**Flexible Disability Supports**

An Enabling Good Lives (EGL) principles-based and outcomes-focussed framework for Developmental Evaluation

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# **Key Definitions**

**In this evaluation framework:**

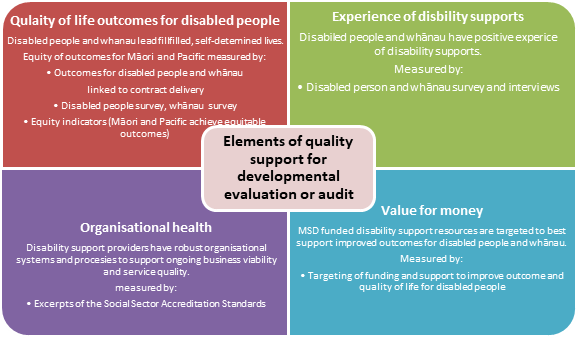
* Whānau may mean family, whānau, spouse/partner, close friends, welfare guardian and advocates. Whānau should be defined by the person and who they consider them to be.
* Disabled people refer to people with a physical, intellectual or sensory impairment.

# **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
* 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

# **Four elements of this evaluation framework**



# **Outcome Areas and Experience**

## **My Identity / Tuakiri**

High level outcome: increased personal growth

|  | **Outcomes** | **Indicators** | | |
| --- | --- | --- | --- | --- |
|  |  | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha[[1]](#footnote-1) and family** | **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. | Contact with supports contributes to strengthening our whānau relationships. | Have policies and practices that benefit Māori and reflect Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan.  Have knowledge of social models of wellbeing that include holistic approaches. |
| 1.2 | My family and whānau are valued. | I experience valuing relationships with those who are important to me. | I can support my whānau to assert their rights and meet their responsibilities.  I can assist my whānau to have a good life. | Acknowledge and support the role of whānau in line with the person’s preferences and abilities. |
| 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.  We are encouraged to develop an understanding of the EGL Principles and how they can become real in our whānau life. | Ensure all information will be assessable and in formats understandable to the people using supports.  Assist with access to appropriate communication technology and approaches, counselling, mental health education, health services and direct support for individuals who may have impaired decision-making abilities. |
| 1.4 | My mana is acknowledged, upheld and enhanced. | I am encouraged to understand my personal and citizenship rights and responsibilities. | Our involvement will be respected and supported.  We are provided with information about the rights and responsibilities of disabled people in formats that are accessible. | See all interactions enhance the life of the person and their status in the community.  Ensure the person’s (legal) status is maximised. |

***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 assessible 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?* * *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?)* |
| ***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, plans and reviews, staff meeting minutes. Information from service policies and procedures**, entry information for whānau completed in accessible formats (providing details on rights and responsibilities), complaint processes, details of how whānau will be included, and service policies and procedures.*  *Support plans that clearly detail communication needs, history of communication styles, methods of communication, communication strategies and aids.*  *Description of strategies and methods used to enhance and uphold the individual’s mana and approaches to enhancing participatory citizenship.* | |
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## **My authority / Te Rangitiratanga**

