HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate support provided by needs assessment and service coordination provider and disability support provider

1. On month 8, year F HDC received a complaint from Dr A about the services provided to Mr B[1] by a community support provider and Taikura Trust from month 1 to month 10 of year A. The community support provider ceased providing care to Mr B in month 4, year A. Mr B suffered two medical events in the two years previous to year A and required assistance with personal cares.[2] He died in year A as a result of several pressure sores that had become infected, resulting in sepsis.[3]

2. Taikura Trust is contracted by the Ministry of Health (MOH) (now Disability Support Servies [DSS] — Ministry of Social Development) to provide needs assessment and service coordination (NASC) services to people in the Auckland area. Taikura Trust said that its ongoing role is then to reassess the client's needs at least every five years and to complete annual or bi-annual phone reviews with the person and/or their family to check that the supports remain appropriate. The community support provider is a nationwide disability support provider that provides home and community support services.

3. In month 1 the year prior to year A Taikura Trust undertook a needs assessment for Mr B and made a referral to a disability support service[4] to provide 42 hours of personal care[5] per week. Around month 3 of this year, there was a change to the service provider when the community support provider acquired the aforementioned support service. At the time, Mrs B was employed[6] by the community support provider as a support worker. The following month the community support provider employee who had been providing support to Mr B resigned. Mr B expressed that he did not want strangers to care for him, and so his support was suspended.

4. In month 1, year A, Mrs B told Taikura Trust and the community support provider that she was no longer living with Mr B, which made her eligible to receive payments from the community support provider to provide six hours of daily support to Mr B. The community

[1] Mr B had a number of pre-existing medical conditions.
[2] Such as showering, dressing, toileting, therapy exercises, feeding, mobilising and positioning, and other activities of daily life.
[3] A life-threatening condition that occurs when the body has an extreme response to an infection.
[4] The support services were initially provided by a Ministry of Health-contracted service provider.
[5] Including exercises, feeding, transferring Mr B from the bed to the shower, assisting with showering and toileting, daily physiotherapy exercises, and walking around the house, and completion of safety checks and positioning.
[6] Mrs B's employment ended in month 6, year A.

support provider was re-engaged to provide payments to Mrs B as Mr B's carer, and she became Mr B's primary carer from late month 1, year A.

5. In month 4, year A a Taikura Trust staff member visited Mr B and suspected that Mrs B was being paid to support Mr B in contravention of the Ministry of Health Funded Family Care (FFC) guidelines. Mrs B was asked for proof that she did not live with Mr B, and she provided a photo of a letter from Work and Income dated month 11, the year prior to year A, which was addressed to a separate address to that of Mr B. Mrs B again confirmed to Taikura Trust that she did not live with Mr B.

6. However, Taikura Trust did not accept this explanation, and in month 4, year A a staff member sent an email to the community support provider advising that supports to Mr B were to be ceased until Mrs B provided further evidence that she was not living with Mr B. It is unclear why Taikura Trust did not accept the letter as sufficient evidence. The email stated: 'I will also speak with [Mrs B] in regard to other options, if she is not able to do this e.g. find another person.' However, there is no evidence that Taikura Trust spoke to Mrs B about other options or attempted to arrange another carer for Mr B. The staff member also discussed the situation with another staff member, who agreed to escalate the situation to the Ministry of Health Audit and Investigations Team (now Health Payment Integrity Team[7]). However, this did not occur for another six weeks. In the interim, Mrs B was advised that she could not be paid to support Mr B, and paid supports through the community support provider ceased in month 4, year A.

7. As part of my assessment of this complaint, I sought independent clinical advice from disability support specialist Mr John Taylor.

Responses to provisional opinion

Taikura Trust

8. Taikura Trust told HDC:

> 'We take this opportunity to assure you of Taikura Trust's commitment to ensuring it will apply the learnings arising from these circumstances to the ongoing improvement of our services. We were encouraged by the acknowledgment by Mr Taylor in his second report to you, around our transparency and accountability, and his recognition that our service pathway has evolved and improved over the past […] years. We are happy to carry out the proposed recommendations in your Provisional Opinion … Further we advise that we are engaged with the Ministry of Social Development (MSD) regarding this investigation, your findings, and the actions we have taken and are taking to address the issues that have been identified in relation to service delivery.'

9. Taikura Trust said that it agrees that there is a critical difference between 'contractual minimums' and 'best practice'. It said that it was fully supportive of a deliberate shift in the

[7] The Ministry of Health's Health Payment Integrity Team is a group within Health New Zealand|Te Whatu Ora focused on preventing and recovering overpayments, fraud, and errors within the health system.

Government's expectations and did not wait for the new Enabling Good Lives evaluation framework and tools to be launched in year E before it began work on its own service in year C. Taikura Trust said that in the first half of year C, it initiated an internal change programme premised on the Enabling Good Lives principles. Taikura Trust stated:

> 'This action, in our view, was not a demonstration of reliance on maintaining contractual minimums, but rather it was a show of our willingness to align with policy shifts, in a responsible manner as they were signal[l]ed by the Government.'

Opinion: Community support provider — educational comment

10. Mr Taylor advised that there is a level of risk associated with assigning a sole carer, because one person cannot always be available due to sickness, leave, or other unplanned circumstances. He advised that the appropriate standard of care would be to have a team of staff involved in a support package. The community support provider told HDC that Mr B did not want strangers caring for him, and it was respecting Mr B's cultural preferences (in line with their internal policies) when assigning Mrs B as the sole carer. The community support provider also said that its contract with Taikura Trust did not require there to be multiple support workers assigned to a client. Mr Taylor advised that there is no written standard relating to this situation, but 'experienced practitioners and managers know that assigning a single … person to support any individual puts that support at risk'.

11. Mr Taylor considers that the decision to have a sole carer for Mr B constituted a moderate departure from accepted practice. Mr Taylor noted the mitigating factors that the arrangement was requested by Mr B, who appeared to have a preference for no support from strangers, and taking into account the available funding and contractual expectations. Mr Taylor advised that it is the responsibility of the provider to alert people to any risks inherent in the decisions they make, and the community support provider should have informed Mr B and Mrs B about the possible risks of having a sole carer and should have worked with them to mitigate those risks. Mr Taylor advised: 'A laissez faire approach of "it is what the person wanted" and/or "it is not required by contract", or even "it is standard industry practice" is not adequate practice.'

