Follow-up report

A follow-up report on government progress completing recommendations for change to the collection, use, and reporting of information about the deaths of people with intellectual disabilities

Ombudsman
Kaitiaki Mana Tangata

July 2026

Off the record: A follow-up report on government progress completing recommendations for change to the collection, use, and reporting of information about the deaths of people with intellectual disabilities

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Why this report? Why now?

Our original investigation

In 2018, serious concerns were raised with us about the recent deaths of a group of people with intellectual disabilities receiving full-time residential support. The concerns primarily related to a lack of visibility surrounding the deaths. There were questions about whether the appropriate people and agencies were being informed and the necessary enquiries made, particularly following a sudden or unexpected death. There was a sense from those who contacted us that the deaths of these people were not seen as important and had been overlooked, including by the Ministry of Health.

That year we launched an investigation into how the Ministry of Health (Ministry) recorded and reported the deaths of intellectually disabled people in full-time residential support. We did this because we were concerned about the treatment and care of a vulnerable population of New Zealanders.

People with intellectual disabilities have poorer health outcomes and shorter life expectancies than those without intellectual disabilities, despite having higher than average contact with the health system.

At the time of our investigation, the Ministry was responsible for leading New Zealand's health and disability systems, funding, purchasing, and monitoring disability support services for more than 6000 intellectually disabled people.

As with any government service, the effective use of quality data is foundational to supporting quality health care and improving lives. For marginalised groups like intellectually disabled New Zealanders, good administrative practice and data/information management, and alignment with international conventions including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), is a requirement.

Our investigation into the Ministry's policies and practices focused on the Ministry's systems of information collection, analysis, and reporting in relation to the deaths of people living in facilities run by district health boards (DHBs) and non-DHB providers. At the time, Disability Support Services was the Ministry's responsible agency.

What we found

When we released our report,[1] *Off the Record: An investigation into the Ministry of Health's collection, use, and reporting of information about the deaths of people with intellectual disabilities* in 2020, the final opinion was that:

> *for the period under review, the Ministry's systems for the collection, use, and reporting of information about the deaths of people with intellectual disabilities receiving residential support, and associated record keeping, were unreasonable.*[2]

We identified several issues with how the Ministry collected, stored, used and reported information.

We found the Ministry's arrangements for collecting information about the deaths of its service users were not adequate or robust. The Ministry's systems and processes did not support the collection of information that was complete, accurate, or sufficient. They did not provide a sound basis for staff to determine whether there was a need for further enquiry or other follow-up actions. In the absence of clear guidance for staff, the follow-up that did occur appeared to have been limited and inconsistent.

To compound matters, there was no internal audit process that might have identified these issues, and record keeping was not adequate. Significantly, there was no evidence to indicate the information the Ministry collected, or should have collected, was used to inform its own service or policy development or shared with residential support providers in ways that might support their quality improvement efforts.

1 During our investigation, the Ministry implemented several changes to improve its administrative processes, which we took into account when making the final opinion and recommendations.

2 See link Off the Record: An investigation into the Ministry of Health's collection, use, and reporting of information about the deaths of people with intellectual disabilities | Ombudsman New Zealand p.12

We made ten recommendations[3] to the Ministry of Health to address our concerns, related to data collection and matching, death notification processes, auditing, information management systems, and senior leader oversight. The Ministry accepted these, and with the support of Te Tāhū Hauora | Health Quality & Safety Commission and The Chief Archivist, committed to ongoing improvements to implement each recommendation to ensure best practice.

Why we're following up now

We monitored Ministry of Health's progress addressing the recommendations through to June 2022. The final communication from the Ministry reported six completed recommendations, and four still in progress.

Since that last update, there have been a number of significant changes to disability support service provision and oversight, all of which have bearing for the agency with responsibility for oversight of the conditions for intellectually disabled people in residential care.

In light of these changes, we wanted to ensure the importance of the recommendations made in *Off the record* to improve outcomes for people with intellectual disabilities receiving full-time residential support had not been lost sight of. This report assesses whether our recommendations have been fully implemented.

Sector changes

In late 2021, the incumbent government announced the establishment of a new ministry within the Ministry for Social Development (MSD), to bring together functions and services supporting disabled people under one umbrella. Whaikaha | Ministry for Disabled People was formally stood up on 1 July 2022.