High level outcome: increased personal control

|  | **Outcomes** | **Indicators** | | |
| --- | --- | --- | --- | --- |
|  |  | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha and family** | **Supports and services will:** |
| 2.1 | I make choices about my life. | I am assisted to progress towards my desired outcomes. | If requested, our whānau can provide encouragement and support. | Support the person to make informed choices about where they live, who they live with and how they are supported.  Recognise that people’s choices may change over time. |
| 2.2 | I choose and realise personal goals. | I can lead the development and review of a Support Agreement that includes the documentation of aspects such as where and how I want to live, who I live with, what I want to achieve, and how I will be supported.  I can oversee the provision of support agreed in the Support Agreement and make day-to-day decisions about how that support is provided.  I can change my goals as my needs/perspectives/ideas change.  I can lead/direct a regular review of my support arrangements. | I can help to develop and review My Plan and the Support Agreement and its implementation\*. | Assist the person to achieve outcomes set out in a person’s ‘My Plan’ and must do so in ways that are consistent with the EGL Purchasing Guidelines.  Ensure support delivered will be agreed in a signed Support Agreement between the person and the provider.  Ensure ‘outcome statements’, written in a Support Agreement, are understood by everyone and are clear and explicit.  All parties are present when support agreements are signed.  Work with the person and other stakeholders (including the Funding Manager, the person’s family/whānau), where appropriate, to develop the Support Agreement documenting how the person will be supported including the provider’s role in commissioning and organising that support.  Commit to undertaking a list of agreed activities and actions to support the person according to the Support Agreement.  Provide and organise support according to the person’s Support Agreement.  See that the Support Agreement is reviewed at least annually. |
| 2.3 | I make decisions about my daily life and funding. | I experience transparency in decisions regarding my funding.  I can access support from others who can assist me with funding decisions.  I can manage my own home and living arrangements including tenancy (if I am renting), with support where necessary.  I can access training and support so I am confident about making and expressing decisions. | Whānau can support and provide input if requested.  We can access forums where we are encouraged to think creatively and positively about our whānau member’s choices and life options.  I can help to identify suitable housing and support (where applicable). | Provide information about funding and access to supports/services is easy to use.  Disclose to the person and to the Funding Manager, any practical limits they believe exist, including limitations on the range of options they offer to the person and their family as soon as these limitations become apparent.  Disclose, prior to the person agreeing to use Flexibility Disability Supports provided by that provider, all fees that the provider would charge the person and take from their Personal Budget, so that the person can make informed decisions.  Demonstrate partnership approaches when working together to provide practical support that is consistent with the EGL Principles. |

***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 and what are 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***   * 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.*   2. *Relevant documents might include:*   3. *Contact notes and plan reviews, 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.*   4. *Service contract/agreement, needs assessment information and personal budget. Processes to access to advocacy and/or Kaituhono/Connectors/brokers (information regarding these services provided in accessible formats). Information regarding fees payable within the support agreement.* | |
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## **My connections / Te Ao Hirihuri**

High level outcome: increased meaningful relationships and inclusion

|  | **Outcomes** | | **Indicators** | | |
| --- | --- | --- | --- | --- | --- |
|  |  | | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha and family** | **Supports and services will:** |
| 3.1 | | I associate with people and networks of my choosing. | I can have whānau and friends in my life.  I have information about what is happening in my community and country. | We can assist our whānau member to:   * attend or join groups or organisations of their choice * meet new people and enjoy a range of social encounters. | Ensure community-based networks are promoted and people can access mainstream community options.  Ensure the EGL Principles are promoted in all settings.  Support people to connect with networks (where appropriate).  Identify possible barriers to “mainstream” participation, eg, transport, specialist sporting equipment, reasonable accommodation. |
| 3.2 | | I am part of the community. | I live, work, recreate and interact in environments that are modified to accommodate my needs (eg, accessible, barrier free).  I have access to typical community services such as education, medical and therapy specialists (doctors, dentists, podiatrists, counsellors, physiotherapists etc) and places (such as shops, hairdressers, libraries, cafes, restaurants, gyms, swimming pools etc).  I can have access to specialist services for disabled people (including health, employment support, education).  There is an easy to use process to access equipment. | We understand what equipment and supplies are funded and which need to be purchased by our whānau. | Work to develop solutions to barriers people face in accessing the community networks are sought.  Promote the use of the EGL Principles in all settings.  Provide information and/or support for the person to access specialist equipment and supplies. |

***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?* * *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, referrals to specialists, eg, occupational therapy and physiotherapy etc* |

## **My wellbeing / Hauora**

High level outcome: increased personal and whānau wellbeing

|  | **Outcomes** | **Indicators** | | |
| --- | --- | --- | --- | --- |
|  |  | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha and family** | **Supports and services will:** |
| 4.1 | I am safe. | I am free from all forms of abuse and neglect.  I am supported by people who are competent (equipped to fulfil their roles).  I have “unpaid people” in my life and I am supported to maintain these relationships.  My environments are safe (hygienic, enable personal safety, accessible, well ventilated and heated, meet fire, earthquake and civil emergency requirements).  I know who to contact if I feel unsafe or have concerns about safety and I am able to contact them. | We are able to contribute to safeguarding approaches.  We can work in partnership with supports to discuss safety and safety concerns. | Ensure that what to do when things go wrong has been anticipated and strategies identified.  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*”. |
| 4.2 | I have the best possible health and wellbeing. | I have access doctors and other health professionals as I need them (eg, dentist, mental health, podiatry, audiology, physiotherapy, specialist services).  I have regular check-ups (including health and personal or age-related health screening at least annually). | We are supported to understand any changes in health and health support needs. | Ensure plans are in place to enhance wellbeing, independence and skills.  Advocate a holistic approach to health, eg, mental, social, emotional, spiritual and physical. |

