maintained with the following Services:

18.1.1 Specialist acute care services of Health New Zealand - Te Whatu Ora.

18.1.2 Paediatric and Child Development services of Health New Zealand - Te Whatu Ora.

18.1.3 ACC case management staff.

18.1.4 Vocational provider services.

18.1.5 Client's General Practitioner.

18.1.6 Mental Health services.

18.1.7 Burns services.

18.1.8 Tertiary and quaternary level pain services.

18.1.9 Sensory Loss services, e.g., Blind Low Vision New Zealand, Deaf Aotearoa.

18.1.10 Community treatment, rehabilitation and disability support service providers.

18.1.11 Peer Support agencies.

18.1.12 Paediatric Society.

18.1.13 Paediatric Clinical Networks.

18.1.14 Adult Spinal Cord Impairment Rehabilitation Services.

19. PERFORMANCE REQUIREMENTS

19.1 The Supplier will meet the measures shown in Table 4 – Performance Measurement

Table 4 – Performance Measurement

Objective	Performance measure	Target	Data Source
Discharge from Inpatient Non-Acute Rehabilitation and Community Integration Services meets best practice timeframes.	The period in Inpatient Non-Acute Rehabilitation and Community Integration Services matches evidenced based best practice.	95%	AROC data and ACC held length of stay data
Immediate post-discharge follow-up is provided for each Client following Inpatient Non-Acute Rehabilitation and Community Integration Services.	All Clients receive post-discharge follow-up within five days of discharge from Inpatient Non-Acute Rehabilitation and Community Integration Services.	100%	Supplier reported data
Outreach clinics are provided where indicated	Clients who require a reassessment are followed up via Outreach clinics or via video conference. Measure is number of reassessments	90%	Supplier reported data

Objective	Performance measure	Target	Data Source
	required compared to number provided.		

20. REPORTING AND NOTIFICATION REQUIREMENTS

20.1 The Supplier will provide reports in accordance with Table 5 – Reporting Requirements. The Supplier may submit information via email or via ACC form.

Table 5 – Reporting Requirements

Information	Frequency	When	Responsibility
ACC 1375 Inpatient Rehabilitation Transfer of Care Notification Form	Client's entering the Service following completion of acute care services Clients re-entering the Service following transfer from acute care services	Within three working days of the Client's entry to Services	Key Worker assigned by the Service
ACC 1377 Active Rehabilitation Goal Setting Report Form	Following the Multidisciplinary meeting where goals are set	Within 15 working days of the Clients admission to the Service	Key Worker assigned by the Service
Discharge Report (copy of discharge summary as provided to the onward service and/or general practitioner) – email to Recovery Team Member	Following discharge or transfer from Inpatient Non-acute Rehabilitation and Community Reintegration Services	On discharge or transfer	Key Worker assigned by the Service
ACC 1376 Interruption of Care – Change of Service Level – or send email to Recovery Team Member	Transfer of a Client to acute care services following a significant complication requiring acute care	Report within two working days of transfer to acute care services	Key Worker assigned by the Service
ACC 1378 Prior approval to commence or extend Services – or send email to Recovery Team Member	To obtain approval to extend Services beyond 40 inpatient days or to provide Services to Clients following elective surgery or for Clients admitted directly from the community.	Within 10 working days of the expiry of Services or intended commencement of Services.	Key Worker assigned by the Service
ACC 1379 Request for Trial Home Leave Form – or send email to Recovery Team Member	To obtain approval for any home leave trials	Within 10 working days of leave being required	Key Worker assigned by the Service
Ancillary report (such as recommendations for	As appropriate	As appropriate	Key Worker assigned by the Service

Information	Frequency	When	Responsibility
referrals to other services)			

20.2 The Supplier will notify ACC Client Service staff for a Client in accordance with Table 6 – Notification requirements

Table 6 –Notification requirements

Notification requirement	When to notify
Appointment of a key worker	Within three working days of a Client's admission to the Service
Dates for key Client meetings (e.g. Multidisciplinary team meetings that include the Client)	10 working days prior to meetings
Client travel required – to attend a Reassessment appointment	At least 10 working days before the Reassessment appointment
Did Not Attend – Outreach, Outpatient or Specialist Reassessment	Within two working days of non-attendance at a scheduled Reassessment appointment

