**Outcome Focussed Evaluation Tool for**

**Community Residential Services for People with an Intellectual, Physical or Sensory Disability**

An Enabling Good Lives Principles-based framework for

Developmental Evaluation against the contract

Disability support providers contracted by the Ministry of Health are independently evaluated to ensure they are meeting contractual requirements to deliver quality supports and improved outcomes for disabled people.

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# **Key Definitions**

* **Whānau** may mean: family, whānau, spouse/partner, close friends, welfare guardian and advocates[[1]](#footnote-1). Whānau should be defined by the person and who they consider them to be.
* **Disabled people** refers to people with a physical and/or intellectual and/or sensory impairment.

# **Reference Documents**

Key documents in the development of this evaluation framework have been:

* the Enabling Good Lives Vision and Principles
* Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan
* Faiva Ora 2016–2021
* Disability Support Services, Tier Two Service Specification, Flexible Disability Supports – Enabling Good Lives
* the disabled persons survey tool, MidCentral Baseline Study, 2019
* the Convention on the Rights of Persons with Disabilities.

**There are four elements to this evaluation framework:**

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# **Outcome Areas and Experience**

## **My Identity / Tuakiri**

High Level Outcome: My contribution is valued, promotion of equity

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata whaikaha / Disabled people** | **Whānau whaikaha[[2]](#footnote-2)** | **Supports and services will:** |  |
| 1.1 | My culture, beliefs and preferences are supported. | I am respected as an individual.  This includes my:   * personal, political and spiritual/religious beliefs * sexuality and relationship preference * reproductive rights.   I can share my personal story. | Our culture is valued in the support of our whānau.  Contact with supports contributes to strengthening our whānau relationships. | Have policies and practices that benefit Māori and reflect Te Ao Māori.  Demonstrate cultural competency (eg, Whāia Te Ao Mārama or the cultures people identify with).  Supports and services **may**:  Continue to seek opportunities for training and knowledge in Te Ao Māori. | Tier one Cultural Acceptability SS 6, 6.1, 6.2 and 6.3  Tier two Personal planning SS  6.1.2(e)  Tier one SS Principle 3.5, 4.3, 4.4, 7.11, 8.1  Tier two Service objective SS 3.1(f)  Access to the Community SS 6.4.1(f) |
| 1.2 | My family and whānau are valued. | I choose how much involvement I have with my whānau. | We can support our member to assert their rights and meet their responsibilities.  We can assist tāngata whaikaha to have a good life. | Support tāngata whaikaha and their whānau to participate in Te Ao Māori or the culture they are associated with. | Tier one Person, Family/ Whānau and Referrer Input SS 8.3  Tier Two  Involvement of person and their family/ whānau and others SS6.7.1(a)  Eligibility and Entry SS 5.1 |
| 1.3 | I am understood. | I am supported by people who understand, respect and support me and my forms of communication. | We can assist supports and services to understand the achievements, strengths, preferences and communication approach of our whānau member. | Ensure information will be assessable and in formats that are understood by the people using supports and their whānau.  Assist with access to appropriate communication technology and supports, counselling, mental health support, health services and supported decision-making. | Tier two Communication 6.6 and 6.6.1(a)  Tier one SS Principle 4.3, 8.2, 8.3, 8.3(b)  Tier two Primary Support Worker 6.2.2(a)  Supervision, assistance and support 6.3.1(a) |
| 1.4 | My mana is acknowledged, upheld and enhanced. | I am encouraged to understand my personal and citizenship rights in a format that I understand. | Our involvement will be respected and supported.  We are provided with information about the rights of disabled people in formats that are accessible.  We can ensure our whānau is treated with dignity and respect at all times. | Ensure all interactions enhance the life of the person and their status in the community.  Ensure dignity and respect of the person is upheld and the person’s status (legal and/or cultural) is maximised.  Have clear policies related to restraint/enablers and positive/non-aversive behaviour support.  Supports and services **may***:*  Advocate and encourage wider understanding of EGL Principles in local communities and organisations. | Tier one SS Principles 3.1, 3.2, and 3.7, 4.3, 4.4  Tier two Access to the community SS 6.4 and 6.4.1(i)  Involvement of the person and their family/ whānau and others) SS 6.7 and 6.7.1(a, g)  Risk management SS 6.11  Behaviour Support SS 9.3.1, 9.3.1(e) |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *a plan that describes strategies to action Whāia Te Ao Mārama* * *various organisation materials (are they accessible to service users?)* * *protocols that describe the range of communication strategies that are supported* * *personal communication plans and resources.* |
| ***Key questions associated with this section may include:***   * *How are your culture, beliefs and preferences supported?* * *To what extent is a culturally appropriate service being delivered in a competent manner?* * *Do you believe your family, whānau and friends are valued by supports?* * *Do you feel understood by your supports?* * *What sorts of things do you contribute to in your community? (How are you encouraged to be an active citizen?)* |