3 See link Off the Record: An investigation into the Ministry of Health's collection, use, and reporting of information about the deaths of people with intellectual disabilities | Ombudsman New Zealand p.15

This new ministry took over functions previously delivered by the Ministry of Health's Disability Support Services—the ministry subject to our original investigation.

However, the scope of responsibilities, coupled with legacy issues and funding challenges, resulted in uneven delivery and performance issues for Whaikaha. Cabinet decisions resulted in funding restrictions and an Independent Review in 2024 to determine what steps should be taken to ensure Whaikaha's ongoing sustainability. In August of 2024, Cabinet announced Whaikaha would be restructured and its remit narrowed, and MSD would assume the role—through its Disability Support Services (DSS) unit—of overseeing disability support services delivery and quality assurance.

With these changes, responsibility for robust administration of support services and oversight for people with intellectual disabilities receiving full-time residential care shifted between ministries to its current home with DSS at MSD.

Royal inquiry into abuse in care

New Zealand's Royal Commission of Inquiry into Abuse in Care was an in-depth inquiry into the experiences of children and young people in state and faith-based care settings between 1950-1999. As part of its remit, the Commission looked at the experiences of disabled people and recorded their experiences of institutionalisation and pathologisation, ablism and stigma, abuse and neglect. Findings, recommendations and lessons learned—released in June 2024—have further informed DSS's improvement work, including in the area of information management.[4] This was also a significant focus of our investigation (see recommendation 9).

4 See link Recommendations | Abuse in Care - Royal Commission of Inquiry: See recommendations 39 and 40, and 41.

How we assessed the Ministry's response to our recommendations

Because of the rehoming of disability support services delivery and quality assurance, it was timely to follow up with DSS, the new oversight agency, to determine whether all our recommendations had been fully implemented.

At the end of 2025 we wrote to Ministry of Health, Whaikaha, and Ministry of Social Development requesting information on progress towards the completion of our recommendations. DSS provided a fulsome response to our query, outlining progress made to date, and ongoing improvement work. We reviewed this response against our recommendations and monitoring updates to determine progress and completion.[5]

We asked Ministry for Social Development to comment on our summary report, and to give the Ministry the opportunity to provide any further updates since our initial request for information in September of 2025. A summary of their response is included within the body of this report. Their full response is included in the last section.

5 We operate a high trust model when monitoring the implementation of recommendations. We rely on agencies to provide honest, transparent responses to our inquiries that they have implemented recommendations.

What we found

Despite changes in responsibilities, most recommendations have been met, and there are improvements in the collection, use, and reporting of information about the deaths of people with intellectual disabilities receiving residential support, and associated record keeping.

Two recommendations are outstanding, one of which is important for ongoing good practice.

Progress on recommendations

Recommendation 1: Complete

Review the system recently introduced by the Disability Directorate to cross-check its data with Mortality Collection data to ensure this includes information received from the coroner, including final coroners' findings.

Recommendation 2: Complete

Review the implementation and operation of the 'Death notification and management' SOP introduced on 1 July 2019, including its operation with respect to disabled service users living in aged residential care facilities, and service users in hospital level secure services.

Recommendation 3: Complete

Review and amend the death notification form to ensure it captures sufficient relevant information from providers following a death, in the context of Ministry's role and responsibilities.

Recommendation 4: Complete

Undertake an audit of Disability Directorate records for a sample of the last 20 deaths notified to the Ministry between 1 July and 31 December 2019 to ensure that in accordance with the new SOP and good administrative practice:

a. appropriate steps are being taken to identify and manage any quality issues;

b. relevant feedback is shared with providers; and

c. the necessary records are being made and stored.

Recommendation 5: Complete

Establish a process for ongoing audits of Disability Directorate records for a sample of deaths on an annual basis.

Recommendation 6: In progress

Develop a comprehensive, robust, and durable plan to engage with and support providers and other relevant stakeholders, including service users (through representative bodies/organisations), in order to:

a. ensure an appropriate level of review is undertaken following the deaths of all people with intellectual disabilities receiving Ministry-funded residential support;

b. ensure provider reviews are routinely supplied to and reviewed by the Ministry;

c. establish mechanisms for review learnings to be shared with providers and other relevant stakeholders;

d. ensure the Ministry's expectations in relation to provider reviews are reflected in its contracts/service specifications; and

e. explore options for establishing, in the longer term, a national independent review system.