***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.* |
| ***Key questions associated with this section may include:***   * *How do you feel about where you live and who helps you?* * *What happens if you need to go to the doctor or dentist?* |
| ***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: 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, use of restraints and enablers. Training in syndrome/condition and/or person specific training, training with regard the specific needs of the person (eg, 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 crisis.*  *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*.   * 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: records of medical appointments. Evidence of access to health and specialist services. Menus and dietary plans based on personal choices and health needs.* |

## **My contribution / Tāpaetanga**

High level outcome: increased participation

|  | **Outcomes** | | **Indicators** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha and family** | | **Supports and services will:** | |
| 5.1 | I contribute to my community and society. | I have socially valued roles.  I participate in a range of places in the community, eg, education, social events, workplace.  I am recognised as a citizen with equal opportunities in the community.  I have opportunities to join in with things that reflect my culture, interests, aspirations, skills and abilities.  I make informed decisions on where, when and how my involvement with all things happens. | | | We can share the responsibility for exploring opportunities for our whānau to be involved in the local community. | | Seek opportunities for people to hold valued roles. |
| 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. |

***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?* * *How do you let the service know what you think about what they do?* |
| ***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”*  *Support plans, goals and review notes. 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 person and whānau involvement in internal reviews, consumer surveys, access to hui, strategic planning and policy development. Membership and/or involvement in disability groups, support groups or political groups. Notes outlining access to petitions and advocacy.* |

## **My support / Taupua**

High level outcome: increased relevance of support

|  | **Outcomes** | | **Indicators** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha and family** | | **Supports and services will:** | |
| 6.1 | I am able to choose my support, who supports me and how I am supported. | I have the assistance available to help me manage my supports.  I manage the support options I access in the community, with assistance where necessary.  My supports work in partnership with me and with each other. | | | We can be involved in the monitoring of the person’s living and/or support arrangements\*.  We can be involved in the development of the team of support workers associated with our whānau member. | | Be flexible and change the support arrangements on request of the person, provided that the changed support will remain within the terms of this Agreement. |
| 6.2 | I can express my views and will have them listened to. | I can raise any concerns/ complaints I have with the service being provided in a safe and supportive manner.  I have access to independent support if I want to make a complaint. | | | We have access to and understand the complaints processes. | | See that where the person is not satisfied with the support delivered by the provider, the provider and the person will work together to ensure that ongoing supports are delivered in a way that is consistent with the EGL Principles.  Ensure responses to complaints are timely and complete and the resolution of a complaint is communicated and understood.  Develop a complaints process that is aligned to the EGL Principles. In particular, the complaints process must promote self-determination, remain person-centred and be mana enhancing. |
| 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 am a key contributor to the monitoring and Developmental Evaluation of the support/service I engage with.  I have opportunities to participate in a way that meets my needs and communication preferences.  I experience transparency within the monitoring and evaluation process.  I can have someone to support me during any evaluation process. | | | With permission, we can access records associated with the support of our whānau member.  Whānau may participate in the Developmental Evaluation and monitoring of how well the Support Agreement is working.  Whānau experience transparency within the monitoring and evaluation process. | | Records are kept in a form accessible to the disabled person and the people they choose to have access to them.  Support the person to initiate a regular person-directed monitoring process to ensure the Support Agreement is reviewed and revised regularly.  Report to the Ministry and the relevant Funding Manager on the outcomes achieved against the Purchasing Proposal at the person’s review date.  Assure that expenditure of the Personal Budget by the person or the provider meets the requirements of this Agreement.  Ensure there is transparency within the monitoring and Developmental Evaluation process. |

***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)* * *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?* * *What happens to your information/file?* * *How can you share your views with others?* |
| ***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.*  *Service contract/agreement, needs assessment, contact notes, support and personal plan and review notes. Service provider policies and procedures related to privacy and management of records.*  *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, support groups or political groups.* |