## **My Authority / Te Rangatiratanga**

High Level Outcome: I can exercise choice and control

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata whaikaha / Disabled people** | **Whānau whaikaha** | **Supports and services will:** |  |
| 2.1 | I make choices about my life. | I can live my life as a valued citizen of New Zealand.  I am given information in a format which is ‘easy-to-understand’ and/or have someone I trust to help me understand.  I can talk with my whānau and disability providers about options for self-directed funding.  I am given help to make informed choices if I want this.  I choose the services I want to support me.  I can change who supports me if things are not working. | We are consulted and communicated with regarding our whānau planning, care and support.  We are given time to make informed choices with our whānau. | Demonstrate how their policies and practices take into consideration a person’s identity, cultural and religious preferences.  Be open and flexible to a person’s choices and desire for change.  Provide information on how people can transition into other service options (eg, IF, CiCL, SIL, FDS, etc).  Be respectful of the preferences of those not wanting to commit to further change with purposeful encouragement and support for those open to new possibilities.  Explain how individual autonomy, choices, personal development, social participation and well-being will be supported.  Supports and services may:  Provide the opportunity for people to have different living experiences so they are able to make an informed choice. | Tier one SS 2, 4.3, 4.4, 7  Tier two SS 2 Service Definition  Residential Support Subsidy  SS 5.2.3  Primary Support Worker SS 6.2.1(a)  Home and setting SS 6.9, 6.9.1(o, q,)  Guidelines, policies and legislation SS 8.1, 8.2 |
| 2.2 | I choose and realise personal goals. | People are supporting me with my plan and understand my choices, goals and aspirations.  I am supported to explore my goals (good life). | We can contribute to our whānau member’s plan. | Assist the person to achieve outcomes set out in a person’s plan and do so in ways that are consistent with the EGL Principles and Purchasing Guidelines.  Ensure the support delivered will be agreed in a signed Support Agreement between the person and the provider[[3]](#footnote-3).  See that the Support Agreement is reviewed at least annually. | Tier one SS Principles 3.1(a), 3.3(b), 3.7(a), 4.3, 4.4  Tier two SS 2 Service Definition  Personal Planning SS 6.1, 6.1.1, 6.1.2 (a, b, c, d)  Primary Support Worker SS 6.2.2(d)  Involvement of the person and their family/whānau or others SS 6.7.1(b)  Home and settings SS 6.9.1(a, c) |
| 2.3 | I make decisions about my daily life and funding. | I choose who I live with and where I live.  I can manage my own home and living arrangements including my tenancy (if I am renting), with support where necessary. | We can help to identify suitable housing and support (where applicable). | Ensure supports are organised around supporting the decisions made by disabled people.  Consult with tāngata whaikaha in all decisions about where the person might live and who they live with[[4]](#footnote-4). | Tier one SS Principle 3.6  Tier two Service objectives SS 3.1, 3.1(b)  Service entry criteria SS 5.1.3    Supervision, assistance and support SS 6.3.1(c, f, g, h), 6.3.2(b)  Home and setting SS 6.9.1(f, h, I, o)  Supported Decision Making SS 6.12.1  Exit Criteria SS 7.1  Moving homes SS 7.3.2 |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *planning processes that assists service users to achieve outcomes in ways which are consistent with EGL Purchasing Guidelines* * *protocols related to the development of an annual Support Agreement (or similar) which may include:*   + *commitment to support the service user*   + *agreed actions to support identified outcomes* * *signed Individual Support Agreement between the service user and the provider which is understood by everyone* * *protocols describing how the service user is involved in decisions related to their funding.* | |
| ***Key questions associated with this section may include:***   * *What kind of choices do you make about your life?* * *How are your goals supported?* * *What happens if you want to change your mind?* * *What do you know about your budget / personal money?* * *How do you make decisions about your life?* | |
| ***Additional guidance***  *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from direct support workers and service managers. Comment from funding agencies/connectors etc. On-site observation of interactions and environment.*  *Relevant documents might include:*  *Contact notes and plan reviews, relevant documents might include: personal plans detailing methods of developing plans, how goals were devised, who was involved, how resources will be allocated, who will be responsible for assisting with goal competition or overseeing goal competition, details of achievable steps to realise goals, time frames and written reviews of progress and adaptations.*  *Service contract/agreement, needs assessment information and personal budget. Processes to access advocacy and/or Kaituhono/Connectors/brokers (information regarding these services provided in accessible formats). Information regarding fees payable within the support agreement.* | |