20.3 The Supplier will report to ACC in accordance with Table 7 – Supplier level reporting requirements

Table 7 - Reporting requirements – Supplier level reporting

Report	When to complete	When to submit / notify
Quarterly Service report that includes quantitative data demonstrating delivery of Services under each service component using a format as provided by ACC	Quarterly	By 31st of each month: April, July, October and January (one month following the completion of each quarter) Submit to spars@acc.co.nz
Client inpatient rehabilitation volumes and length of stay (admission and discharge date)	Monthly via invoicing spreadsheet	Submit to spars@acc.co.nz
Client/Family/whānau satisfaction or experience survey	Annually	31 March (for the year ending February) – include in Annual Report
Supplier to provide an Annual Report describing delivery of Services under: in-reach, advisory, re-assessment, reassessment, and transition services. This can include a narrative description on:	Annually	31 March (for the year ending February) Submit to spars@acc.co.nz

Report	When to complete	When to submit / notify
• the developing of local capability • successes and challenges of these services • and any other relevant information Please also include where possible any: • relevant geographical information • outcomes data, such as those reporting via AROC reports and/or of any other outcomes data measured. • volumes (i.e. percentage of inpatient of inpatient clients accessing these services),		

21. OPERATIONAL CONTACT

21.1 During the Term of this Service Schedule the Supplier will nominate a person (as specified in Clause 4 of the Quick Reference Information in Part A of this Service Schedule) to be the main contact for ACC who will:

21.1.1 Have primary responsibility for relationships with ACC and the operation of this Service on a day to day basis;

21.1.2 Be proactive in informing ACC of issues with provision of Services as outlined;

21.1.3 Raise issues and suggest solutions regarding this Service;

21.1.4 Ensure that the Service is operated in accordance with this Service Schedule;

21.1.5 Represent the Supplier in discussions on performance; and

21.1.6 Ensure that ACC is advised promptly when the person's contact details change.

22. RELATIONSHIP MANAGEMENT

22.1 To ensure the continuing effective operation of the service, formal working relationships are to be maintained as defined in Table 3 - Relationship Management.

23. PAYMENT AND INVOICING

23.1 Services prices are defined for this Service in Table 1 - Service Items and Prices and Table 2 – Programme Funding.

23.2 ACC agrees to pay the prices set out in Table 1 - Service Items and Prices and Table 2 – Programme Funding.

23.3 Programme Funding invoices should be sent to Accounts.payable@acc.co.nz quoting cost code 718.

23.4 Where a combined total of more than 78 Inpatient Non-acute Rehabilitation clients and 60 Reassessment clients have received Services within a financial year, the Supplier is able to request a package payment for every additional client by agreement with ACC until commencement of the next financial year.

24. DEFINITIONS AND INTERPRETATION

"ACC Client Service staff" means a person employed by ACC who works directly with Clients such as: a Recovery Team Member or Recovery Administration Assistant. Other ACC Staff could include: a Portfolio Team Member or an Engagement and Performance Manager.

"ACC Transfer" means a transfer of the Client to another rehabilitation Supplier at ACC's request.

"Active Rehabilitation" means a level of rehabilitation that is actively working toward functional outcome goals set by the Multi-disciplinary team.

"Active Rehabilitation Goal Setting Report" means the report required under table 5.

"**Admission"** means the documentation process by which a Client is admitted to the Supplier's facility; and "Admitted" and "Admit" have a corresponding meaning.

"Clinical Review" means an on-site periodic evaluation by an ACC Clinical Reviewer of the Suppliers service delivery against this service specification.

"Discharge" means the process of documentation that changes the admission status of the Client whereby the Client leaves the inpatient facility of the Supplier having received Services.

"Discharge Report" means a report developed following a Client's rehabilitation at the time the Client exits the service and which contains the information outlined in the Operational Guidelines.

"Hotel Services" means standard meals, power, heating, accommodation, but excludes individual purchases such as telephone calls, toiletries, personal items such as clothing.

"Initial Specialist Assessment" is an initial assessment of a Client referred for Reassessment services having not had prior Non-acute rehabilitation Services or where the Client has not regularly attended Reassessment services and more time is required to undertake a more comprehensive assessment.

“Inpatient” means a Client formally admitted to the Service where their length of stay will include an overnight stay.

“Inpatient Rehabilitation-Interruption of Care” means the report required under Appendix 6, table 1 and attached as appendices to the Operational Guidelines.

“Inpatient Rehabilitation-Transfer of Care Notification” means the report required under table 4 and attached as an appendix to the Operational Guidelines.

“Key Worker” means a member of the Multidisciplinary team who works with the Client, family and the team from the time of Admission to the Service. This role includes co-ordination of the team in setting goals and monitoring goal achievements. This person also acts as the primary contact for the Client, family and ACC Client Service staff.

“Medically Stable” means medical stability as defined in Appendix 1.

“Multidisciplinary team” means a team composed of members from different healthcare professions with specialised skills and expertise. The members collaborate together and work with the Client, their family and whānau to provide an integrated service to the Client.

