**Outcome Focussed Evaluation Tool for**

**Needs Assessment and Service Coordination Services (NASC)**

**For NASC services contracted by the Ministry of Social Development**

**DSS Needs Assessment and Service Co-ordination (DSS1040)**

**Including Discretionary Funding (DSS1039D)**

An Enabling Good Lives Principles-based framework for

Developmental Evaluation against the contract

Disability support providers contracted by the Ministry of Social Development 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** reference topeople with a physical, intellectual, sensory impairment and have Autism Spectrum Disorder or a combination of these.

# 

# **Reference Documents**

The Service Provider must provide supports in accordance with:

* The United Nations Convention on the Rights of Persons with Disabilities.
* The Enabling Good Lives Vision and Principles
* The relevant service specification
* Pacific Community Talanoa Feedback Report, 2024
* 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 2016-2026
* Health Practitioners Competence Assurance Act 2003
* Relevant policies, 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

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

# **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.  We are more comfortable approaching the service to work to design plans for our whanau member | Have policies and practices that benefit Māori and reflect Te Ao Māori.  Demonstrate cultural competency (eg, Whāia Te Ao Marama or the cultures people identify with).  Demonstrate by increased representation of Maori taking up and driving services and thereby reducing inequity  Continue to seek opportunities in the context of professional development for training and knowledge in Te Ao Māori. | Tier Two Cultural components 5.7  5.8 Acceptability (SS 8.2.3)  (SS2.1. 2.3)  Maori Health and Disability |
| 1.2 | My family and whānau is valued. | I choose how much involvement I have with my whānau. | We can support our whanau 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 Two Person, Family/ Whānau and Referrer Input (SS 5.2 5.2.1  5.3 5.4 8.2.2  Eligibility and Entry SS 5.1 5.2 5.4) |
| 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 accessible 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.  Staff members are trained in supported decision making | Tier two Communication  (SS 8.2 8.2.3)  Information management (SS 5.10 5.11.1  5.11.2  SS 6)  Cultural component of assessment 5.2.1  Specialised assessment 5.3 |
| 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.  Disabled people/tāngata whaikaha are self-determining and achieving what they want for their life. | 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 always treated with dignity and respect. | 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.  Services may source advocacy support, facilitate circles of support and encourage wider understanding of EGL Principles in local communities and organisations. | Tier Two SS Principles 3.1, 3.2, and 3.7, 4.3, 4.4  Tier two Access to the community SS 5.10, 6  Involvement of the person and their family/ whānau and others) (SS 8.2.2)  Safety: SS 8.2.4  Access to Behaviour Support (SS 5.3; 5.5) |

***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?)* * *personal support plans and evidence of partnership in service coordination* * *Samples of a diverse range of service users across all spa levels and ethnic groups* * *Evidence of service linkages* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.***  ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from provider partners. Interviews with service facilitators/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.*   * 1. *Potential sources of information: Track through client journeys via Socrates*   *Relevant documents might include: 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. staff training on methods used to enhance and uphold the individual’s mana and approaches to enhancing participatory citizenship in the context of the planning process.* | |

## **My Authority / Te Rangitiratanga**

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. | Tier Two:(SS 5.2,1 5.7)  Tier two (SS 2.1) Service Objectives  SS 8.2.3  (SS 5.11.2)  Provider information  5.2 Facilitated Needs Assessment  Guidelines, policies and legislation (SS 11.1 11.2 11.3) |
| 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 identify 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 Agreement between the person and the NASC service coordinator[[3]](#footnote-3).  Agree to review every two years or sooner if circumstances change. Re-assessments occur every five years | Tier Two SS Principles  3.1(a), 3.3(b), 3.7(a), 4.3, 4.4  Tier two (SS 5.2)  Facilitated needs assessment  Review and reassessment  (SS 5.6)  Involvement of the person and their family/whānau or others (SS 8.2.2) |
| 2.3 | I make decisions about my daily life. | 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 Two SS Principle 3.6  Tier two Service acceptability (SS 8.2.3)  5.4 Service coordination  Service Access (SS 4, 5.2; 5,4)  5.5 Intensive service coordination |
| 2.4 | Supports are highly tailored to my needs | I have a range of people in my life who support me in different ways at home and in the community | Our family member is socially connected and well supported at home. We are included in ongoing planning | Disabled people and family/whanau experience access to supports (services and people) that are:   * highly tailored to their needs * in the community and like everyday life in the community (not standardised, congregate care and custody) * strongly supporting social inclusion |  |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *planning processes that assist service users to identify goals and outcomes in ways which are consistent with EGL Purchasing Guidelines* * *protocols related to the development of a Support Agreement (or similar) which may include:*   + *commitment to allocation of support hours*   + *agreed actions to support identified outcomes* * *A support agreement that links coherently to the self-assessment and planning process* * *protocols describing how the service user is involved in decisions related to their funding* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.*** |
| ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from service providers partnered with the NASC. Interviews with service facilitators/connectors; observation of interactions and environment.*   *Relevant documents might include: contact notes and sampling support plans in Socrates.*   * 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. Interviews with service coordinators /connectors etc. On-site observation of interactions and environment.*   *Relevant documents might include: personal plans detailing methods of developing plans, how goals were devised, who was involved, how resources will be allocated and what kind of support is available for each person with goal completion, details of achievable steps to realise goals, time frames and written reviews of progress and adaptations.*   * 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 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 funding allocation within the support agreement. Sight examples of intensive service coordination- is this a dedicated position or integrated? High cost package applications and related service plan.* |