## **My resources / Nga Tūhonohono**

High level outcome: increased flexibility

|  | **Outcomes** | **Indicators** | | |
| --- | --- | --- | --- | --- |
|  |  | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha and family** | **Supports and services will:** |
| 7.1 | I am involved with my funding | I have information about my funding.  I can ensure that the support purchased/received is the most cost effective and relevant way to support me to achieve outcomes identified in my plan, with support where necessary.  I have information about how FDS is delivered and how it differs from what I have used in the past.  I am supported to retain and supply necessary records  I will retain and make available all necessary documentation to support expenditures related to my Personal Budget.  I understand my obligations to retain necessary documentation.  I am able to effectively use my resources.  I manage everyday costs of daily living, with support where necessary. | Whānau are given information about how FDS is delivered and how it differs from previous funding and support options.  If requested, whānau can provide oversight and support with completion and retention of documentation. | See the amounts charged against the person’s Personal Budget must be fair and reasonable for the service provided.  Ensure the person is aware that they must communicate with the Funding Manager if the support being purchased or delivered differs from support identified.  Work to see arrangements are affordable for all parties.  Support the person to access any form of income assistance they may be eligible for and assist them to obtain the best outcomes when dealing with government agencies:   * is the information communicated well * is the information understood * is the application process easy to use * is the person treated with respect * are they experiencing a holistic approach * what is the process if things go wrong? |

***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?* * *How do you know what information you need to keep safe?* * *How can you get support to manage your personal money?* |
| ***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 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/agreements.* |

# **Organisational Health**

See [Social Services Accreditation Standards](https://xn--tekhuikhu-7bbe.govt.nz/accreditation/standards.html).

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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 whanau.  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 whanau 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 hapu or whanau. This leads to improved health and disability outcomes | Tāngata whaikaha and whanau have increased uptake of flexible support options.  Tāngata whaikaha and whanau report their wellbeing is improving and disability supports contribute to their achievement of a good life. | Organisation demonstrates commitment to Whaia Te Ao Marama  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*

# **Equity**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Outcomes** | **Indicators of effectiveness** | **Measured by** | **Organisation will demonstrate** | **References** |
| 10.1 | Supports are equitable for disabled people | Supports are designed and delivered taking into account culture, gender, disability, age, sexual orientation, ethnicity, economic situation, or geographic location, have timely and equitable access to appropriate health  and disability support services | Review of a range of client files to assess:   1. equity of support and services designed, allocated, and delivered 2. the link to outcomes for the disabled person 3. monitoring and adaptation as necessary to better align with individual characteristics in order to achieve outcomes   Disabled people and their families report that their well-being is improving, and that disability support contributes to achieving a good life. | Robust person-centred design and delivery of supports and services based on individual characteristics of service users  Setting and reviewing goals in collaboration with the person and their whānau.  Review of support plan ensures that identified outcomes for people are being achieved and that support is developed, delivered, and adapted for individual circumstances. |  |
| 10.2 | Supports are equitable 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 access to and uptake of support options that they prefer including flexible supports.  Tāngata whaikaha and whānau report their wellbeing is improving, and that disability support contributes to achieving a good life. | The organisation demonstrates a commitment to Whaia Te Ao Mārama  There are connections and engagement with Iwi and other services/supports delivering in line with Te Ao Māori. |
| 10.3 | Supports are highly tailored to my needs | Supports are designed and delivered taking into account the unique and specific circumstances of individual service users | Evidence of support being designed and delivered for individual circumstances  Evidence of support being adapted when a person’s circumstances or needs begin to change.  Examples of tailored and flexible person-centred approaches to support are well-documented | Organisation demonstrates the ability to consider unique and specific circumstances of individual service users  Supports are developed and delivered for individual circumstances and are adapted when circumstances change for a disabled person.  Evidence that planning discussions with disabled people and family are timely and include consideration of a range of approaches based on unique and specific circumstances of individual service users |
| 10.4 | Entry is Easy | Disabled people have equitable access to supports and services | Disabled people and families report a positive experience in applying for, entering, moving between, and exiting services. | Documentation samples circumstances have changed for a disabled person but supports have been adapted, and outcomes have continued to be achieved |