## **My Connections / Te Ao Hurihuri**

High level outcome: I have positive relationships

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata whaikaha / Disabled people** | **Whānau whaikaha** | **Supports and services will:** |  |
| 3.1 | I associate with people and networks of my choosing. | I have a network of people who support me (whānau, friends, community and, if needed, paid support workers).  The people who are important to me are encouraged and supported to play an active part in my life.  I choose my friends and relationships.  I have friends outside of where I live (not paid staff/flatmates etc).  I am respected and supported to have intimate relationships and express my sexual preferences.  I have privacy when I want it. | We can support the friendships and relationships of our whānau member.  We can assist with ensuring our whānau are in safe relationships.  Our whānau is supported to express their sexuality and have intimate relationships and sexual choices. | Provide support opportunities for people to make new and maintain old friendships.  Encourage the building of ‘natural supports’.  Ensure the people providing support are equipped with the values and skills required to building ‘right relationships’ with disabled people and whānau.  Support the person by offering opportunities to meet others and make community connections (clubs, events, cultural networks and community organisations).  Have plain language or ‘easy read’ information stating how a person’s sexuality will be respected and supported.  Ensure there is appropriate training to support people, whānau and support staff for them to support the development of relationships and express sexuality. | Tier one Principle SS 4.3  Tier two, SS 2 Service Definition,  Primary Support Worker SS 6.2, 6.21, 6.2.2(b)  Supervision, Assistance and Support SS 6.3(3)  Access to the Community SS 6.4.1(f, j, k)  Communication SS 6.6, 6.6.1(c)  Staffing SS 6.8, 6.8.1(b, e, k)  Home and settings SS 6.9.1(u, v)  SS 6.11.2(b)  Risk Management  Policies SS 8.2.1(e) |
| 3.2 | I am part of the community. | I choose the activities I want to participate in.  I use every day/universal community services (e.g., hairdressers, dentists, cafes, bars, doctors, shops etc).  I have access to the support and resources I need, e.g., transport.  I can attend community events that interest me, e.g., hui, kapa haka, concerts, and celebrations.  My supports assist me to strengthen my relationship with the community and connect me to people and places that are important to me. | We are involved in supporting our whānau member’s choice of what they do during the day.  We are provided with information about what is available for our whānau. | Encourage and support disabled people and their whānau to express themselves and voice what they want.  Support exploration of a range of opportunities based on the person’s preferences that are individualised, mana enhancing and encourage community participation.  Have supportive links with allied services who may support the people in their daily activities and connections.  Support and Services may:  Connect with the wider local community who can be a resource for disabled people. | Tier one SS Principle 2, 3.2 (a, b, c, d), 3.4, 3.4(a, 4), 4, 4.3  Tier two SS 2 Service Definition  Service objectives SS 3.1(e)  Supervision, assistance and support SS 6.3.2    Access to the community SS 6.4, 6.4.1(a, c, d, e, g, h)  SS 9, 9.1(g, i, l)  Linkages  SS 9.2.1, 9.2.2, 9.2.4 Equipment services |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *protocols describing how EGL Principles will be promoted in all interactions/settings* * *organisational material which supports the provision of services that are accessible* * *assessments clearly indicating any need for specialised equipment.* | |
| ***Key questions associated with this section may include:***   * *How do you stay in touch with people who are important to you?* * *How well are people in relationships supported?* * *Do you have access to sexuality education or counselling if required?* * *What kind of places do you like to go to?* * *Do you need any special equipment, if yes, how do you get it?* | |
| ***Additional guidance***  *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from direct support workers and service managers. Comment from funding agencies/connectors etc. On-site observation of interactions and environment.*  *Relevant documents might include personal and support plans, contact notes and plan reviews, support plans, goals and review notes. Personal plans, goals and review notes, safeguarding and risk assessment information, transportation options, written daily contact notes, staff or personal support group meeting minutes.* | |