12. While I agree with Mr Taylor's advice that there are inherent risks involved in assigning a sole carer, I have considered several other factors involved in this decision, such as Mr B's clear preference for having only his wife care for him; that the community support provider's contract with Taikura Trust did not require there to be multiple support workers assigned to a client; and that there were no written standards relating to a sole carer arrangement. While I agree that best practice would be for consumers to have several carers involved in their support package, it is my role to assess the care provided against accepted standards at the time of the events. Accordingly, I am not critical of the community support provider's decision to rely on a sole carer for the provision of Mr B's support needs.

13. Mr Taylor advised that, in his view, there was a lack of oversight of Mr B's care, and the appropriate standard of care would have been for the community support provider to have gathered some direct feedback on the support that it was providing to Mr B. Mr Taylor

considers that the failure to do so constitutes a mild to moderate departure from accepted standards, but he noted that it 'is one that is common within Home and Community Support Services providers because of, as the community support provider noted, the paucity of funding and other contractual requirements they receive for this work'. Mr Taylor opined that providers of Home and Community Support Services are not paid sufficiently to provide the level of oversight that should be available to the people they support.

14. The community support provider told HDC that usually it would not intervene in the care of a client without due cause, such as a complaint or request for review by a client. They also said that the 'support period' was only 10 weeks (late month 1 to early month 4, year A), which meant that there was no planned review of Mr B's support package as it was not contractually required.[8]

15. While I accept Mr Taylor's advice that it would have been best for the community support provider to have gathered some direct feedback on the support it was providing to Mr B, I also acknowledge the mitigating factors in this case, including that Mr B was in the care of the service for a period of only 10 weeks, and the other financial and contractual restraints in place for the community support provider. I also note Mr Taylor's comments that overall, the support provided to Mr B by the community support provider would be considered 'within the general bounds of acceptability' and that '[i]t is not a very high standard, but it is how things are for disabled people within the current system'. I also note that with respect to the cessation of services to Mr B, Mr Taylor advised that the community support provider did what it was required to do at the direction of the funder (Taikura Trust).

16. Accordingly, I find that the community support provider did not breach the Code of Health and Disability Services Consumers' Rights (the Code). While I am not critical of the care provided to Mr B by the community support provider, I note that this complaint highlights the importance of having robust systems in place to ensure appropriate monitoring and oversight of sole family carers. I will write to MSD to highlight my concerns in this respect.

Provisional opinion: Taikura Trust — breach

External review

17. I note that Taikura Trust provided HDC with an external review[9] that it commissioned into the care it provided to Mr B. The review found that Taikura Trust was acting within the bounds of the contract it had with the Ministry of Health[10] (particularly the 1994 version). The report was sent to Mr Taylor, and he was asked to advise whether the report changed any of his previous advice (discussed above). In summary, Mr Taylor advised:

[8] To occur every 12 months.

[9] In response to the provisional opinion, Taikura Trust told HDC that it had no involvement in the content of the external review report, nor did it have any contact with the reviewer during the external review process. Taikura Trust said that the external review was commissioned and coordinated through its independent legal advisor.

[10] The Ministry of Health was the funder of disability support services at the time of these events. The responsibility now sits with DSS — Ministry of Social Development.

> '[The review] assessed Taikura Trust's compliance with the Ministry of Health contract (particularly the 1994 version) as its primary focus. It appears to be quite literal in its interpretation and did not consider person-centered outcomes, best practice expectations, nor the accepted standard of care. It showed no alignment with the principles of Enabling Good Lives and the broader aspirations of the Disability Strategy that were operating at the time. This means that it does not really impact many of my comments since, in my view, contractual minimums, especially ones that were over 25 years old at the time, do not determine best practice.'

18. I do not disagree with Mr Taylor's sentiment regarding the best practice approach Taikura Trust could have taken to the provision of care. However, I acknowledge that my role is to assess the appropriateness of the care provided at the time of the events, against the relevant standards in place at that time. For this reason, I am more measured in my consideration of this issue.

19. In response to the provisional opinion, Taikura Trust acknowledged that a shift toward 'best practice' expectations aligning with the 'Enabling Good Lives' (EGL) Principles and the NZ Disability Strategy was being developed during this time. However, it said that providers in Auckland at the time were continuing to work to the standard DSS1040 NASC service specifications. Taikura Trust told HDC:

> 'We contend that it was the operational service specifications in place at the time that provide the relevant context and premise for the delivery of NASC services, and for considering the appropriateness of care to Mr B that Taikura Trust provided at the time.'

20. I acknowledge the comments made by Taikura Trust in this respect and note that my opinion on the care provided to Mr B by Taikura Trust has focussed on the accepted standards at the time of the events, rather than best practice standards.

Continuity of care

21. Taikura Trust undertook an initial assessment of Mr B's needs in month 1 the year prior to year A. The needs assessment identified that Mr B also required support and services from the relevant district health board (DHB) (now Health New Zealand|Te Whatu Ora (Health NZ)). Mr Taylor advised that the assessment appeared to be adequate, but there was a lack of coordination with the relevant DHB and there is no evidence that Taikura Trust took appropriate steps to ensure that Mr B did not 'fall between the cracks'. Mr Taylor advised that if there was no policy to guide Taikura Trust in ensuring connectivity between services, then this would constitute a severe departure from accepted standards. Taikura Trust told HDC that its policy to ensure connectivity with health services involved developing practical ways of working and support tools, which included specialist roles, processes for information sharing, and agreements that set out how each party would work with the other. In response to the provisional opinion, Taikura Trust acknowledged that its initiatives to increase connectivity were still in their early stages and reiterated the challenges with this at the time.

22. I acknowledge the response from Taikura Trust in this respect. However, Mr Taylor advised that despite the tools in place, the connectivity 'clearly did not happen', as there is no evidence that Mr B received the support from the DHB that he required. Mr Taylor advised that this failure constitutes a severe departure from accepted standards, and I agree. The circumstances of this case illustrate the profound ramifications for vulnerable consumers when providers are not joined up and there is poor communication and a lack of coordination of care.

Cessation of support

23. When Mrs B was asked by Taikura Trust for proof that she did not live with Mr B, she provided a letter from Work and Income and again confirmed that she was not living with Mr B. However, Taikura Trust did not accept this and proceeded to direct the community support provider to cease Mr B's support. It is unclear why the evidence provided by Mrs B was not considered sufficient. Taikura Trust told HDC that the staff member involved was mistaken about the requirements of the FFC guidelines in place at that time, and this led her to make enquiries about Mrs B's address that were irrelevant because according to Taikura Trust, regardless of where she was living, Mrs B was not eligible to be employed and paid by the community support provider to provide support to her husband.

