

**Review of the
Ministry of Health
Pacific Provider
Development
Fund (PPDF) 2018**

Final Report

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Acknowledgements

la ō gatasi le futia ma le umele

The sinnet ring and the stand for the fishing rod must be equally strong. Both ropes must be of equal strength, lest one of them tear when a bonito bites.

We must be of one mind in the undertaking.

(Samoan proverb)

Thank you to all those who continue be of one mind in building on the strengths of Pacific health providers. The PPDF review and the steps following are opportunities to continue to work together in this undertaking.

The review project team¹ would like to acknowledge the Pacific health providers for their participation in this review – for the generous sharing of their time and experiences, for welcoming us into their fale, and also for their passion and dedication to improving the health of Pacific peoples through-out New Zealand.

The review project team would like to thank the Project Sponsor Matafanua Hilda Fa'asalele (Chief Advisor Pacific Health), Danilo Coelho de Almeida (in his role as Senior Contract Manager for Pacific Provider Development Fund, Operational Excellence), and the Ministry of Health Advisory Group for their guidance and generous sharing of knowledge and wisdom. Thank you also to Grant Pollard (Group Manager, Operational Excellence) and Te Miha Ua-Cookson (Manager Infrastructure, Operational Excellence) for their support of the review as part of the overall project governance.

¹ See Appendix 7 for details of the review project team, governance and Advisory Group.

Executive summary

This report presents the result of the Ministry of Health (the Ministry) 2018 review of the Pacific Provider Development Fund (PPDF).

The PPDF is a Ministry of Health administered fund that aims to strengthen the sustainability of Pacific health providers and support the delivery of quality health services with a distinctive Pacific focus to achieve the best health outcomes for Pacific peoples.

Purpose/Objectives

The purpose of the review was to identify potential improvements to the PPDF process and inform future investment priorities for the fund. The three key objectives are to:

1. describe the operational challenges faced by Pacific health providers and how they are dealing with these
2. assess the effectiveness of the PPDF for Pacific health providers
3. inform the types of provider capacity and capability development on which to focus the PPDF investment.

Methods

The review uses mixed research methods that include: literature scan, service documentation review, stakeholder interviews (providers and Ministry of Health), a survey to assess providers' ratings of their capacity and capability across time, and sharing of Most Significant Change stories² as a result of the PPDF contribution.

To inform potential improvements to the PPDF and future investment opportunities, the review draws on stakeholders reported experiences of operational challenges (Objective 1) and of the effectiveness of PPDF (Objective 2), and identified key success factors, issues and priorities for future development and investment in PPDF (Objective 3), and takes into account other factors that impact on the success of the fund (broader findings).

² For more information on Most Significant Change Stories please see Davies, R. and Dart, J. (2005) The 'Most Significant Change' Technique - A Guide to Its Use. URL <http://www.mande.co.uk/wp-content/uploads/2005/MSCGuide.pdf>

Summary of key findings

Objective one: Operational challenges

There are ongoing operational challenges for Pacific health providers. The key operational challenges experienced by Pacific providers include:

- operational management: insufficient funding to secure and retain the necessary number of staff with the required qualifications, skills, cultural competencies and experience.
- workforce development: there is a shortage of experienced and qualified Pacific people across health and other sectors (eg, for management roles) in the current competitive employment market. As a result, some providers train staff on-the-job and in-service to enable them to identify and grow staff from within their service. There is a lack of relevant free training courses available. While providers were able to use the PPDF to fund training and qualifications, there are ongoing challenges in this area (eg, backfilling roles – clinical and health promotion roles - while staff are on training; insufficient funds to support ongoing professional development; availability of relevant training appropriate to Pacific health context).
- information technology (IT): not having fit-for-purpose IT and/or ongoing funding for essential operational upgrades and maintenance.
- financial resourcing and viability: challenges include: securing new contracts; service contracts not adequately funded to cover operating costs; and having short-term contracts.