***Evaluator Guidance***

*This section focuses on how the organisation demonstrates a commitment to improving equity and the outcomes achieved for service users.*

*Evaluator will sample a variety of plans and review them to see how unique and specific circumstances of individual service users have been taken into account for designing, delivering, and adapting services.*

*Evaluator will endeavour to establish the level of consideration of individual circumstances at the time of service planning, and any correlation to desired or achieved outcomes. Interviews with disabled people, family members and provider staff and management will inform the assessment.*

*Evaluator will consider all previous domains in the assessment of equity.*

# **Enabling Good Lives**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Outcomes** | **Indicators of effectiveness** | **Measured by** | **Organisation will demonstrate** | **References** |
| 11.1 | Self-determination | Disabled people are in control of their lives. | Disabled people   1. are understood and responded to when they communicate. 2. choose what happens in their lives. 3. have help to make choices if they need/ want it | Organisation demonstrates that disabled people   * have been able to choose who supports them and how they are supported * are respected as individuals * have access to supports that are assisting them progress towards their desired outcomes * have the support that they require to be able to exercise the level of self-determination and management they wish over their supports and lives * can engage with their family, whānau, and communities | Disability support services outcome agreement; section 9.13 |
| 11.2 | Begin early | Invest early in families and whānau to support them; to be aspirational for their disabled child; to build community and natural supports; and to support disabled children to become independent, rather than waiting for a crisis before support is available. | Disabled people   1. can easily find out about the things they need for their support. 2. get to try new things 3. learn new things. |
| 11.3 | 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. | Disabled people   1. can take part in their interests. 2. can make plans based on what they want and what they are good at. 3. are achieving the things they want in their lives. 4. are encouraged to think about what they want in their lives. 5. have plan and goals that reflect their culture, beliefs and values |
| 11.4 | Ordinary life outcomes | Disabled people are supported to live an everyday life in everyday places; and are regarded as citizens with opportunities for learning, employment, having a home and family, and social participation - like others at similar stages of life. | Disabled people   1. have a network of people in their life (family, whānau, friends, community and, if needed, paid support workers). 2. feel they belong in their community. 3. are supported to be an active member of their community. |
| 11.5 | Mainstream first | Disabled people are supported to access mainstream services before specialist disability services. | Disabled people use typical/universal community services (e.g., hairdressers,  dentists, cafes, bars, doctors, shops etc). |  |
| 11.6 | Mana enhancing | The abilities and contributions of disabled people and their families are recognised and respected. | Disabled people feel   1. their culture (i.e., ideas, beliefs and ways of doing things) is respected. 2. their spirituality/beliefs are respected (e.g., go to marae, church, talk to elders, meet with others who share their beliefs). 3. they are involved in developing support services if they wish to be. 4. safe. 5. that the people in their life value what they can do. 6. Their support staff have access to training that focuses on their support needs, culture and safety. |
| 11.7 | Easy to use | Disabled people have supports that are simple to use and flexible. | Disabled people feel   1. they have choices about the kind of support they receive. 2. their support matches their priorities and schedule. 3. their support fits their lives. |  |
| 11.8 | Relationship building | Supports build and strengthen relationships between disabled people, their whānau and community. | Disabled people   1. can choose who their support staff will be if they have any. 2. feel their whānau is recognised as part of their life and the supports they require. 3. feel their whānau is as involved in their life as they want them to be. 4. have friends outside of where they live (not paid staff/flatmates etc). 5. feel their supports assist them to strengthen their relationship with their community (incl. culture/community of choice). 6. feel their supports help them connect to people and places that are important to them (incl. whānau and culture). 7. know where to get help to manage their own supports. |  |

***Evaluator Guidance***

*This section focuses on how the organisation demonstrates a commitment to the EGL Principles in the provision of disability support services.*

*Evaluator will endeavour to establish the level of consideration and implementation of various EGL Principles and any correlation to desired or achieved outcomes. Interviews with disabled people, family members and provider staff and management will inform the assessment.*

*Evaluator will consider all previous domains in the assessment of equity.*

**Appendix One**

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

|  |  |
| --- | --- |
| **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 Flexible Disability 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. 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-1)