## **My Wellbeing** **/ Hauora**

High level outcomes: I am happy and healthy; I have rights and protection

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata whaikaha / Disabled people** | **Whānau whaikaha** | **Supports and services will:** |  |
| 4.1 | I am safe. | I feel safe.  I am free from all forms of abuse and neglect.  I have a way to communicate how I am feeling and know who to contact if I feel unsafe.  I have all the equipment I need to be safely supported.  My paid support workers understand how to support me safely and have the training they need.  My home is safe (hygienic), enables me to have personal safety, and meets fire, earthquake and civil emergency requirements. | We have information about how the service will ensure our whānau member will be safe from abuse and neglect.  We can work in partnership with supports to discuss safety and safety concerns. | Assess risks and develop appropriate personal safeguards.  Ensure polices and processes reflect zero tolerance to any form of neglect or abuse.  Supports and services may:  Advocate and inform health providers around appropriate and effective individualised support.  Have evidence that the organisation’s policies and practices are consistent with the Ministry of Health’s guidance: *“The Prevention and Management of Abuse: Guide for services funded by Disability Support Services*”. | Tier one SS 3.8, 4.3 4.4, 7.3, 7.3(c), 7.7(a i, iv, b ii), 7.8(a, b), 8.2(b), 8.4, SS 9 Safety  Tier two Service Objectives SS 3.1(c),  Supervision, assistance and support SS 6.3.1(i, j)  Communication SS 6.6, 6.6.1(e)  Personal Planning SS 6.1.2(f)  Staffing SS 6.8.1, 6.8.1(c)  Home and Setting SS 6.9.1(a, j),  Risk Management SS 6.11, 6.11.1(a, b), 6.11.2(a)  Guidelines, frameworks and research SS 8.3  Equipment Services SS 9.2.3(c) |
| 4.2 | I have the best possible health and wellbeing. | I know who to talk to if I feel unwell.  I have a way to communicate how I am feeling, physically and emotionally.  I can ask for help if I need it.  I can access a GP and community health services of my choice and I can access specialist services when I need to (occupational therapist, physiotherapist, optometrist, podiatrist etc).  I have regular health checks, including age relevant public health screening. | We can support our whānau to have the best possible health.  We can work in partnership with supports to ensure our whānau member’s physical, medical, emotional, spiritual and cultural needs are met.  We are informed about any changes to our whānau member’s health.  Concerns around the wellbeing of our whānau member is raised with us as soon as it becomes evident. | See the person has the best possible health and has access to regular health checks and specialist services and counselling.  Ensure the person is living in a safe, accessible and barrier-free environment.  Ensure that appropriate resources are available when a person’s behaviour support needs change. These interventions are consistent and reviewed.  Provide relevant ongoing training for staff on health and wellbeing and specific to the health and wellbeing needs of tāngata whaikaha. | Tier one SS 4.3, 4.4, 7.7(a), 8.1, 9, 9.2, 9.3, 9.4  Tier two Service Objectives SS 3.1(d)  Supervision, Assistance and Support SS 6.3.1(m)  Access to community SS 6.4.1(a, b, e)  Staffing SS 6.8.1(e, h, k)  Health, medicine and first aid SS 6.10.1(a, b, c, d), 6.10.2  Admission to a  Specialist Service SS 7.4  Policies SS 8.2(e),  Linkages SS 9.1(f)  Behaviour Support SS 9.3.1(b, c, d, f, h) |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *organisational material which promotes the awareness of and unacceptability of abuse* * *processes that describe how abuse is reported and responded to* * *personal file – information related to health is documented* * *personal safeguarding documents/plans.* | |
| ***Key questions associated with this section may include:***   * *How do you feel about where you live and who helps you?* * *Do you feel safe where you live?* * *How do you feel about the people you live with?* * *What happens if you need to go to the doctor or dentist?* | |
| ***Additional guidance***  *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from direct support workers and service managers. Comment from funding agencies/connectors etc. On-site observation of interactions and environment.*  *Relevant documents might include: support plans, goals and review notes. Risk assessments that may include behaviour support, mental health, health, relationships, physical safety (environments), civil and fire emergency, and medication protocols. Incident/accident reports, complaints (written and verbal) and contact notes. Staff training in abuse and neglect, infection control, medications, first aid, health and safety, and use of restraints and enablers. Training in syndrome/condition and/or person specific training, training with regard to the specific needs of the person (e.g., tube feeding, lifting and transfers, diabetes, diet, epilepsy). On-site orientation methods and processes. Policies and procedures including privacy, informed consent, behaviour support, risk management, health and safety (including civil emergencies, fire safety, crisis procedures, infection control etc), medications etc. Information about who to contact in a crisis.*  *Records of medical appointments, evidence of access to health and specialist services, risk management documents, menus and dietary plans based on personal choices and health needs.*  *The prevention and management of abuse guide can be found here*[*https://www.health.govt.nz/publication/prevention-and-management-abuse-guide-services-funded-disability-support-services*](https://www.health.govt.nz/publication/prevention-and-management-abuse-guide-services-funded-disability-support-services)  *Check that organisations have sound policies, practices, checks and measures in place in line with the guide. The organisation may also have completed a self-assessment against the guidance to identify and implement areas for improvement*. | |