24. The external review provided by Taikura Trust states that the FFC guidelines preclude a disabled person's spouse or civil union or de facto partner from receiving payments to care for that person, under the FFC 'primary criteria'. The external reviewer noted that there can be exemptions, but only to the secondary criteria, which therefore precludes a spouse or civil union or de facto partner being a paid caregiver under the FFC guidelines in any situation. The reviewer noted that this made Mrs B ineligible for FFC regardless of where she resided, and therefore Taikura Trust acted in accordance with the funding and policy boundaries of the Ministry of Health.

25. Contrary to Taikura Trust's view and the external review it provided, Mr Taylor advised that the FFC guidelines did not preclude Mrs B from being a paid carer for Mr B. Section 5.1 of the guidelines allows for exceptions when '[t]here is significant risk to the safety or well-being of either the disabled person or a non-family/whānau carer if the chosen family/whānau carer is not employed to provide the disability supports'. The guidelines also state that specific cultural considerations may be a relevant factor when considering an exception.

26. Mr Taylor also advised that the staff member should have proceeded with the presumption that the evidence (that Mrs B did not live with Mr B) was correct, not 'on the presumption that her assumption, based on no evidence, was correct'.

27. When Taikura Trust contacted the community support provider to advise that Mr B's support should be ceased, the staff member told the community support provider that Mrs B would be advised of other support options. However, this did not occur. Taikura Trust acknowledged that the community support provider should have been instructed to assign suitably skilled staff immediately to provide care to Mr B and confirm with Mrs B that she

would continue to provide care to Mr B in the meantime. Taikura Trust also accepted that the documentation around internal and external communications did not meet an acceptable standard.

28. Mr Taylor advised that when the staff member discussed the situation with another staff member via email, the other staff member 'did not offer any advice that [the staff member's] actions might have been ill-considered'. The other staff member also agreed to escalate the situation to the Audit and Compliance Investigators at the Ministry of Health, but this was not done for a further six weeks.

29. I have considered the advice provided by Mr Taylor in respect to the cessation of Mr B's support. It is my view that the shortcomings discussed above are the result of a systemic failure by Taikura Trust, as it is clear that several staff members failed to take appropriate action when ceasing Mr B's support and failed to ensure that his needs were being met. I have also considered Mr Taylor's comment that the failures reflect process and cultural issues within Taikura Trust.

30. Mr Taylor considers that the failure to ensure that support was available to keep Mr B safe and adequately supported represents a severe departure from the accepted standard. Further, Mr Taylor said that it appears that Taikura Trust did not take into account Mr B's cultural needs (in particular, that he wished to have only a family member care for him) in its consideration and adherence to the FFC guidelines. Mr Taylor advised that in failing to accommodate people of different cultures, there appears to have been a significant departure from the accepted standard of care.

31. In response to the provisional opinion, Taikura Trust disagreed that the failures identified a systemic issue, but it accepted that the actions of two staff did not meet an acceptable standard in relation to communication and documentation. Taikura Trust also disagreed that there were cultural issues at Taikura Trust and noted several instances[11] where Mr B's cultural preferences were taken into account during the provision of his care.

32. Mr Taylor, Taikura Trust, and the external reviewer have interpreted the FFC guidelines differently. Due to the complex arrangements that existed at the time, I am unable to determine whether the guidelines were followed by Taikura Trust correctly. Notwithstanding this lack of clarity, I remain concerned that Mr B's support was ceased in such a manner that it left him without immediate support and lacking continuity of care. I

[11] Including the following: When planning for Mr B's discharge from hospital, Taikura Trust advocated for him to be supported at home instead of in supported living; in a month 4, year A review of supports, an in-person meeting was arranged (this review is usually conducted over the phone) in line with Mr B's cultural requirements as it enabled Mr B to participate (due to his limited speech), his family (including Mrs B) were able to be part of the discussions, and the home environment was where they were most comfortable; having made a personal connection with Mrs B during the home visit, the staff member used communication methods with which they knew Mrs B was most comfortable (including emails and text messages); in year A and currently there are formal contracted support providers, and Taikura Trust staff actively promote engagement with these services; and Taikura Trust has an internal team supporting colleagues with guidance on how to respect and respond to cultural needs across the diverse communities and in different settings.

am concerned that two staff at Taikura Trust failed to take appropriate action when ceasing Mr B's support. Accordingly, while I acknowledge that Taikura Trust considers that the actions of its staff do not amount to systemic issues, I hold Taikura Trust responsible for their actions, which in my view were a result of shortcomings in Taikura Trust's systems and processes.

Conclusion

33. Right 4(5) of the Code states that every consumer has the right to cooperation among providers to ensure quality and continuity of services. In my view, by failing to communicate appropriately with the DHB (now Health NZ) to ensure that Mr B received the care and medical intervention that he required, and by failing to communicate appropriately, both internally and externally, to ensure that Mr B was safe and adequately supported when his supports were ceased, Taikura Trust breached Right 4(5) of the Code.

Changes made

34. The community support provider told HDC that it did not make any changes as a result of these events. However, it said that since the events, several improvements have been made that would reduce the likelihood of a similar situation occurring, including the following:

a) It changed its internal processes, and a registered nurse now completes the initial visit and service planning process, and complex clients are now managed by the referral and onboarding team with an assigned registered nurse. A risk matrix for assessing risk, and an escalation pathway to manage that risk (including escalation to a multidisciplinary team) has been implemented.

b) A specialist disability lead has been assigned to provide oversight of all disability services, and new Care and Protection guidelines have been implemented to support staff in identifying abuse and neglect.

c) A new Clinical Risk Management — Complex Case Review management process has been implemented to facilitate the management of complex, challenging cases.

35. Taikura Trust told HDC that since these events, it has made the following changes:

a) It partnered in a regional multi-agency project to develop guidelines for working with vulnerable adults, which was due for completion in December year H.

b) It is working with other health agencies to strengthen information sharing in relation to the disabled people to whom it provides support, in order to improve its health and disability outcomes.

c) Its outreach team works with the hospital discharge processes to ensure that responsibilities are clearly understood between the health and disability funders.

d) It implemented a procedure where it offers formal supports to clients while an outcome is pending, when a concern regarding funding has been referred to Audit and Compliance for investigation.

e) It is reviewing its 'exit from service' procedures.

f) It introduced specialist roles that provide daily support to frontline staff.

g) It aims to employ people with clinical skills within the service delivery teams.