Recommendation 7: Complete

Engage and work with the Health Quality & Safety Commission to explore options for supporting providers to improve the quality of experience and the safety of the care and services their residents receive. This will be achieved through reporting, reviewing, and learning from adverse events and near misses, including by increasing compliance with the National Adverse Events Reporting Policy among non-DHB providers, and through supporting quality improvement projects to effect change.

Recommendation 8: Complete

Confirm arrangements for undertaking in-depth analysis of information about the deaths of service users (eg when and how often this will occur), and information from critical incident reports, and utilising that analysis to inform future policy and practice.

Recommendation 9: In progress

Consider what actions can be taken to develop and implement an improved information management system that better supports Disability Directorate staff to capture, store, access, and utilise relevant information, and compliance with the Public Records Act 2005.

Recommendation 10: Complete

Review the measures currently in place to ensure relevant senior leaders have sufficient oversight of operational practice in relation to the Ministry's expectations and obligations following the death of a disabled service user.

Assessment of the implementation of our recommendations

Recommendation 1:

Review the system recently introduced by the Disability Directorate to cross-check its data with Mortality Collection data to ensure this includes information received from the coroner, including final coroners' findings.

Progress: Completed

Ombudsman's comments

DSS confirmed this work was completed by Ministry of Health prior to Whaikaha being stood up.

As part of DSS's internal audit process, it now conducts monthly quality assurance reviews, including checks of the 'master death log' against the national mortality collection, as well as assurance checks of provider information to validate reporting.

We are also pleased to see DSS has taken the additional step of registering with the Coroner as an interested party on individual deaths, and that this process is now part of the DSS's Standard Operating Procedure (SOP).

Recommendation 2:

Review the implementation and operation of the 'Death notification and management' SOP introduced on 1 July 2019, including its operation with respect to disabled service users living in aged residential care facilities, and service users in hospital level secure services.

Progress: Completed

Ombudsman's comments

The Ministry of Health's SOP was updated within our monitoring period. However, DSS continues to review its SOP to ensure it reflects best practice and the needs of the disability sector.

At the time of reply, DSS was engaged in aligning its critical incident reporting with Te Tahu Hauora | Health Quality & Safety Commission's (HQSC) Severity Assessment Code (SAC) ratings to ensure consistency of reporting across government agencies. DSS noted ongoing organisational changes that also require SOP adjustments.

It is important SOPs are under regular review to ensure they meet the requirements of the day, and we are pleased to see DSS has a schedule of ongoing improvement work in this area.

Recommendation 3:

Review and amend the death notification form to ensure it captures sufficient relevant information from providers following a death, in the context of Ministry's role and responsibilities.

Progress: Completed

Ombudsman's comments

This work was completed within our monitoring period. Whaikaha communicated intentions to further strengthen information gathering and develop IT systems to store these data, though what work was completed is not clear.

Although DSS does not consider this recommendation within their purview because it was completed during our monitoring period, a schedule of regular review of this information gathering tool, and its integration into electronic data collection, would have merit.

Recommendation 4:

Undertake an audit of Disability Directorate records for a sample of the last 20 deaths notified to the Ministry between 1 July and 31 December 2019 to ensure that in accordance with the new SOP and good administrative practice:

a. appropriate steps are being taken to identify and manage any quality issues;

b. relevant feedback is shared with providers; and

c. the necessary records are being made and stored.

Progress: Completed

Ombudsman's comments

This work was completed within our initial monitoring period.

Recommendation 5:

Establish a process for ongoing audits of Disability Directorate records for a sample of deaths on an annual basis.

Progress: Completed

Ombudsman's comments

This work was completed within our monitoring period, and the Ministry of Health conducted several audits within this time.

Since DSS assumed oversight, DSS has transitioned from an annual audit of deaths to an ongoing review approach whereby deaths are continually monitored and reviewed by staff as they come in. DSS undertakes a monthly audit to ensure it meets recommendation 5.