## **My Contribution** **/ Tāpaetanga**

High Level Outcome: I belong contribute and am valued

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata whaikaha / Disabled people** | **Whānau whaikaha** | **Supports and services will:** |  |
| 5.1 | I contribute to my community and society. | I have roles that are valued by society.  I contribute in a range of places in the community, e.g., education, social events, workplace (paid or volunteer).  I can try new things and have new experiences. | We can be part of our whānau member’s community life. | Have supportive links with allied services which assist people to achieve their goals.  Work alongside tāngata whaikaha and whānau to achieve their goals.  Supports and services may:  Ensure people have forums to share their stories with others if they choose. | Tier one SS Principle 3.2, 3.3  Tier two Access to the community SS 6.4.1  Staffing SS 6.8, 6.8.1(d)  Home and settings SS 6.9.1(u)  Linkages SS 9.1(o) |
| 5.2 | I am involved in service development. | My views are sought in the co-development, review and adaptation of approaches used by my supports. | Our views are sought in the co-development, review and adaptation of approaches used by supports and services. | Utilise hui, and other methods, to involve people in review of strategic plans, policies and procedures, internal review and evaluation.  Support and services may:  Develop opportunities to mentor and partner with tāngata whaikaha in service development. | Tier one SS Principle 3.6, 7.2, 7.3(c)  Tier two Service Objectives SS 3.1(g)  Involvement of the person, and their family/ whānau and others SS 6.7.1(b) |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *staff training records which support the promotion of EGL Principles in day-to-day practices* * *processes outlining how service user participation in service development and review will occur.* |
| ***Key questions associated with this section may include:***   * *What kinds of things do you like to do?* * *What do you like to contribute to (participate in)?* * *How do you let the service know what you think about what they do?* * *How can you let the service know how they can better support you?* |
| ***Additional guidance***  *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from direct support workers and service managers. Comment from funding agencies/connectors etc. On-site observation of interactions and environment.*  *Relevant documents might include: support plans, goals and review notes. Membership and/or involvement in disability groups, support groups or political groups. Notes outlining access to petitions and advocacy. Personal plans, goals and review notes. Transportation options. Written daily contact notes. Staff or personal support group meeting minutes. Documentation such as electoral roll, passport, mobility and community card.*  *Documentation outlining the involvement of the person and whānau in internal reviews, consumer surveys, consumer involvement in staff development, access to hui, strategic planning and policy development.* |