Recommendations

36. I recommend that Taikura Trust:

a) Provide an update to HDC on the changes it introduced following this event, including the guidelines that were to be implemented for working with vulnerable adults.

b) Conduct an audit of 20 appropriate clients to ensure that they have been offered formal support when their support package has been under review by the Standards and Assurance team and provide HDC with the results of the audit, along with any remedial actions, within six months of the date of this report.

c) Provide HDC with an update on its 'exit from service' procedures, within three months of the date of this report.

Follow-up actions

37. A partly anonymised copy of this report, naming Taikura Trust and the advisor on this case, will be sent to DSS — Ministry of Social Development and to Health NZ, and the report will be placed on the Health and Disability Commissioner website (www.hdc.org.nz) for educational purposes.

38. I will write to MSD to highlight the learnings that must be taken from this case, including that robust systems must be in place for overseeing sole family carers.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent advice

The following independent advice was received from disability support specialist Mr John Taylor:

'**Complaint:**	Community support provider and Taikura Trust
Our ref:	21HDC01811
Independent advisor:	John Taylor ONZM

I have been asked to provide clinical advice to HDC on case number 21HDC01811. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I have the following qualifications and experience to fulfil this request. Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh. Experience: over 35 years of working within the disability sector including the following roles: direct support worker, agency management (over 20 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up a number of support agencies and disability related businesses.
Documents provided by HDC:	1. Letter of engagement from the HDC — month 12, year I. 2. Letter of complaint dated month 8, year F. 3. Community support provider responses dated month 10, year G and month 3, year H. 4. Taikura Trust's responses dated month 4, year H and month six, year H. 5. Clinical records covering the period

Referral instructions from HDC:	I have been asked to provide my opinion to the Deputy Health and Disability Commissioner as to whether I consider the care provided by the community support provider and Taikura Trust matched the expected standard of care for our sector and if not, how significant any departure was. The specific areas I have been asked to comment on are: In relation to the community support provider: 1. Whether the community support provider provided an appropriate standard of care to Mr B in month 1, year A, particularly in relation to it sending a non-health professional [staff member] to assess Mr B (who was a complex client). 2. Whether there was appropriate oversight of Mrs B's ability to provide care to Mr B in her role as his full-time caregiver, between month 1 and month 10, year A. 3. Whether the community support provider had appropriate oversight of Mr B's care in month 1, year A, particularly when his wife became his full-time caregiver. 4. The appropriateness of the overall care provided to Mr B by the community support provider, in particular whether it fulfilled its expected roles and responsibilities in its care of Mr B. 5. The appropriateness of the community support provider's cessation of services to Mr B. In particular, whether the community support provider provided an appropriate standard of care to Mr B when payments to Mrs B were stopped by Taikura Trust in month 4, year A. 6. Any other matters that you consider warrant comment. In relation to Taikura Trust: 1. The appropriateness/adequacy of Taikura Trust's initial assessment of Mr B's needs (completed in month 1, the year prior to year A).

	2. Whether Taikura Trust provided an appropriate standard of care to Mr B in month 4, year A, when payments to Mrs B were stopped. In particular, whether it was appropriate for Taikura Trust to not organise any alternative support options or re-assess Mr B's needs. 3. Whether Taikura Trust appropriately supported Mrs B in her role as Mr B's caregiver. In particular, whether respite care should have been considered/organised in light of Mrs B's concerns about her ability to cope at home with her other commitments. 4. Any other matters that you consider warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	In month 8, year F, HDC received a complaint from Dr A about the care provided to the late Mr B by the community support provider and Taikura Trust. Dr A raised concerns about the care Mr B received from month 1, year A to late year A, when Mr B passed away from sepsis due to infected pressure sores on his buttocks […]. In month 2, the year prior to year A, Mr B was left suddenly severely disabled following two [health events]. Taikura Trust completed a needs assessment, concluding that Mr B was a "complex client" with the following needs: "bathing or showering, dressing, grooming, feeding and eating, medication oversight, mobility and positioning, safety check, skin care, support and assistance, therapy exercises, [toileting] and transfers". Taikura Trust made a referral to the community support provider to provide support to Mr B with personal care, exercises, feeding and certain activities of daily living. The community support provider offered Mr B six hours of assistance per day, seven days a week, split into two visits and he required supervision 24 hours a day. In month 1, year A, Mrs B told Taikura Trust and the community support provider that she was not living with Mr B, but she was living next door. This made Mrs B eligible to receive payments from the community support provider to provide six hours a day support for Mr B. Mrs B, who was already an employee of the community support provider, became Mr B's primary carer from late month 1, year A until Taikura Trust asked her to cease this in month 4, year A.

	In month 4, year A, Taikura Trust asked the community support provider to stop Mrs B's payments while it investigated her living arrangements and they, Taikura Trust, relayed this to Mr B and Mrs B. In month 4, year A, the community support provider stopped its provision of services to Mr B on Taikura Trust's request and did not reengage with Mr B and Mrs B again. In late year A, Mr B died […].

Comments relating to Community support provider

Questions 1–4:	1. Whether the community support provider provided an appropriate standard of care to Mr B in month 1, year A, particularly in relation to it sending a non-health professional [staff member] to assess Mr B (who was a complex client). 2. Whether there was appropriate oversight of Mrs B's ability to provide care to Mr B in her role as his full-time caregiver, between month 1 to month 10, year A 3. Whether the community support provider had appropriate oversight of Mr B's care in month 1, year A, particularly when his wife became his full-time caregiver. 4. The appropriateness of the overall care provided to Mr B by the community support provider, in particular whether it fulfilled its expected roles and responsibilities in its care of Mr B.
Advisor's opinion	I have taken the first four questions together as they are closely related and overlap. In regards to the [staff member] that the community support provider sent out to assess Mr B's support arrangements, it is important to note that this person was not responsible for assessing Mr B's needs; that was done by Taikura Trust. The community support provider [staff member] was translating the needs assessment into a support arrangement. Because of this distinction, it is not standard practice within the sector to have a health professional do this work. On that basis it is my opinion that the community support provider did what was expected of them: that is send out someone who is experienced at discussing support arrangements with individuals who may have difficulty understanding how support works. I would also note that from this person's [account], Mr B was able to

communicate via his partner and daughter, understand what was happening and move around without assistance from another person. The way she described the interaction seemed to fit with expected practice.

I do not think the community support provider did provide appropriate oversight of Mrs B's ability to provide the care, 6 hours per day, 7 days per week to Mr B. The decision to have Mrs B as the sole caregiver is not good practice. I do not know who was responsible for this decision and it does indicate poor judgement and/or a lack of experience. As with many things in the disability support sector, there is no written standard relating to this situation, however experienced practitioners and managers know that assigning a single staff person to support any individual puts that support at risk. It does so because the staff person cannot be expected to always be available due to sickness, leave or other unplanned eventualities.