The capacity and capability development needs of Pacific providers varied according to the size and purpose of the organisation, geographic location, the type of services, and its maturity.

Providers noted that the PPDF funding support had assisted them to manage or mitigate some challenges to some degree.

Objective two: Effectiveness of PPDF

Providers identified the extent and type of support the PPDF has provided to their organisational development. Providers' capacity and capability development was particularly supported in the areas of:

- information technology (IT). The investment in IT has a strong flow on effect on organisational efficiency, performance management, client management, communication, practices and systems, and the ability to report to funders.
- strategic governance. PPDF support for strategic governance mostly took the form of governance training. Providers noted this support should be ongoing where new issues of governance arise (eg, new legislation) or where there are a number of new board members.
- operational management. The PPDF has supported development of capacity and capability for operational management through a wide range of activities including: development and implementation of policies and procedures; funding capital purchases including equipment and refurbishment of buildings; providing expertise and support for operational issues; funding effective communications; quality

assurance systems and activity; staffing key positions, and funding operational planning sessions and organisational reviews.

- financial resourcing and viability. The PPDF has contributed to financial resourcing, and to some extent, viability including through making providers more attractive to funders, investing in financial systems, and funding costs of running an organisation.

Objective three: Future focus of PPDF investment

Future investments need to be aligned with:

- strengthened cross agency strategic and operational planning of investment in Pacific providers
- the nature of the more holistic and wrap-around approach to service delivery by Pacific providers (including Pacific models of health care)
- the assessed needs of providers (informed by a Pacific specific needs assessment tool)
- clear goals, criteria, and measurable outcomes for the PPDF
- the nature of partnership and collaboration needs.

Broader findings

There are benefits of working together as a Collective. However, the degree and nature of benefits vary among the current Collectives. Ensuring a good relationship within the Collectives is critical for the success of the PPDF. Some of the issues observed during this review are reflective of those mentioned in the 2016 evaluation undertaken by Allan and Clarke (Allan and Clarke, 2016).

Conclusions

Pacific health providers have a unique point of difference in being Pacific for Pacific; having strong connections to the communities they serve; and in the way they deliver services to diverse Pacific communities with complex health and social needs through a wraparound family focussed model of care.

Providers who participated in this review are experiencing ongoing operational challenges and their capacity and capability development is variable. While PPDF was able to provide support for some challenges, many require a wider health sector response from agencies with a role in the health of Pacific peoples.

PPDF is an effective contributor to provider capacity and capability development and supports provider viability and sustainability.

PPDF is a relatively small pot of funding and to maximise its contribution to Pacific health providers, it needs to be considered in the context of other funding that supports Pacific provider development and service delivery.

To optimise the operation of the fund:

- the Ministry needs to work with key stakeholders to:
 - increase clarity on the PPDF model – vision, purpose, outcomes, eligibility criteria

- strengthen the process and transparency of the allocation of funding to regions and by the Collective
- develop a Pacific specific needs assessment tool that is appropriate for providers of different sizes and at different stages of organisational maturity
- strengthen monitoring and reporting – to support demonstrating accountability for PPDF and identify opportunities for future quality improvement
- having a well-functioning Collective model is key.

Recommendations

Based on the above findings and conclusions, the review makes the following recommendations.

1. The Ministry should continue to invest in capacity and capability development for Pacific providers. The review has found this to be needed and an effective way to increase capacity and capability for these providers who have an important and unique role.
2. Strengthen strategic and operational alignment for PPDF across social sectors and within health.
 - a. Greater cross-government collaboration around supporting Pacific providers across all of the social sector (health, education and social development).
 - b. Ministry, district health boards (DHBs) and Pacific health providers will benefit from a stronger articulation of the alignment between the government's priorities (eg, equity in health), the New Zealand Health Strategy (Ministry of Health 2016), 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–18³ (Ministry of Health 2014a) and local DHB priorities.
 - c. Take a systems view to investment in Pacific providers - including strengthening the relationship with DHBs/PHOs to better align PPDF investment with other sources of funding important for provider development and financial viability.
3. Increase clarity and transparency of PPDF investment parameters
 - a. Clearer criteria for: (i) provider eligibility to access PPDF (ii) eligibility and process for Collective membership (iii) the types of activities qualify as investment in capacity and capability development.
 - b. Ensure a clear articulation of the vision, purpose, goals, and key outcomes expected by the Ministry from PPDF investment.
 - c. Strengthen monitoring and reporting requirements
 - d. Contract terms with Collectives and individual providers should be increased to at least 3 years to better enable providers to plan and to allow for the investment to bed in. This will also reduce the administrative burden.