“Named Facility” is the facility’s name. The AROC information provided can be linked to the facility that provided the care.

“Operational Guidelines” is the document produced by ACC from time-to-time to reflect the processes and procedures that should be followed in support of this Service.

“Outpatient” means a Service provided at the Supplier’s premises where the Client attends that Service and does not require an overnight stay.

“Outreach” means a Service provided at a clinic location away from the Supplier’s premises.

“Prior Notification/Approval to Commence/Extend Services” means the report required under Appendix 6, table 1.

“Radiology procedure – high tech” means Medical imaging procedures such as Magnetic Resonance Imaging (MRIs) or CT Scans, excluding radiology (x-rays).

“Reassessment” means services as described in clause 9**.**

“Service” means the Supplier providing Specialist Paediatric and Adolescent Rehabilitation Service to ACC Clients.

“Serious Injury Support Needs Assessment” means an Assessment of the Client’s support needs considering needs and strengths using an evidence based approach. The assessment advice to ACC will be directed towards enhancing independence, facilitating a client’s participation in typical and valued life roles in home, work, leisure and community independence and promoting quality of life.

“Specialist” means a medical practitioner other than a General Practitioner who holds or is deemed to hold vocational registration that is relevant, or, in the reasonable opinion of a General Practitioner, likely to be relevant, to the injury sustained or apparently sustained by the Client.

“Specialist Rehabilitation” means the specialist aspect of the paediatric rehabilitation service continuum for children and adolescents with highly complex needs who as a result of injury, or surgical intervention following surgery will benefit from a developmentally appropriate goal based multidisciplinary rehabilitation programme.

APPENDIX 1 – Clinical Criteria for Transfer from Acute to Non-Acute Services

1. PURPOSE OF CLINICAL CRITERIA

The clinical criteria are intended to:

1.1 Provide a framework for assessing when a person's needs are no longer considered acute and when the person is suitable for transfer to a rehabilitation service;
1.2 Clarify funding responsibility for funders and providers; and
1.3 Contribute to greater consistency of decision making.

2. CONDITIONS FOR TRANSFER

There are three conditions that must be met before a patient can transfer from acute to non-acute ACC funded services:

2.1 The person is medically stable and likely to improve, as well as there being no life-threatening condition that would require emergency surgery or intensive monitoring; and
2.2 The clinical team responsible for discharge from acute services and the rehabilitation team agree to the transfer; and
2.3 The person has been accepted, or is likely to be accepted, as an ACC Client.

3. GENERIC CRITERIA

The person's condition is medically stable and likely to improve, and injured person is medically stable when the following conditions are met:

3.1 Absence of any life-threatening condition which would require emergency surgery, for example:

3.1.1 to depressurise an intra-cranial haemorrhage; or

3.1.2 to arrest potentially catastrophic haemorrhage from a ruptured aneurysm, ruptured spleen or liver.

3.2 Absence of any life-threatening condition requiring intensive monitoring, for example:

- no significant infection;
- no raised intra-cranial pressure;
- no cerebro-spinal fluid leak;
- no naso-gastric drainage.

3.3 Airway secure and patient can control respiration, or can only control respiration with routine assistance from machine/people where this assistance is subordinate to rehabilitation needs.

3.4 Airway secure, excluding patients with acute, short term tracheostomy who have just come off a ventilator; the tracheostomy must be removed or be stable before medical stability is achieved.

3.5 Fractures firmly fixed either internally or externally which allow the Client to move the affected limb to participate in rehabilitation, strengthening of that limb.

3.6 No issues requiring daily clinical input from the (non-rehabilitation) specialist clinical team or with issues requiring daily medical input but which are subordinate to rehabilitation needs.

3.7 Where the above clinical conditions are met, transfer to active rehabilitation care may be suitable for people with the following conditions:

- patients feeding by mouth, naso-gastric tube or percutaneous gastrostomy;
- patients requiring IV antibiotics with or without central line;
- patients requiring CAPD, or haemodialysis, and who are stable with this management.

4. SPECIFIC CLINICAL CRITERIA

4.1 People with spinal cord injury

No pressure areas or ulcers requiring surgical intervention. People with pressure areas that require significant time on bed rest may be suitable, provided they are able to be mobilised and participate in active rehabilitation. The person is able to tolerate a semi-upright posture for up to one hour a day.

4.2 Clinician agreement to transfer care

The clinician responsible for acute care (who may be a discipline-specific specialist) agrees to Discharge with reference to this framework **and** the clinician who is to continue non-acute care agrees to accept (that is, take over responsibility).