## **My Support** **/ Taupua**

High level outcome: I have what I need

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata whaikaha / Disabled people** | **Whānau whaikaha** | **Supports and services will:** |  |
| 6.1 | I am able to choose my support, who supports me and how I am supported. | I have the support I need to be able to exercise the level of self-determination and management I wish over my life.  The people who support me, understand my choices and aspirations and support me to achieve these.  A personal plan forms the basis of my support.  I can change my support/living situation if I choose and am offered options and information about this. | We can be involved in the monitoring of our whānau member’s living and/or support arrangements.  We can be involved in the development of the team of support workers associated with our whānau. | Be flexible and change the support arrangements on request of tāngata whaikaha[[5]](#footnote-5).  Ensure staff are able to access qualification pathways that are future focused, reflect the EGL Principles in practice and are part of planned organisational change and development. | Tier one SS Principal 2, 3.5, 4.3, 4.4, 7.6, 8.5  Tier two Introduction SS 1  Primary Support Worker SS 6.2(a, b), 6.2.1(a)  Service Objectives SS 3.1(a)  Personal Financial Management SS 6.5.1(a, e)  Staffing SS 6.8.1(e, g, k),  Linkages SS 9.1(l) |
| 6.2 | I can express my views and will have them listened to. | I can raise any concerns/complaints I have with supports in a safe and supportive manner. | We have access to and understand the complaints process. | Develop a complaints process that is aligned to the EGL Principles. In particular, the complaints process must be easy to use, promote self-determination, be person-centred and mana enhancing.  Work with the tāngata whaikaha to develop a contingency process in case the support arrangement (or aspects of it) don’t work as planned. | Tier one SS Principle 3.8, 8.5  Tier two Supervision, Assistance and Support SS 6.3.1(l)  Communication SS 6.6.1.(d)  Home and Settings SS 6.9.1(c, p, t)  Complaints Resolution SS 11.1 (a, b, c) |
| 6.3 | I monitor and evaluate the support provided. | I have access to clear records describing the support I receive.  I can understand the records associated with my support.  I can provide feedback about how I feel about the support I receive.  If my support needs change, I will have an appropriate reassessment. | With permission, we can access records associated with the support of our whānau member.  We can provide feedback about the support our whānau receives. | Records are kept in a form accessible to the disabled person and the people they choose to have access to them.  Regularly review the support needs of the tāngata whaikaha/ disabled people. | Tier one SS Principle 6.2, 6.3  Tier two Eligibility and Entry SS 5.1.2,  Home and Settings SS 6.9.1(p)  Risk Management SS 6.11.2(b) |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *organisational material describing how the needs and aspiration of the service user and the objectives of the service/programme are met* * *signed consent forms (including those which may be relevant to the Service Agreement)* * *policies related to internal and external evaluation* * *complaints process – is it easy to read/understand and accessible.* |
| ***Key questions associated with this section may include:***   * *Who decides who supports you?* * *Who listens to you if you want to change things?* * *How can you share your views with others?* * *What ways can you let people know what you like and don’t like about your support?* * *How can you help your supports to do a better job?* |
| ***Additional guidance***  *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from direct support workers and service managers. Comment from funding agencies/connectors etc. On-site observation of interactions and environment.*  *Relevant documents might include: entry information (in accessible formats) and descriptions of how individuals can choose and change support workers. Service contract/agreement. Support plan and personal plan goals and review notes. Incident reports and complaints.*  *Information on how to access independent advocacy, supported decision-making and information regarding the Health and Disability Services Consumer Rights. Protocols outlining ease of access to support workers and management (via telephone or physically). On-call systems ease of access. Incident reports, complaints register (both verbal and formally recorded by the service) and contact notes.*  *How disabled people and whānau are involved in internal reviews, consumer surveys, access to hui, strategic planning and policy development. Membership and/or involvement in disability groups and support groups.* |