This approach allows DSS to have timely information regarding deaths and critical incidents, which in turn supports decision making regarding whether a death in care should be further investigated or the provider audited.

Four issues-based audits were conducted after 2022, under Whaikaha's auspices. However, despite DSS now reporting monthly figures relating to deaths in residential care, there appear to have been no new investigations or issues based audits commissioned into deaths or critical incidents that have occurred under DSS's oversight. We note the two 'interested party' registrations with the coroner (see recommendation 1), however. We look forward to ongoing reporting on the effectiveness of these new approaches to reporting with respect to identifying matters of concern that require review.

Recommendation 6:

Develop a comprehensive, robust, and durable plan to engage with and support providers and other relevant stakeholders, including service users (through representative bodies/organisations), in order to:

a. ensure an appropriate level of review is undertaken following the deaths of all people with intellectual disabilities receiving Ministry-funded residential support;

b. ensure provider reviews are routinely supplied to and reviewed by the Ministry;

c. establish mechanisms for review learnings to be shared with providers and other relevant stakeholders;

d. ensure the Ministry's expectations in relation to provider reviews are reflected in its contracts/service specifications; and

e. explore options for establishing, in the longer term, a national independent review system.

Progress: In progress

Ombudsman's comments

Completion of this recommendation was interrupted by COVID and establishment of Whaikaha. Whaikaha's plan to engage the community was again interrupted by the sector restructure.

However, DSS has since engaged with providers and the disability community in several areas. Consultation to ensure the right level of review of critical incidents and deaths has been undertaken. At the time of reply, DSS was finalising outputs from this work, which included new internal operational guidance on handling critical incidents and guidance to support the review of deaths of disabled people.

DSS also initiated work to strengthen provider engagement by establishing groups and forums to connect directly with leaders and providers to improve communication and learning.

With respect to a national independent review system, it is unclear if steps have been taken to establish this, or if DSS considers this complete by way of its expanded audit process using a single independent provider.

Agency response

Recommendation 6(a) and 6(b)

Further updates to DSS's SOP have occurred since the end of 2025, with a focus on strengthening quality assurance and improvement functions, both internally, and with its providers. The development of the new Quality Management System (QMS) (see recommendation 9) supports refinement and systematisation of processes for reviewing deaths. Along with the appointment of a DSS Clinical Lead, and the reporting of SAC 1 death events to HQSC, reporting and learning-from-harm processes have improved further.

More work is underway to integrate these improvements into internal operational guidance. Once the new QMS is in place, updated guidance on the process for assessing a death will include risk-proportionate decision-making, and culturally responsive and person-centred approaches to conducting reviews. DSS indicates a completion date of July 2027 for this work.

DSS continues to review all deaths in DSS contracted community residential services based on the information provided by the provider in the Initial Death Review (IDR) form, with the DSS Quality Assurance team reviewing this information daily. DSS continues to corroborate the data with the Ministry of Health Mortality collection and connect with the Coroner as an interested party.

Recommendation 6 (c)

DSS's new Quality Improvement Team is implementing data and evidence informed improvements to the disability support system. Included in this work are a variety of outputs sharing review learnings with providers:

- Provider Quality Forums: sharing learnings and initiatives online with providers;
- National Quality Leaders' Group: quarterly meetings with 12 disability support providers and DSS quality leaders to discuss quality issues and learnings, and improve DSS understanding of provider perspectives, processes and issues;
- Project to reduce Choking Related Incidents and Deaths: DSS, HQSC and a small cohort of providers are working together to reduce choking-related harm for disabled people by leveraging a quality improvement approach grounded in quality evidence and data. The three-phase project is due to complete in July 2027, with outputs to include best practice guidance, resources and tools for disability providers, disability sector and community;
- DSS Care Records Project: driven by findings from the Royal Commission of Inquiry into Abuse in Care, this project aims to raise the standard of care recordkeeping across disability support service providers. DSS are working with Archives NZ to develop guidance for the disability sector.

Recommendation 6 (d)

As part of DSS's work to strengthen its commissioning and funding work, its standard terms and conditions for residential services were updated in 2025 to include strong requirements for reporting deaths to DSS. Conditions include requirements for critical incident reporting and internal reviews, with a focus on robust process, culturally responsive and person-centred practice.