## **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 am part of the community. | I choose the activities I want to participate in.  I identify in my planning process every day/universal community service I use or want to use e.g. Hairdressers, dentists, cafes, bars, doctors, shops etc).  I am supported to identify and access support and resources I need  I can identify in my plan community events that interest me, eg, hui, kapa haka, concerts, and celebrations.  I am supported in the planning process 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 choices of what they do in their lives  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.  Service coordinators/connectors  Connect with the wider local community who can be a resource for disabled people. | Tier Two 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 2.1; 2.2; 2.3)  (SS 5.4; 5.5; 6)    Linkages (SS 6  3.6)  (SS 5.3) Specialised assessment |
| 3.2 | I have relationships with others that are important to me. | I have a network of people who support me (whānau, friends, community and I am supported to identify what paid supports may be needed.  The people who are important to me are encouraged and supported to play an active part in my planning process.  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 sexuality in my choice about how and where I live  Disabled people/tāngata whaikaha and their family/ whānau enjoy constructive and supportive relationships with their families, whānau, communities, iwi and friends. | 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 connectors/service coordinators are equipped with the values and skills required for building ‘right relationships’ with disabled people and whānau.  Support planning enables the person to consider opportunities to meet others and make community connections (clubs, events, cultural networks and community organisations).  Ensure there is appropriate training for service facilitators, connectors and where appropriate whanau for them to support the development of relationships and express sexuality. | Tier Two Principle SS 4.3  Tier two, SS 8.2.2  Person/family/whanau/aiga involvement  Objectives (SS 2.1))  (SS 4) Service access  Definitions (SS 1)  Key functions  Facilitated Needs Assessment (SS 5.2)  Other cultures (SS 5.4)  Safety (8.2.4)  Acceptability (SS2.3.3)  Maori Health and Disability (SS2.3) Maori service components (SS 5.7)  Cultural component of needs assessment (SS5.2.1)  Service Linkages (SS 6) |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *organisational material which supports the provision of services that are accessible* * *assessments clearly indicating any need for specialised equipment.* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.***  ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from providers where appropriate. 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.*   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Review plans made with Maori and Pacific peoples to reflect culturally appropriate approaches. Information from service providers. Interviews with service providers/connectors etc. On-site observation of interactions and environment.*   *Relevant documents will include sampling of needs assessment and support plans, goals and review notes. Safeguarding and risk assessment information where appropriate* |

## **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** | **Service will:** |  |
| 4.1 | I have the best possible health and wellbeing. | My support plan identifies with me who I talk to if I feel unwell.  I am supported in the planning process to communicate how my health and wellbeing is, 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 where necessary my service coordinator/connector can ensure I access specialist services when I need to (occupational therapist, physiotherapist, optometrist, podiatrist etc).  My support plan includes 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. | Include in needs assessment a check that 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 two Service Objectives (SS 2.1  Maori Health and Disability (SS2.2)  Interface with personal health (SS 3.5)  Specialised assessment  (SS 5.3)    Linkages (SS 6)  Interface with other agencies  (SS 3.6) |
| 4.2 | I am safe. | I feel safe.  My planning process ensures I receive support and am free of 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.  I have an emergency plan | 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.  Evidence that the organise collaborates with funders and provider to improve safeguarding of disabled people.  Ensure polices and processes reflect zero tolerance to any form of neglect or abuse.  Where appropriate, source advocacy or circles of support, and inform health providers around appropriate and effective individualised support. | Tier two (SS 8.2.3) Acceptability  (SS 8.2.4) Safety  Monitoring of service delivery  (SS 5.120  Risk Management SS 6.11, 6.11.1(a, b), 6.11.2(a)  Guidelines, frameworks and research (SS 8.1) |