It is my opinion that this would be perceived by most as only a moderate departure from the expected standard of practice, which is to have a team of staff involved in a 7 day per week support package. The reason I think most peers would downgrade this departure is that it was requested by Mr B who appeared to prefer to have no formal support than support by strangers.

My personal opinion though is that this is a significant departure from good practice and was a contributing factor in Mr B being left without support once Taikura Trust requested that Mrs B no longer support him due to questions about her living arrangements.

I read no evidence of the community support provider providing any oversight of the care Mr B received. Their response was that they would not usually intervene without due cause such as a complaint or request from the client in question or their next of kin. This is again a very poor practice but it is one that is common within Home and Community Support Services providers because of, as the community support provider noted, the paucity of funding and other contractual requirements they receive for this work. Providers of Home and Community Support Services are not paid sufficiently to provide the level of oversight that should be available to the people they support.

Nevertheless the industry standard would be to have some direct feedback on the support situation and this does not appear to have happened. I suspect their peers would have only seen this as a minor to moderate departure from the expected standard given that the support situation only continued for about 10 weeks during the period in question.

	Overall, I think the support provided would be considered by most of the community support provider's peers as being within the general bounds of acceptability. That is they (the community support provider) delivered the support hours as contracted to; employed a person suitable to the client, turned up every day and there were no complaints. It is not a very high standard, but it is how things are for disabled people within the current system. I was encouraged to read that the community support provider has invested in a better system for recording work as it is done and have improved their risk analysis process so they can be ahead of similar issues in the future.

Question 5.	The appropriateness of the community support provider's cessation of services to Mr B. In particular, whether the community support provider provided an appropriate standard of care to Mr B when payments to Mrs B were stopped by Taikura Trust in month 4, year A.
Advisor's Opinion	It is my opinion that the community support provider did exactly what they were required to do under their contract when they were asked to cease support by Taikura Trust, the funder. Providers, if they wish to be paid by the Ministry of Health (as it was in year A), were (and still are) required to only support those people they have a valid service agreement for from the funder (NASC). If they work outside of this arrangement then they do so at their own expense. In this system the NASC is acting on behalf of the client when it contracts a provider. The NASC works out with the client what support they need, the frequency and extent of support and they assist the individual to select a provider to carry out that support. Further to these understandings, the community support provider was told by Taikura that Taikura would follow up with Mrs B and work out with her alternative support options if the housing arrangement could not be satisfactorily clarified.

Further comments relating to the community support provider

I have only two brief, additional comments to make. Firstly, [the services] were contracted by the Ministry of Health with an extremely transactional view of the work to be done. It was poorly funded and required providers to maximise numbers of clients to be able to afford any sort of infrastructure. As such, there were, and frankly still are, plenty of gaps for people to fall through. Enabling Good Lives and the way funding is shaped through that lens is designed to overcome many of the inadequacies of the previous, and current dominant, system.

Secondly, one of the responses the community support provider made to an HDC request seemed strange to me. HDC asked to see clinical records for Mr B. The community support provider responded that it was not a medical provider and therefore did not have clinical records. This displays a slightly disturbing ignorance as to what clinical records are. For clarity, within the disability support system, clinical records comprise the following, and are a critical element of good, safe support.

1. Personal Information: This includes the individual's name, date of birth, address, contact information, and other demographic details.
2. Care/support Plans: Customised plans outlining the specific care needs and support requirements of the disabled person. This may include details about assistance with activities of daily living (ADLs), mobility, communication, and other aspects of support.
3. Health Assessments: Regular assessments as required.
4. Medical History: A detailed account of the individual's medical conditions, diagnoses, and treatment history.
5. Medication Records: Information about prescribed medications, dosage, frequency, and any observed side effects.
6. Communication Records: Documentation of communication between healthcare professionals, caregivers, and the individual, including discussions about care preferences, treatment decisions, and any concerns raised.
7. Incident Reports: Records of any accidents, incidents, or changes in the individual's condition that may impact their care.
8. Progress Notes: Regular notes documenting the day-to-day care provided, observations of the individual's well-being, and any modifications to the care plan. (This is the piece that the community support provider demonstrably lacked for Mr B's support.)
9. Consent Forms: Documentation of informed consent for specific treatments, interventions, or services provided.
10. Emergency Contact Information: Contact details for individuals to be notified in case of emergencies.

Comments relating to Taikura Trust

Question	The appropriateness/adequacy of Taikura Trust's initial assessment of Mr B's needs (completed in month 1, the year prior to year A).
Advisor's opinion	I do not have enough information to be confident in my ability to assess this; however, on the face of it, the initial assessment done by the needs assessor appears to be adequate to me. Where the assessment falls down is in the lack of coordination with the DHB. Clearly Mr B needed support arranged from two different sources, as acknowledged in the NASC assessment, but there is no evidence that either took the lead to ensure that he did not fall between the cracks. This is not necessarily the fault of Taikura Trust unless they have no policy to guide them in ensuring this connectivity can be arranged. No such policy was offered in the material I read and its absence, if it is absent, would constitute a severe departure from the expected standard as it can leave people vulnerable. As it did in Mr B's case.

Question	Whether Taikura Trust provided an appropriate standard of care to Mr B in month 4, year A, when payments to Mrs B were stopped. In particular, whether it was appropriate for Taikura Trust to not organise any alternative support options or re-assess Mr B's needs.
Advisor's opinion	The [staff member] involved writes that they visited with Mrs B and everything looked like it was going well. During the conversation it became apparent that Mrs B was using some of the hours inappropriately and was being paid to support Mr B in contradiction to the Ministry of Health Funded Family Care (FFC) guidelines. In response to this the [staff member] reduced the support package by 50% and told both Mrs B and the community support provider that Mrs B cannot be paid to support Mr B. The [staff member] then instructed the community support provider to cease support for Mr B as of month 4, year A. This is a severe departure from the expected standard of service for three reasons. I am not a NASC peer but I have checked this with a NASC colleague (without any details of the parties involved) who managed NASC services for […] for 6–7 years. She confirms my view on this. The first severe departure is related to the standard for duty of care which

is to never remove support if it could put a person at risk until another option has been agreed and is available. The [staff member] did not do this. Instead she instructed the community support provider to cease support and then did not guarantee an alternative safe option for Mr B.

The second severe departure was in the poor communication process the [staff member] followed during this time. There are two parts to this.