Recommendation 6 (e)

As commissioner, funder and steward, DSS provides independent quality assurance functions and national audit oversight. This work includes an enhanced audit programme with a wider coverage of contracted service providers. DSS has engaged KPMG to support this work, and will use a new maturity model-based audit framework moving forward. Stronger independent review mechanisms will be considered as the QMS is further embedded.

Recommendation 7:

Engage and work with the Health Quality & Safety Commission to explore options for supporting providers to improve the quality of experience and the safety of the care and services their residents receive. This will be achieved through reporting, reviewing, and learning from adverse events and near misses, including by increasing compliance with the National Adverse Events Reporting Policy among non-DHB providers, and through supporting quality improvement projects to effect change.

Progress: Completed and ongoing 

Ombudsman's comments

This recommendation was not completed during our monitoring period, nor was Whaikaha able to complete this work as the role of the HQSC was unclear after the sector restructure.

However, DSS has worked with HQSC and providers to update the DSS critical incident severity reporting definitions to align with the HQSC SAC ratings and learning from harm process. Providers must now report SAC 1 and 2 level incidents to both DSS and HSQC.

DSS and HQSC now coordinate on high-risk incidents and deaths to promote learning and capability building as part of the review process.

Recommendation 8:

Confirm arrangements for undertaking in-depth analysis of information about the deaths of service users (eg when and how often this will occur), and information from critical incident reports, and utilising that analysis to inform future policy and practice.

Progress: Completed

Ombudsman's comments

This recommendation was completed within our monitoring period and resulted in several recommendations to community providers to improve outcomes for disabled people.

DSS continues this work, instituting improvements in its monitoring and analysis process. This includes improvements to cross-checking data quality and completeness processes, with ongoing work as part of the establishment of a quality management system (see recommendation 9).

DSS continues to focus on provider practice improvements in relation to deaths reported at the end of 2024, as this was identified as a system-level issue.

Recommendation 9:

Consider what actions can be taken to develop and implement an improved information management system that better supports Disability Directorate staff to capture, store, access, and utilise relevant information, and compliance with the Public Records Act 2005.

Progress: In progress 

Ombudsman's comments

Ministry of Health and Whaikaha explored options to implement an improved incident management system, but these did not come to fruition.

DSS is currently working to develop a new Quality Management System (QMS) to manage and analyse critical incidents, deaths, and complaints. This work is funded as a result of the Royal Commission of Inquiry into Abuse in Care.

Although we encourage this work and are pleased DSS is moving away from a spreadsheet-based information management and data analysis system, this recommendation is overdue. We look forward to confirmation this work is being expedited and will soon be completed.

Agency response

DSS is working with an external provider to develop its new Quality Management System (QMS). Described as "a foundational IT enabled system" the QMS will support the reporting, review, work-flow management, and data analysis of critical incidents, deaths and complaints. The QMS will support rigorous engagement with quality data, support analysis and management of critical incidents, and provide an evidence base for timely insights and improvement tracking.

DSS is currently engaged in change management activities to support the uptake of new systems and processes internally, and across the sector as the system is rolled out in Q1 of 2026/27.

Recommendation 10:

Review the measures currently in place to ensure relevant senior leaders have sufficient oversight of operational practice in relation to the Ministry's expectations and obligations following the death of a disabled service user.

Progress: Completed and ongoing

Ombudsman's comments

Both the Ministry of Health and Whaikaha reviewed and adjusted measures and indicators used for reporting to leaders, and reported these on a regular basis.

DSS is continuing this work and has developed a quarterly Critical Incident Report for the Minister and DSS Leadership Team to ensure better visibility of sector performance. More work is planned, with dashboards for both internal and external reporting as the Quality Management System is stood up.

We note that reporting at present does not disaggregate critical incidents and deaths, and we look forward to more nuanced reporting as DSS improvements progress.

Agency response

The DSS Quality leadership team now receive a weekly update on critical incidents and deaths logged in the previous week. More nuanced reporting will occur once the new QMS is rolled out.