***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 in sample of files in Socrates* * *personal safeguarding documents/plans.* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.*** |
| ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from providers. Interviews with service facilitators/connectors etc. On-site observation of interactions and environment.*   *Relevant documents to be sampled are: support plans, goals and review notes. Sight presence of 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, Training in syndrome/condition and/or person specific training. 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). Information about who to contact in a crisis.*   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from service providers and observation of any interactions and environment (where consent has been given by the person). Evidence of environmental assessment during support planning process*   *Relevant documents might include: referrals and evidence of facilitated access to health and specialist services. Risk management documents.* |

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

High Level Outcome: I belong contribute and am valued

|  | **Outcomes** | **Indicators** | | | **References** |
| --- | --- | --- | --- | --- | --- |
|  |  | **Tāngata Whaikaha / Disabled people** | **Whānau whaikaha** | **Services will:** |  |
| 5.1 | I can contribute to my community and society. | I have roles that are valued by society.  I contribute in a range of places in the community, eg, 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 and in the development of dreams goals and aspirations | Have supportive links with allied services which assist people to achieve their goals.  Work alongside tāngata whaikaha and whānau to identify and achieve their goals.  Ensure people have forums to share their stories with others if they choose. | Disability Sector information  (SS 5.11.2)  Provider information  (SS 5.11.3)  Tier two Service Linkages (SS 6) |
| 5.2 | I am involved in service development. | My views are sought in the co-development, review and adaptation of approaches used in my support planning. | Our views are sought in the co-development, review and adaptation of approaches used. | Utilise hui, and other methods, to involve people in review of strategic plans, policies and procedures, internal review and evaluation.  Develop opportunities to mentor and partner with tāngata whaikaha in service development. | Tier Two SS Principle 3.6, 7.2, 7.3(c)  Tier two Service Objectives (SS 2.1) (SS 8.2.2) |

***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.* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.***  ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from provider partners. Interviews with Service facilitators/connectors etc. On-site observation of interactions and environment.*   *5.2 Relevant documents might include: support plans, goals and review notes.*  *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: 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 Two SS Principal 2, 3.5, 4.3, 4.4, 7.6, 8.5  Tier two (SS 5.17) Key inputs (Staff training)    Service Objectives (SS 2.1)  Review and re-assessment (SS 5.6)  Linkages (SS 6) |
| 6.2 | I can have my say. | 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 and in keeping with the Health and Disability Services Standards. 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 Two SS Principle 3.8, 8.5  Tier two Acceptability (SS 8.2.3)  (SS 5.12) monitoring of service delivery  Complaints Resolution HDSS SS 11.1 (a, b, c) |
| 6.3 | I can be involved with monitoring and evaluation. | I can provide feedback about how I feel about the support I receive.  If my support needs change, I will have an appropriate reassessment. | We can provide feedback about the support our whānau receives. | Review as required or within two years, the support needs of the tāngata whaikaha/ disabled people.  Re-assessment can be requested at any time if needs change | Review and re-assessment (SS 5.6) |
| 6.4 | I have a relationship of shared power in the planning process | I feel respected and that the facilitator is respecting me and ensuring I have power to make my own decisions | We feel respected and valued as equals | Evidence of how staff provide a range of choices and the tools they use to ensure understanding of the various funding streams to support achievement of outcomes |  |

***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 Support Agreement)* * *policies related to internal and external evaluation* * *complaints process – is it easy to read/understand and accessible.* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.*** |
| ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Surveys and face to face or zoom interviews Information from service facilitators/connectors and management.On-site observation of interactions and environment.*   *Relevant documents might include: funding and Rights information (in accessible formats) and descriptions of how individuals can choose and change their connector/service facilitator or service provider. Service contract/agreement. Support plan and personal plan goals and review notes. Incident reports and complaints.*   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from provider partners. Interviews with service facilitators/connectors etc. On-site observation of interactions and environment.*   *Relevant documents might include: 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 service facilitators 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.*     * 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: 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 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 chooses. | 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 funding host or service facilitator/connector and funding specialist 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 tangata whaikaha and their whānau. | Tier Two SS Principle 7.5  Tier two SS Principle 2,  Information management  (SS 5.10)  Monitoring of support service delivery  (SS 5.12)  Budget management  (SS A1.1)  Provider information  (SS 5.11.3) |
| 7.2 | I am presented options and information so that I can make choices on how my funding is managed | I have choices on how my budget is managed and I have adequate information to make a choice | We have all the information about options we require to make the best choice with our family member.  I am offered flexible support options, such as personal budgets, IF, FDS, CICL. | Evidence of a range of information tools available and appropriate support to enable people to access the funding stream that best suits them |  |