³ And any future updates (eg, Pacific Health and Disability Action Plan)

4. Strengthen the method to allocate PPDF funding to each region (with consideration to proportionality to need and equity).
5. Develop an appropriate Needs Assessment Tool tailored for Pacific health providers to guide investment at the provider level to better assist identification of priority areas for capacity and capability development.
6. PPDF future investment should continue to fund all the focus areas of capacity and capability development (see full recommendations for details).
7. Increase the profile and accessibility of information on the PPDF.
8. Explore the next steps to best support the sustainability and development of Pacific health providers. It is suggested that this includes a more in-depth discussion on supporting providers' different and evolving development and partnership needs.
9. Establish a post-review implementation plan to follow up on the recommendations.

Main report

Background and context

Pacific health context

Approximately eight percent (389,900 people) of the resident New Zealand population self-identify as belonging to one or more Pacific ethnic groups (based on Statistics NZ population projections for 2018), an increase of around 30% from 2013 Census (Stats NZ). This is a youthful population (with more than half under 25 years), largely urban (with approximately two-thirds residing in the Auckland region) and diverse. There are over 40 different Pacific ethnic groups within this total (the largest being Samoan, followed by Cook Island Māori, Tongan and Niuean), with diversity in language, culture and history (Ministry of Health 2014b). There are similarities across Pacific ethnicities in the focus on extended family and community and shared values, and beliefs (Tiatia and Foliaki 2005). Sixty percent of Pacific in New Zealand are New Zealand born, with many identifying with one or more ethnic groups and with both their ancestral Pacific Island(s) and New Zealand (Ministry of Health 2010).

Pacific communities have many strengths including strong social and cultural capital. However, Pacific peoples in New Zealand experience poorer health outcomes across a range of indices compared with total New Zealanders. The underlying causes are complex and include increased exposure to factors such as poor housing, poverty, and poorer access to education and health services that fully engage with the population to meet their needs. These inequities are enduring and the focus of the government's and the Pacific Health Strategy priority to address inequity. The Pacific Health Strategy outlines the importance of systems and services that meet the needs of Pacific peoples. Building the capacity and capability of Pacific providers and workforce are key enablers to improve access to appropriate, acceptable and affordable services to achieve equitable health outcomes for Pacific peoples.

Pacific health providers

There are approximately 39 Pacific health providers known to the Ministry of Health. These providers meet the Cabinet Minute (01) 31/6B definition of a Pacific Provider, namely that they are owned and governed by Pacific peoples, and provide services primarily but not exclusively to Pacific peoples (Cabinet 2001).

Pacific health providers emerged in the 1980s with a focus on allowing Pacific communities to take greater control over their own health (Ministry of Health 2010). Some of the services started as ethnic specific services, to cater and advocate for specific communities (eg, Langimalie, Tongan Health Society).

Frontline health interventions are provided in Pacific settings, with engagement with churches, schools, community groups, and sports clubs. Services are delivered based on

Pacific models of care where they are tailored according to the patient's family environment, community setting and cultural beliefs. The services offered integrate primary care, health promotion, secondary care and social services. For example, many primary care practices include community health workers who undertake home visits and health promotion (Ministry of Health 2010).