Response from Disability Support Services

Disability Support Services

Te Kāwanatanga o Aotearoa
New Zealand Government

The Aurora Centre
56 The Terrace, PO Box 1556
Wellington
Phone: 04 916 3300; Fax: 04 918 0099

IN CONFIDENCE

26 May 2026

John Allen
Chief Ombudsman
Office of the Ombudsman | Tari o te Kaitiaki Mana Tangata

Email: Ombudsman_and_Privacy@msd.govt.nz

Dear John,

The Ombudsman's recommendations in his report, *Off the Record* – update from Disability Support

Thank you for your letter to Debbie Power, Chief Executive, Ministry of Social Development asking for an update on the Ministry's progress implementing the recommendations in the former Ombudsman's 2020 *Off the Record* (OTR) report. Your letter has been forwarded to me for a response.

Disability Support Services (DSS) welcomes the opportunity to update you on the continued progress being made in implementing the recommendations in the report, following on from our previous response to you in November 2025.

A significant amount of work has already been done to implement the recommendations in OTR, and ongoing improvements are a priority for us.

We are pleased to note your finding in the draft follow-up report that most of the recommendations have been completed, and there are improvements in the collection, use, and reporting of information about the deaths of people with intellectual disabilities receiving residential support, and associated record keeping.

Your draft follow-up report to OTR, *Charting Change*[1], finds that 2 of the 10 recommendations – recommendation 6 and recommendation 9 – are incomplete.

DSS has provided you with updates in response, inserted into your draft report attached, outlining the progress of work being completed to address both of these recommendations. In addition we have provided a few clarifying comments for your consideration in the body of your report.

Please contact me if you have any questions, or need any further information.

Yours sincerely

Anne Shaw
Deputy Chief Executive
Disability Support Services

Copy: Debbie Power, Chief Executive, Ministry of Social Development

Enclosed: *Charting Change*, a follow-up report to *Off the Record*: Ministry progress completing the Ombudsman's recommendations for change

File Reference: DSS 1225

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[1] Note, a draft of this report was provided to MSD for comment, with the provisional title *Charting Change*.

Alt text: letter from Disability Support Services at the Ministry for Social Development to the Chief Ombudsman

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IN CONFIDENCE

26 May 2026

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Chief Ombudsman
Office of the Ombudsman | Tari o te Kaitiaki Mana Tangata

Email: Ombudsman_and_Privacy@msd.govt.nz

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Anne Shaw
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Full agency responses to recommendation 6, 9 and 10

Response to recommendations 6a & 6b

In October 2025 DSS changed its operating design, which included significant strengthening of the DSS quality function. This included building a more fit for purpose Quality Assurance and Improvement Team, creating a stronger focus on quality improvement, strengthening our provider engagements, and establishing a Clinical Lead role. With these changes DSS has been able to continue to build its quality assurance and quality improvement functions that together are strengthening the procedures and mechanisms to ensure appropriate review of deaths.

Actions include:

- The development of the new Quality Management System (QMS), as outlined in the narrative for recommendation 9, has provided the opportunity to further refine and systematise our processes for reviewing deaths.
- The appointment of a DSS Clinical Lead, who provides clinical advice to inform DSS reviews of deaths and is developing clinical networks with providers and other agencies.
- In July 2025 DSS residential providers commenced reporting of SAC 1 death events to the Health Quality and Safety Commission (HQSC), which has provided opportunities for DSS providers to undertake HQSC training on learning from harm, and to submit their learning from harm reports to HQSC. DSS and HQSC are working together to share learnings from these reports.

DSS will update and finalise the internal operational guidance to support the review of deaths of disabled people in DSS-funded community residential services to incorporate these recent improvements, in parallel with the new quality management system being introduced.

The updated guidance will include the process for assessing the death to apply a risk-proportionate decision on the level of further review or investigation required (in addition to the initial death review). This will include consideration of how best to implement a culturally responsive and person-centred approach to conducting reviews and informed by clinical oversight. DSS will prioritise this work following the rollout of the QMS and will continue to engage with HQSC to look at alignment with their learning from harm reviews. The completion timeframe is July 2027.