***Evaluator guidance***

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| ***Evaluators may examine the following documents:***   * *organisational material and day-to-day processes which ensure budget management and allocation are done appropriately and ethically* * *financial systems (organisational).* |
| ***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.*** |
| ***Additional guidance***   * 1. *Potential sources of information: experiences of disabled person(s) and their whānau (including advocates, friends etc). Information from service facilitators/connectors and service providers. On-site observation of interactions and environment.*   *Relevant documents might include: personal budget allocation and other allocation across a diverse group. This will be sampled in Socrates and include needs assessment, support and personal plan. Funding agency/NASC policies and procedures that clearly detail the process* |

# **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 |
| 8.3.1 | Disabled Peoples Leadership | At an organisation level disabled people are fully involved at governance and management levels   * direction setting * values * policies and procedures * accountability * staff appointments * monitoring * operational | Commitment in practice to inclusion of disabled people at all levels of the system |
| 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 | Funding packages are targeted to those eligible with the highest need | Prioritisation is effective and allocations align with the SPA bands set out | Review of a range of client files (across all package size ranges) to assess eligibility and allocation practices and processes.  Funding allocation trends. | Appropriate determination of eligibility, funding allocation and service coordination.  Person centred practices are in evidence  Assessment, SPA and allocation aligned with sound logic documented | **A.1.1 System information in Socrates demonstrates good allocation processes**  **A1.4 Tier Two SS** |
| 9.2 | Funding packages are targeted to improve outcomes for disabled people | Funding (for all package sizes) is appropriately targeted to improving quality of life for the disabled person, taking into account the age and stage of the disabled person.  Additional requirements for approval and review of high funding packages are met. | Review of a range of client files (across all package size ranges) to assess alignment of:   1. the size of the funding package 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 packages ensures identified outcomes for people are being achieved, and package adapted appropriately.  Additional requirement for high funding packages (over $170k per annum):   1. Proposals are well documented with strong reasoning, aligned with similar cases, and are peer reviewed by another NASC. 2. Correct funding tool used. 3. Prior to approval of any high-cost package, including renewals, ensure that the client’s quality of life has been assessed and the contribution of the package to this quality of life has been documented. |
| 9.3 | Funding packages are targeted to improve outcomes for Maori | Increased engagement with Maori 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. |
| 9.4 | Funding packages are targeted to reduce barriers in the system and reduce long term costs | Early investment leads to longer term cost benefits and improved outcomes | Children, young people and adults are receiving up front support early to prevent longer term dependence on the system – examples and numbers in transition | Organisation demonstrates the ability to prioritise using an early investment approach  Evidence that service coordination discussions with disabled people and family includes flexible support options and supports that prevent the need to enter residential care. |
| 9.5 | Disabled people feel positive about funding reductions where they deem appropriate. | Where funding packages have been 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 funding reduction: Disabled people and family report a positive experience in the planning process that supports their ongoing quality of life. | Documentation samples where funding allocation has been decreased and outcomes have been achieved |

***Evaluation guidelines***

*A.1.1 Budget management practices are robust and good practices in funding allocation and documentation are evident in Socrates*

*Equitable and consistent outcomes in service coordination*

*A1.2 The organisation works well with the Ministry to manage financial and information systems (PMRS)*

*A1.3 and A1.4 predicting and managing pressures – evidence and examples of prioritisation and creative use of service packages aimed to achieve better outcomes*

*Please consider when talking to service facilitators or searching files in Socrates*

1. *The coherence of the needs assessment process regarding setting goals recording outcomes with the service coordination support plan.*
2. *Have goals and outcomes been well reviewed or are they rolled over?*
3. *How well can the service facilitator describe the persons story goals and outcomes particularly if the package has been recently reviewed?*
4. *Has the support plan reflected the correct spa allocation (This can be seen in Socrates)*

***Survey of disabled people and family - at minimum, complete the survey as provided in the reporting template to inform this and other outcome areas.***

*Additional guidance: Potential sources of information: Contact the Ministry if service trend data is required.*

# **Equity**

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|  | **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**

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|  | **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**

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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, if they choose. |
| **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. |

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)