## **My Resources** **/ Nga Tūhonohono**

High level outcome: I am developing and achieving

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha** | **Supports and services will:** |  |
| *7.1* | *I am involved with my funding* | *I have information about my funding.*  *I have access to plain language and/or ‘easy read’ information about my support.*  *My support utilises all the resources available to assist with my activities, aspirations and needs as identified in my plan.*  *I manage everyday costs of daily living, with support where necessary.* | *We can see the amounts charged against our whānau and this is fair and reasonable for the service provided.*  *We are given information about the range of options available, including self-directed funding in a clear format if our whānau member choses.* | *Ensure there is transparency around funding and that all parties understand how the funding operates.*  *Ensure the person is aware that they must communicate with the fund manager if the support being purchased or delivered differs from the support identified.*  *Work to see that the arrangement is affordable for all parties.*  *Support people to access any form of income assistance they may be eligible for.*  *Be accountable to tāngata whaikaha and their whānau.* | *Tier One SS Principle 7.5*  *Tier two SS Principle 2,*  *Access to the Community SS 6.4.1(j, k)*  *Personal Financial Management SS 6.5, 6.5.1*  *(a, b, d, e, f)*  *Supervision, Access and Support SS 6.3.1(d, k)*  *Home and settings SS 6.9.1(k)* |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *organisational material and day-to-day processes which ensure handling of the service user’s money is done appropriately and ethically* * *financial systems (personal and organisational).* |
| ***Key questions associated with this section may include:***   * *Who informs you about your funding?* * *Do you know how much funding you get and what this is used for?* * *How can you get support to manage your personal money?* |
| ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from direct support workers and service managers. Comment from funding agencies/connectors etc. On-site observation of interactions and environment.*   *Relevant documents might include: personal budget, needs assessment, support and personal plan. Funding agency and/or service provider policies and procedures that clearly detail the information the person needs to compile, retain and/or make available. Personal files/folders of relevant information – personal budget information and service contracts/agreement.* |

# **Organisational Health**

See Social [Services Accreditation Standards](https://www.msd.govt.nz/what-we-can-do/providers/social-services-accreditation/accreditation-standards.html#:~:text=About%20Social%20Sector%20Accreditation%20Standards,Sector%20Accreditation%20Standards%20(SSAS).&text=To%20gain%2C%20and%20retain%2C%20accreditation,of%20the%20services%20they%20deliver.).

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|  | **Outcomes** | **Indicators** | **Organisation will demonstrate** | **References** |
| 8.1 | Staffing | The organisation has the staffing capability and capacity to deliver services safely. | Robust plans for all aspects of human resource management that can be demonstrated to the auditor | Social Services accreditation standards will be met |
| 8.2 | Health and Safety | The organisation ensures clients, staff and visitors are protected from risk | Evidence of robust health and safety practices following the standards and all work safe legislation |
| 8.3 | Governance and Management Structure and Systems | The organisation has a clearly defined and effective governance and management structure and systems. | Systems and structures are clearly laid out with robust checks and balances. Governance structure reflects diversity and the service user base |
| 8.4 | Financial Management and Systems | The organisation is financially viable and manages its finances competently | All financial management systems are transparent robust with clear responsibilities and delegations |
| 8.5 | Resolution of complaints related to service provision | The organisation uses an effective process to resolve complaints about service provision | The complaints process at every level is well known and communicated to staff and clients |

***Evaluator guidance 8.1-8.5 against standards*** ***–*** ***Note if another auditor/accreditor has recently completed an audit against these organisational health standards then you do not need to repeat here. Seek a copy of their findings for your report.***

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| ***Evaluators may examine the following documents:***   * *Operations Manual (or similar), staff training consistent with the EGL approach (records of courses, course content and staff attendance).* * *Mission Statement* * *commitment to EGL Principles and Vision, a framework for organisational review that is aligned with the EGL Principles* * *Disability survey results.* |