Firstly, the [staff member] asked Mrs B for proof that she did not live with Mr B. Mrs B provided this via an email with a photo attached. The photo was of a letter from [organisation] dated month 11, the year prior to year A addressed to Mrs B at […]. This information conflicted with the information the [staff member] received from the service provider. They further checked this with Mrs B who said that the address was the one she was at in [month]. The [staff member] did not accept this explanation and proceeded to direct the community support provider to cease support of Mr B.

Given that the [staff member] now had both Mrs B and the community support provider offering evidence that Mrs B did not live with Mr B, it seems incredible that the [staff member] continued in their action of ceasing service on the grounds that Mrs B did live with Mr B prior to further investigation. They should have proceeded with the presumption the evidence was correct, not on the presumption that their assumption, based on no evidence, was correct.

Secondly, the [staff member] commented in their [account] that they "contacted the service provider again … I indicated other options would need to be put in place and by this I meant that the service provider would need to make arrangements for other paid carers." This is in stark contrast to my reading of the email that they sent to the community support provider which is copied below.

Sent: Month 4, year A.

To: J

Subject: Supports to be put on hold

[…], Mr B

Hi J,

As discussed the supports for this client are to be put on hold until the worker sends me documentation that shows that she is not at the same

address as the client. I will also speak with her in regards to other options, if she is not able to do this e.g. find another person

Nga mihi

[…]
[Staff member]

The message here is clear I think. The [staff member] is instructing the community support provider to cease support and is taking responsibility upon themselves to progress this situation to a safe conclusion.

The third area where the [staff member's] actions fell severely short of the expected standard relates to the Funded Family Care (FFC) decision. The [staff member] cancelled Mr B's support because they decided that Mrs B was living with him and therefore was precluded from being a paid carer under the FFC guidelines. Even if Mrs B was living with Mr B, the guidelines allow for exceptions for exactly this type of situation.

5.1 of the FFC guidelines allow for exceptions when:

- There is significant risk to the safety or well-being of either the disabled person or a non-family/whānau carer if the chosen family/whānau carer is not employed to provide the disability supports (e.g. evident distress to the disabled person caused by alteration of routine and changes of carer); and
- Specific cultural considerations … may be a contributing factor when considering an exception on other grounds.

Some other NASCs that I know of routinely used these exceptions to ensure people's needs were met in a way that was physically, culturally and spiritually safe for them. Either the [staff member] acted outside of Taikura Trust guidance on this or Taikura Trust did not have a sufficiently person-centred approach to allow for safety ahead of an inappropriate legalistic adherence to the letter of the law.

I should also note that the [staff member] appears to have discussed this situation via email with [another staff member] who did not offer any advice that her actions might have been ill-considered. Instead, this person agreed to pass on the situation to the Trust's Audit and Compliance Investigators, and then "forgot" to do this for a further 6 weeks.

Based on this latter point, and on the responses sent to the HDC from the Trust's CEO, it is my opinion that this reflects a process and cultural issue within Taikura Trust rather than just a single [staff member] doing a poor

	job.

Question	Whether Taikura Trust appropriately supported Mrs B in her role as Mr B's caregiver. In particular, whether respite care should have been considered/organised in light of Mrs B's concerns about her ability to cope at home with her other commitments.
Advisor's opinion	It is my opinion that the [staff member] significantly overstepped the bounds of what a NASC worker should involve themselves with regard to Mr B and Mrs B. The NASC is responsible for a needs assessment and then arranging for other agencies to provide the support. One would not expect a NASC worker to get involved in the way the [staff member] did. That is, suggesting that they would work out with Mrs B options for doing the support when there was an agency already contracted to do this. This overstepping appeared to have caused a breakdown in who was responsible to ensure Mr B received support and, ultimately, led to him not receiving support. The [staff member], as mentioned earlier, made some very strange decisions in this case. One was in their reducing both the hours of support, and ultimately stopping all support, and removing respite as an option for Mrs B. The former was on the basis that Mrs B lived with Mr B, which should have meant that Mrs B was then entitled to the latter. It makes no sense that both options would be removed and demonstrates again a severe departure from the expectation of a NASC to ensure that support was available to keep people safe and adequately supported.

Additional Comments relating to Taikura Trust
I suspect that Taikura Trust was operating in a very transactional way with their clients and, quite possibly, were not well resourced enough to operate at an appropriate level. There is nothing in the documents I read that indicates they have moved beyond this state yet and I would suggest they undertake some significant development of their operating policies to better match the current expectation of disabled people and their families being in charge of their support.'

Further advice received from Mr Taylor:

'I have been asked to provide additional advice to HDC on case number 21HDC01811 in response to further communication from both the community support provider and Taikura Trust. I will take each of these in turn.

The community support provider has responded to my previous comments with general agreement but three specific disagreements.

1. They "strongly disagree with Mr Taylor's suggestion that the appointment of a sole caregiver in Mr B's circumstances was a significant departure from good practice."

I do have sympathy with this view given the levels of funding and contractual expectations. I would respond though that pragmatics should not determine good practice. The community support provider has quite correctly ensured the wishes of the individual have been recognised. The question is: is that sufficient?

As professionals in the area of support, it is our responsibility to alert people to any risks inherent in the decisions they make. This is not to say that we override their decision, but that we work with them to find ways to reduce the risk we foresee. At the very least, we inform them of the possible risks so they have additional information on which to operate.

A laissez faire approach of "it is what the person wanted" and/or "it is not required by contract," or even "it is standard industry practice" is not adequate for good practice. Their response does not alter my previous opinion.

Having said that, I do applaud the community support provider for working around the system as it was to attempt to have culturally and personally acceptable support for Mr B.

2. Lack of oversight.

I commend the community support provider on the changes it has made to improve this area. In the context of supporting [a large number of people] within a very constrained budget, it is easy to see how oversight may only occur as deemed necessary by "red flag." Nevertheless, I would comment that getting support right from the start is critical to its success over time so a process where early support is checked and potentially modified is necessary to good practice. However, as I noted in my original advice, this is likely to be considered a minor to moderate departure at worst and they had provided evidence of an improved system.

3. Clinical records

I am happy to consider this a language disconnect. However, for worker and client safety, progress notes are essential. These can be as simple as a checkbox to a few critical questions or standard outcomes. Without these, there is no record of the interventions taken which, as has happened previously, could leave staff and organisations open to unnecessary critique.