DSS continues to review all deaths in DSS contracted community residential services based on the information provided by the provider in the Initial Death Review (IDR) form (emailed to DSS within 15 working days of the death). The DSS Quality Assurance team meets daily to review the incidents and deaths that came in the day prior, then triage and take appropriate action. This includes seeking further information or investigation reports from the providers. Follow-up with a provider may be undertaken to request further information, or to address any issues or concerns in connection with a death.

DSS continues to corroborate the data with the Ministry of Health Mortality collection and connects with the Coroner to register as an interested party to their investigation into the deaths of DSS-funded individuals. Following completion of the coronial investigation, and with the consent of the family, the Coroner's report will be made available to DSS. Any coronial findings will be reviewed and followed up on with the provider through the DSS Quality Team and Contract and Funding Teams as appropriate.

Recommendation 6c

a. establish mechanisms for review learnings to be shared with providers and other relevant stakeholders;

Response to recommendation 6c

DSS is building a new quality improvement function through a new Quality Improvement Team. The team is implementing data and evidence informed improvements to the disability support system. This includes reviewing learnings from quality assurance data and insights to inform improvements. Examples of mechanisms established for developing and sharing review learnings with providers and other relevant stakeholders are provided below:

Provider Quality Forums

DSS is sharing learnings and initiatives through regular online provider quality forums which are recorded and posted online on the DSS website: see link https://www.disabilitysupport.govt.nz/providers/quality-and-safeguarding/provider-quality-forums.

National Quality Leaders' Group

Valuable information sharing is now occurring through quarterly meetings with our provider National Quality Leaders' Group. This group of quality leaders from 12 disability support providers meets with DSS quality leaders to discuss quality issues and initiatives. This mechanism is helping the DSS Quality Group better understand provider perspectives, existing processes, and emerging issues, and supports DSS to develop improvement initiatives that DSS providers can implement.

Project to reduce Choking Related Incidents and Deaths

DSS has a quality improvement project underway to reduce choking related incidents and deaths. DSS and Health Quality & Safety Commission are working alongside a small group of disability support service providers, as part of a proof-of-concept approach, to reduce choking-related harm for disabled people who:

- receive DSS-funded supports, and
- experience eating, drinking, swallowing and behavioural difficulties that may increase choking risk.

This project takes a quality improvement approach that is grounded in evidence and data and will strengthen safeguarding practices. Best practice guidance, resources, and/or tools will be developed to help identify and mitigate risks. These will also support the continuous improvement of reporting and managing choking related incidents. https://www.disabilitysupport.govt.nz/providers/quality-and-safeguarding/reducing-choking-related-incidents

The project is divided into three phases, which will be completed by July 2027.

Phase One: The initial setup of the project includes provider engagement, gaining a common understanding of quality improvement science and principles, and forming a project steering group and working group, so that the scope of the work is clear.

Phase Two: The project team and working group gather information, identify gaps and opportunities, and set baselines to inform the development of best-practice guidance, resources, and/or tools. Change and improvement ideas, informed by this data and intelligence, will be tested across providers involved in the project, as part of a continuous improvement cycle often referred to as PDSA (Plan, Do, Study, Act).

Phase Three: The guidance, resources and/or tools are finalised, published on the HQSC website, and shared with disability providers, the sector, and community, to build a culture of learning and sharing across the sector.

DSS care records project

In response to recordkeeping issues identified by the Royal Commission of Inquiry into Abuse in Care (RCOI), DSS is currently undertaking a quality improvement project to raise the standards of care recordkeeping across disability support service providers. While Archives NZ works to develop overarching cross sector recordkeeping guidance, DSS is working collaboratively with Archives NZ to develop interim guidance for DSS-contracted providers, as a priority.

The guidance and its supporting resources are intended to help disability support service providers to better understand and meet their recordkeeping obligations, including those under the Public Records Act. The guidance material will also provide guidelines and examples to support providers to improve their records creation, management and access practices beyond meeting the relevant legal obligations.

Throughout early 2026, DSS has worked collaboratively with a Provider Reference Group and engaged with the disabled community to ensure that the guidance is fit for purpose and will contribute to improved outcomes for disabled people.

Once the content of the guidance has been approved for publication, design work will be undertaken to ensure the material is digestible and usable for providers. The work will then be shared through DSS's website, provider newsletters, and through a DSS provider quality forum to raise awareness and ensure all DSS providers have access to the guidance.