Pacific health providers are largely community "owned and operated" and most operate on a not-for-profit basis. Many of the providers are small in size, relative to mainstream organisations, and often have to partner with larger organisations (including mainstream providers) in order to secure new contracts in the current market and fiscal environment.

The Pacific Provider Development Fund

The PPDF was first established in 1998 (English 1998; Ministry of Health 2008). "It signalled the Government's commitment to developing Pacific health providers so that Pacific peoples could access healthcare where their language was spoken, their culture understood and where Pacific models of care were delivered" (Ministry of Health 2010). The PPDF aims to strengthen the sustainability of Pacific health providers and support their delivery of quality health services to achieve best outcomes for their Pacific communities.

Provider eligibility to access PPDF

To be eligible to access the fund, providers are required to meet the following nationally set criteria:

- be an existing Pacific health service provider (ie, a provider that is owned and governed by Pacific peoples and provides service primarily, but not exclusively, for Pacific peoples⁴)
- hold a health service contract (within the last 18 months)⁵
- be a legal entity (Ministry of Health 2009).

Administration of PPDF

The Ministry administered the \$1 million fund through the Health Funding Authority from 1998. The fund continued under a new government as part of the Closing the Gaps initiative with an additional \$1.5 million allocated in 2000/01 and \$5 million allocated per annum from 2001/02 (Gosche 2000). The newly established DHBs distributed this funding from 2001 (Ministry of Health 2005). Funding was increased again in 2009 to \$7.4 million per annum (Ministry of Health 2008). Following a review of the PPDF by Ernst and Young (2009), the fund was brought back to the Ministry to administer.

Since 2012/13, the Ministry has administered the PPDF through a regional 'Collectives model'. Under the Collectives model, the Ministry contracts with a lead provider ("lead

⁴ The definition of a 'Pacific Provider' is as agreed by Cabinet in 2001 (from Cabinet Paper 01 31/6B). Providers located in and operating within the governance of a mainstream organisation are not eligible for PPDF. It is expected that their development needs are funded by the mainstream organisation.

⁵ A health service contract is one funded under Vote Health

providers”) for each Collective in four regions (Auckland, Midland, Wellington, and the South Island⁶). The Collective lead provider receives, administers, and distributes the PPDF to Pacific health providers who are members (“non-lead providers”) of the Collective. The lead and the non-lead providers make up the Collective.

The Collective model is not uniform across regions, and continues to evolve since its establishment in 2013, with changing management structures and provider membership. A list of providers receiving PPDF in each Collective in 2018 is set out in Appendix 1.

Auckland region

Alliance Health Plus Collective

In the Auckland region, Alliance Health Plus is the lead provider for the Collective which was the first to be set up in 2012. Alliance Health Plus is a primary health organisation (PHO) established in 2010 through the amalgamation of three Pacific PHOs: Ta Pasifika PHO, AuckPac PHO and Tongan Health Society PHO (Langimalie). The PHO has over 34 practices and delivers Parish Nursing Services, a Rheumatic Fever Programme and a Pacific Integrated Service Programme, in addition to their PPDF administration role (Alliance Health Plus Annual Report 2016). Initially it was made up of five providers and has increased to 12 current provider members. The providers are diverse in terms of: length of time they have been in the Collective; services offered; type of organisation (entity; non-government organisation (NGO)/primary care practice); stage of organisational development/maturity; size and population served. Some of the current primary care practices that are members of the Collective, are affiliated with other Auckland PHOs.

Midland region

The Aere Tai Pacific Midland Collective (Aere Tai) is comprised of seven Pacific providers working together to serve the communities of the Midland region. The Collective includes three foundation members based in Hamilton, Tauranga, and Tokoroa and four more recent members based in Napier⁷, Gisborne, New Plymouth, and Rotorua. Members of the Collective deliver a range of primary care, community based health, education, social and Whānau Ora services. Aere Tai promotes the use of Pacific models of care and practice, and supports Pacific provider service development across the region.