Taikura Trust

In their covering letter, Taikura Trust gave a very good outline of what went wrong and how they have improved their systems to avoid any repeat of this situation. I recognise that this is very good progress and congratulate them on what they have achieved. In relation to specific responses they made, as with the community support provider above, I have responded separately to each of Taikura Trust's responses.

1. Coordination with the DHB.

Taikura disagrees with my comments and, among other things, says: "Taikura does not agree with Mr Taylor's statement that the assessment by the needs assessor exhibited a lack of coordination with the District Health Board."

To be clear, I was not trying to single out the needs assessor for blame and I apologise if that was how my comment was taken. However, despite all the processes Taikura has now said they have done to ensure connectivity between what they fund and what the DHB provides, the fact remains that the connectivity clearly did not happen.

There is no record of Mr B receiving the DHB support he appeared to need, and this is a substantive failing. Good intent and assumptions are insufficient. Given no new evidence was provided to say that there had been any actual coordination in Mr B's situation, I still consider this a severe departure from the expected duty of care.

2. Ceasing payment to Mrs B

Taikura generally accepts the criticism made here but they do appear to also claim that the [staff member's] intent should have driven what occurred and not what they wrote. The [staff member's] instruction to cease service provision seems entirely clear to me from the evidence provided. That they "intended" it to be understood differently is irrelevant and it is unhelpful of Taikura to now suggest that their intent should have been understood in contradiction to what they said and wrote.

Later on in this section Taikura comments, in relation to the funded Family Care: "Mr Taylor is correct that an exemptions process did exist, however Mr Taylor is not correct that it should have applied to Mrs B."

Then: "Spouses were not eligible to be an exception at the time that Mr B received services through Taikura."

And finally: "At the time that the MOH commenced its review of the PFC policy in around 2009, there were approximately [a number of] people in Auckland supported through Taikura who had these exceptions in place. This included family members who were spouses and partners."

I am unclear what all this means. It appears to me Taikura is saying both that Mrs B could not be paid because she was a spouse AND that up to […] other people were being paid even though they were spouses. Either way, I do not think it answers my critique, nor the

evidence offered by the NASC manager I checked in with about the available options and the fact that many NASCs worked outside of the rules to ensure safety.

The central issue here, as I understand it from the original documents Taikura gave the HDC, was that it was about whether or not Mrs B cohabited with Mr B. Despite Mrs B's assurances that she did not, the [staff member] treated her as if she did. This still stands out to me as the pivotal point where things went wrong and has not been addressed by Taikura Trust in its latest information nor in its earlier information. For this reason I still consider this a severe departure from their duty of care.

3. Arranging respite and other supports.

Again, generally Taikura accepts my comments here. One of their comments though stands out as curious.

"41. Taikura believes it is relevant to consider Mr Taylor's observation in the wider context of the cares and support available to Mr B in relation to all his needs. It was reasonable for the [staff member] to assume that as well as receiving natural supports he was also receiving regular support from Health services both from the DHB and in the community. On that basis it is not accepted that it was foreseeable that by Taikura putting funded disability services on hold, Mr B would receive no supports at all."

The [staff member] did not need to "assume" this at all. All they needed to do was check with the family as to whether or not these "natural supports" and DHB services were in place. They didn't do that and I consider it careless that they would, if indeed they did, make an assumption about DHB support without checking.

I hope Taikura Trust's continued claim that assumptions of this nature are reasonable does not indicate that they are failing to amend their processes to check other supports a person may require are, in fact, happening.

4. Additional comments I made.

I am pleased that Taikura's position is that funding should not be the only determinant to quality. I fully support this view while recognising that funding still does play a part.

I am further heartened with Taikura's description of the current service pathway and how that has evolved over the past […] years. This information was not initially presented and I am pleased that they have clarified their progress.

Name: John Taylor ONZM

Date of Advice: month 4, year I.

Further advice received from Mr Taylor

'**Introduction**

This response is the third I have provided for this case and has been prompted by a review Taikura commissioned from an external reviewer (External Review — month 8, year I). The original report I wrote was dated month 12, year H. I then wrote a second report based on feedback from Taikura and the community support provider dated month 4, year I..

In my original report, the main departures from the expected standard of care I perceived with Taikura's practice were:

1. That they appeared to have no policy to guide them in ensuring connectivity with the DHB for a person who required both parties to assist in their support.
2. That there was a severe departure from the expected standard of care related to their duty of care: that is to never remove support if it could put a person at risk until another option has been agreed and is available.
3. That there was poor communication between the NASC and the client and their family.
4. That the Funded Family Care (FFC) could have been interpreted more generously, and finally,
5. That the [staff member] significantly overstepped the bounds of what a NASC worker should involve themselves with regard to Mr and Mrs B by saying they would arrange a different service.

Since the event that prompted this complaint took place Taikura has worked to improve its service pathway, which they articulated in their further response of month 4, year I.

The External Review

This review was looking at Taikura's practice in relation to my original report and to another report referred to as "the External Report," which I have not cited.

The External Review assessed Taikura Trust's compliance with the Ministry of Health contract (particularly the 1994 version) as its primary focus. It appears to be quite literal in its interpretation and did not consider person-centred outcomes, best practice expectations, nor the accepted standard of care. It showed no alignment with the principles of Enabling Good Lives and the broader aspirations of the Disability Strategy that were operating at the time.

This means it does not really impact many of my comments since, in my view, contractual minimums, especially ones that were over […] years old at the time, do not determine good practice. Neither do they provide the limits of what becomes the expected standard of care in any area of practice as learning and development improve our responses over time.

Below, I will briefly discuss my responses to the External Review on each of my major critiques from the original report.

1. That they appeared to have no policy to guide them in ensuring connectivity with the DHB for a person who required both parties to assist in their support.

On page 6 of the External Review it says in relation to this comment: "The policies and process used by Taikura Trust have not been reviewed as part of this process. It is of note that the MoH have quality and audit processes in place to ensure the NASC's have policies and processes in place to meet the MoH contracted requirements."

Essentially the author of the review appears to be saying that this comment was outside of his scope while implying that whatever is or isn't there will be OK since it is audited to meet contractual requirements.

Again I would reiterate that contractual requirements do not set out the limits of the expected standards of care. When one is working with a person that has been deemed "complex" it is reasonable to expect a higher level of due diligence than might be usual practice. I would also add that Taikura has since this event taken very useful measures to ensure better connectivity between services.

2. That there was a severe departure from the expected standard of care related to their duty of care: that is to never remove support if it could put a person at risk until another option has been agreed and is available.

NB: This particular standard of care was provided to me by the NASC manager I consulted with. It was their view that this was the standard of care operating at the time and was neglected in the Taikura process. (In response to the External Review's author's question, the person I consulted was a manager of NASCs during the time in question and with sufficient experience to adequately comment.)