Recommendation 6d

d. ensure the Ministry's expectations in relation to provider reviews are reflected in its contracts/service specifications; and

Response to recommendation 6d

The DSS standard terms and conditions for residential services were updated in 2025 which included strengthening the requirement for reporting deaths to DSS.

An extract from the revised DSS Standard Terms and Conditions:

> *The provider has in place effective critical incident management system to ensure the timely reporting, investigation and follow up of all critical incidents. This includes ensuring that each critical incident is reported internally in accordance with the providers relevant policies.*

Following a critical incident the provider must, in accordance with any guidance provided by DSS including:

- *take action to ensure that all people involved are safe and that support is provided that meets the needs and preferences of the relevant Disabled Person;*
- *undertake an analysis to understand the root cause of the Critical Incident, and any cluster of Critical Incidents;*
- *learn from the Critical Incident to improve its systems and practices to prevent other Critical Incidents and restore relationships.*

In the case of a death the provider must ensure the internal review is:

- *culturally responsive and person-centred;*
- *focuses on identifying issues with the quality of disability supports that may have contributed to the death, examining whether the supports were strengths-based, person-centred, and focused on enabling the Disabled Person to live a good life in their community; and*
- *provides clarity to the family/whānau or guardian and identifies improvements to prevent similar incidents from occurring in the future, actively protecting the rights and interests of the Disabled Person and their family/whānau or guardian.*

Ongoing reviews of service specifications, for different provider categories, will take place and any further bespoke terms and conditions will be included as necessary.

These activities are part of DSS strengthening its commissioning and funding activities.

Recommendation 6e

e. explore options for establishing, in the longer term, a national independent review system.

Response to recommendation 6e

Independent review mechanism

In our core role as commissioner, funder and steward of disability support services, DSS provides quality assurance functions and national audit oversight that is independent and focussed on the disability supports we commission. Our assurance functions include complaints, critical incident and death reporting and the new enhanced audit programme.

In 2025 DSS designed and commissioned an enhanced audit programme. The programme aims to improve coverage of audits of DSS contracted care service providers to support the safety, wellbeing, and rights of disabled people, while strengthening confidence that contracted services are delivering high-quality, safe, and person-centred care and support across New Zealand. With the introduction of an enhanced audit programme, and changes to our critical incident management systems, there has been a change in some of the contracted service providers working in this area. For more information see Enhanced Audit Programme | Disability Support Services.

KPMG has been engaged as our strategic audit partner to undertake audits across DSS funded services, starting with community residential group homes, complementing the audit work already undertaken across these providers by the Ministry of Health under their HEALTHCERT programme.

Audits under the enhanced audit programme commenced in April 2026. The DSS enhanced audit programme provides a review of service quality that is independent from disability support providers. A new audit framework, adopting a maturity model, has been developed to guide this work. This framework will be published on the DSS website prior to 30 June 2026.

The contracted audit programme means DSS provides assurance oversight, independent of the disability support provider. As the new quality management system is embedded, we will explore steps to consider how a stronger DSS independent death review panel could be established. This would require input from multi-disciplinary perspectives and will be considered as part of the work programme led by the Clinical Lead.

Response to recommendation 9

DSS is working with an external provider to develop a new Quality Management System (QMS). The QMS is a foundational IT enabled system that supports the reporting, review, work-flow management, and data analysis of critical incidents, deaths and complaints. The QMS will significantly improve our ability to effectively manage and analyse critical incidents, deaths, and complaints, while reducing data quality risks. This will also allow us to analyse trends and themes, and provide valuable and timely insights back to providers, identifying opportunities for both local and system wide improvements.

Internal activities to support the development of the QMS are progressing and are on track. Our requirements gathering has been completed, providing a clear foundation for system design and implementation. Change management activities have commenced to support organisational readiness and ensure alignment across teams as new processes and ways of working are introduced. In parallel, early engagement with the disability support sector is beginning to ensure provider perspectives are considered and to support awareness and future adoption of the new system and the change management considerations to ensure a seamless transition to the new system.

Procurement activity is currently on track, with the strategic partnership procurement expected to commence following the signing of the contract. We anticipate the QMS will be rolled out in Q1 2026/27.

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