# **Value for Money**

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| --- | --- | --- | --- | --- | --- |
|  | **Outcomes** | **Indicators of effectiveness** | **Measured by** | **Organisation will demonstrate** | **References** |
| 9.1 | Supports are targeted to improve outcomes for disabled people | Supports are appropriately targeted to improving quality of life for the disabled person, taking into account the age and stage of the disabled person.  Additional requirements are met for ongoing monitoring and review of funding and outcomes for people on high funding packages. | Review of a range of client files to assess alignment of:   1. the size of the funding package / support allocated 2. the link to outcomes for the disabled person 3. monitoring and adaptation to re-adjust or re-target as necessary to better achieve outcomes   Disabled people and family report their wellbeing is improving and disability supports contribute to their achievement of a good life. | Robust person-centred review of goals in collaboration with the person and their whānau.  Review of support plan ensures identified outcomes for people are being achieved, and funding package / support allocated adapted appropriately.  Additional requirement for high funding packages (over $170k per annum):   1. Collaboration with the disabled person, their whānau and the NASC to regularly review funding/support package. 2. Review plan to ensure ongoing quality of life, including findings ways to reduce the undue intrusion of supports in the life of the disabled person. |  |
| 9.2 | Supports are targeted to improve outcomes for Māori | Māori service users have targeted cultural support and are well connected to their iwi hapū or whānau. This leads to improved health and disability outcomes | Tāngata whaikaha and whānau have increased uptake of flexible support options.  Tāngata whaikaha and whānau report their wellbeing is improving and disability supports contribute to their achievement of a good life. | Organisation demonstrates commitment to Whaia Te Ao Mārama  In linkages and engagement with Iwi and services/supports delivering in line with Te Ao Māori. |
| 9.3 | Supports are responsive to changing needs and intervening early | Early investment leads to longer term cost benefits and improved outcomes | Evidence of supports being adapted when a person’s needs begin to change.  Examples of flexible person-centred approaches to support are well documented | Organisation demonstrates the ability to prioritise using an early investment approach  Supports are adapted at an early stage when circumstances change for a disabled person, e.g. illness, emerging issues or transition to a new life stage. Evidence that planning discussions with disabled people and family are timely and include consideration of a range of approaches. |
| 9.4 | Disabled people are supported to make decisions about changes to their support plan. | Where supports have reduced, there is evidence of a joint planning process to support a positive experience and to ensure ongoing quality of life of the disabled person. | In instances of support reduction: Disabled people and family report a positive experience in the planning process that supports their ongoing quality of life. | Documentation samples where supports have decreased or changed and outcomes have been achieved |

***Evaluator Guidance***

*This section focuses on how well the funding is being used compared to the outcomes being achieved by and with the person.*

*Evaluator will sample a variety of plans and review them taking account of the above*

*Interface with the NASC will be required to establish level of funding and gain feedback on goals the person was seeking to achieve at the time of service planning. Interviews with disabled people, family members and provider staff and management*

# **Appendix One – The EGL Principles**

The EGL Principles are the foundation of Flexible Disability Supports and are summarised in the table below:

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| --- | --- |
| **Self-determination** | Disabled people are in control of their lives. |
| **Beginning early** | Invest early in families and whānau to support them, be aspirational for their disabled child, build community and natural supports, and support disabled children to become independent, rather than waiting for a crisis before support is available. |
| **Person-centred** | Disabled people have supports that are tailored to their individual needs and goals and that take a whole life approach rather than being split across programmes. |
| **Ordinary life outcomes** | Disabled people are supported to live an everyday life in everyday places. They are regarded as citizens with opportunities for learning, employment, having a home and family, and social participation – like others at similar stages of life. |
| **Mainstream first** | Disabled people are supported to access mainstream services before specialist disability services. |
| **Mana enhancing** | The abilities and contributions of disabled people and their families are recognised and respected. |
| **Easy to use** | Disabled people have supports that are simple to use and flexible. |
| **Relationship building** | Supports build and strengthen relationships between disabled people, their whānau and community. |

# **Appendix Two**

The Service Provider must provide supports in accordance with:

* + Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan
  + The Code of Health and Disability Services Consumers’ Rights 1996
  + The Health Act 1956
  + The Health Information Privacy Code 1994
  + The New Zealand Disability Strategy 2001
  + Health Practitioners Competence Assurance Act 2003
  + Ministry of Health Policy, as issued by the Ministry from time to time and all other relevant law relating to employment, health and safety, privacy
  + The New Zealand Sign Languages Act 2008
  + Social Sector Accreditation Standards, Level 1, Version 5.4.1 | October 2019

1. An advocate is a person who puts a case on someone else's behalf and represents their interests. [↑](#footnote-ref-1)
2. The disabled person/ tāngata whaikaha will decide how much of a role their family and whānau have in their life and in their support arrangements. [↑](#footnote-ref-2)
3. Include whānau or legal guardian when appropriate. [↑](#footnote-ref-3)
4. Include whānau or legal guardian when appropriate. [↑](#footnote-ref-4)
5. Include whānau or legal guardian when appropriate. [↑](#footnote-ref-5)