I reached out to another very experienced NASC manager to check this original view. This person confirmed the advice I had been given, that is that services should never be removed without an alternative being in place.

This seems an eminently sensible standard and in their previous response to my initial report Taikura generally accepted this criticism. The main comment they made was that they thought that the intent of the [staff member] should have driven the outcome rather than the text of the email they sent.

The Reviewer did not contend it either but instead, the Reviewer placed great weight on the "spouse" status of Mrs B as being central to the defence of Taikura's actions (he mentions it over 20 times). Essentially the Reviewer's view appears to be: Mrs B was never eligible to be paid to support Mr B and therefore, by taking away the support and not considering FFC merely returned things to how they should have been in the first place. Further, according to the Review, it was Mrs B's lack of response to emails that was the cause of no service.

> "The effectiveness of service coordination and the allocation of appropriate services is reliant on the accuracy of information given by the disabled person and their family.

> The Standards for Needs Assessments for People with Disabilities 1994 outlines the responsibilities of the disabled person to "provide full and accurate information so that the best possible needs assessment can be done."
>
> "There is conflicting information on where Mrs B was living, this is central to decisions relating to service co-ordination."

These comments from the Reviewer led me to reflect upon the cultural accommodations that I would have expected to observe and didn't.

I checked with a […] colleague and three people experienced in working with people [from the same] country Mr and Mrs B were from. The advice I received was:

1. In relation to this couple's marital status (which is unclear given the differing accounts): It is entirely plausible that people of that age, who came from the [country], would describe themselves as married to avoid stigma and make dealing with NZ authorities easier.
2. In relation to the lack of response to voice messages, emails and texts: That people of their profile would not necessarily respond in a New Zealander's idea of a timely way to emails or phone calls. They may not respond at all as they may not perceive the need to.

I see no cultural accommodation made in any of the ways they were dealt with at the time nor in the Review.

Were the services ceased?

The Reviewer and Taikura have both claimed that the services were not ceased because they were kept open in the system. (Again, it is possible the Reviewer did not have access to the following evidence although, given these are Taikura emails, he should have.)

Taikura commented in their response of month 3, year I that: "However, it should be noted that their instruction to the community support provider to cease support referred to the community support provider ceasing to pay Mrs B for Mr B's support. The [staff member] did not cancel the supports for Mr B at this time. They remained active with the community support provider in the national client information system until month 1, year B.."

Likewise, the Reviewer stated: "Taikura Trust did not discharge Mr B from service until month 1, year B.." This is both true and ignores the evidence that services effectively ceased when they were required to stop in month 4, year A. .

Email from the [staff member] to the community support provider in month 3, year A:

> "Please find attached the service authorisation for the above-named client. Please note: as of month 3, year A, the supports will be reduced to 21hrs per week. … Also, please notify the worker that we require confirmation that she does not live at the same

> address, as the client. If this is not received before the end of month 3, year A, **then the current support will cease**" (emphasis is mine).

In an email to "Mrs B" in month 4, the year prior to year A:

> "Hi Mrs B
>
> I have not received any documentation to show that you live at a different address to Mr B. As you are aware, **his supports will cease** as of this Sunday month 4, year A. I will be speaking with the provider in regards to this." (emphasis is mine)

And finally, an email to the community support provider early month 4, year A:

> "Hi,
>
> As discussed **the supports for this client are to be put on hold** until the worker sends me documentation that shows that she is not at the same address as the client. I will also speak with her in regards to other options, if she is not able to do this e.g. find another person." (emphasis is mine)

All three emails clearly state that "supports" will cease/be put on hold from month 4, year A and this was acted upon regardless of both the [staff member's] intended message and whether the support was removed from the system.

3. That there was poor communication between the NASC and the client and their family.

The Reviewer, on numerous occasions, says the poor communication was due to Mrs B not responding to emails and phone calls. As per my previous comments, I suspect some of this at least is due to a cultural mismatch. (Below I comment on whether these communications should have been happening.)

4. That the Funded Family Care (FFC) could have been interpreted more generously.

The author of the External Review essentially says of these that Mrs B should never have received any funding/payment for the support she offered in the first place so removing it was just correcting an original mistake. That the family failed to communicate adequately and that FFC was never an option.

In my original advice the NASC manager was very clear that this should not have presented a significant barrier. Taikura also seemed to hint at that in their response to my original advice. They commented that over […] people received FFC including spouses.

The second NASC manager I consulted was, as with the first one, equally clear that the FFC guidelines should not have presented a barrier. In their words: "the prime focus was and should always be, what is best for the disabled person. If a […] person wanted a particular family member to support them then we found a way to make it happen."

In summary then, for the four sections above, I can say that my opinion has not changed other than I would now add in that there appears to have been a significant departure from the expected standard of care to accommodate people of different cultures.

5. That the [staff member] significantly overstepped the bounds of what a NASC worker should involve themselves with regard to Mr and Mrs B by saying they would arrange a different service.

Based on comments from the Reviewer and previously from Taikura, I accept that I worded this criticism incorrectly. It is within the role of the [staff member] to look for other options.

What prompted my comment was that the [staff member] essentially took over the work of the support agency. They were attempting to directly manage an employee of the support agency, namely Mrs B.

The appropriate action for them to undertake, in my opinion, was to let the support agency know of the problem they observed and then request that they rectify it by either finding a different support person or confirming the living arrangements of Mrs B.

This isn't what happened as can be seen from the emails quoted above and, as a result, led to the Taikura [staff member] placing themselves in the middle of the contracted support. If they had not positioned themselves there then the whole communication issue would not have occurred. It would have been the employer who had the communication with Mrs B and, as an employer, they would have had better mechanisms or processes to ensure a response.

Final Comment

The Reviewer points out, quite correctly in my case at least, that neither my report nor the External report were written by people who have expertise on NASC processes. However, to redress this I consulted two very experienced NASC managers. They both offered a view that is contained in this report and which differs from that of the Reviewer and that of Taikura.

The main point I think that is missed in the External Review Report, due to the Reviewer's strictly literal interpretation of the documents, is that any process the NASC uses needs to, and needed to then, align with a broader outcome framework. I don't have access to the Service Specification that was operating in year A but the Service Specification for NASC of year C, and every other Service Specification I have seen, commences with a paragraph or two outlining these overarching outcome statements. It is the fit between the actions taken and the desired outcomes that I have focused on.

Yours faithfully

John Taylor ONZM'