The lead provider is K’aute Pasifika Trust (registered charitable trust) which began as a Pacific community initiative and operates from a strong foundation of cultural and spiritual values. K’aute delivers health, education and social services, as detailed below, and a Whānau Ora Navigation service:

- primary community health / outreach (child adolescent mental health, chronic disease management, home based support, health promotion programmes – adults,

⁶ There is currently no South Island Collective provider since the liquidation of the Pacific Trust Canterbury in September 2016. In 2017, South Island Pacific health providers agreed for PPDF to be administered through the Wellington Collective.

⁷ Note Hawkes Bay DHB is part of the Central region DHBs and not part of the Midland region DHBs.

health visits / advocacy / interpreting, mobile nursing service, outreach immunisation, sexual and reproductive health

- smoking cessation, Well Child/Tamariki Ora Service, Mobility Action Program
- education services (adult education, early childhood education, education support)
- social services (community garden projects, housing support)
- Whānau Ora Navigation service.⁸

Wellington region

The Central Pacific Collective (CPC) is the current lead for the Wellington Collective. CPC was established through an agreement by all Wellington Pacific health providers after the Taeaomanino Trust Board withdrew from the Wellington Collective lead role in 2015. CPC was set up to support Pacific providers and provide back office support. It has a governance structure made up of an independent Chair and the Chairs from each Collective member provider. It acts as an umbrella organisation, holding the Ministry contract for the PPDF and supporting its member organisations through:

- shared services (eg, human resources, finance)
- cost savings (eg, auditing)
- collective strength (eg, leveraging off members)
- secretariat and administrative support (eg, workshops, training and development)
- maintenance of an information hub (data and research to support programme development).⁹

South Island region

There is currently no South Island Collective provider since the liquidation of the Pacific Trust Canterbury in September 2016. In 2017, South Island Pacific health providers agreed for the PPDF to be administered through the Wellington Collective.

Contracted Funding and Allocation by Region

For the 2017/18 financial year, \$3.2 million (GST Excl) PPDF funding was contracted by the Ministry. Current allocations to lead providers of Collectives by region are shown in Table 1 below. Lead providers then distribute funding within their Collective on the basis of individual provider need assessments and associated business case proposals.

⁸ <http://www.aeretai.nz/providers/hamilton/>

⁹ <http://www.cpcollective.org.nz/>

Table 1: PPDF funding contracted by the Ministry of Health by region (2017/18)

Region	Contract Holder	Funding Allocation by contract \$ (GST Excl)	Sub-total Allocation by region \$ (GST Excl)	% Allocation
Auckland	Alliance Health Plus	\$1,200,000	\$1,500,000	47%
	The Fono	\$300,000		
Midlands	K'aute Pasifika	\$600,000	\$600,000	19%
Wellington	Central Pacific Collective	\$800,000	\$1,100,000	25%
South Island		\$300,000		9%
Total		\$3,200,000	\$3,200,000	100%

Evaluation of the Collective Model (2016)

The Ministry commissioned an independent evaluation of the PPDF Collective model (the Evaluation) in 2016, which was undertaken by Allen & Clarke Policy and Regulatory Specialists. The Evaluation focused on the Collective model and considered:

- the effectiveness of the Collective model as an approach to organisational capability development
- return on investment for the Collectives and associated Networks.¹⁰

Key findings of the Evaluation included:

1. the investment model was well aligned with most of the developmental needs of most providers
2. PPDF works well when there is high trust and collaboration, good leadership, transparency and communication and an equity focus
3. sustainability of the benefits of the PPDF are largely dependent on providers accessing reliable and long-term income streams
4. providers identified the benefit of the Collective model compared with the previous model of fund distribution. Aspects of the PPDF support that generated the most benefit for the investment made were in: strategic governance, collaboration, IT enhancement and clinical competency.

The Evaluation also provided some recommendations that should be taken into consideration when investing PPDF through the Collective model, particularly in the areas of communication, planning and reporting (Allan and Clarke 2016).

¹⁰ Regional Pacific Providers Networks (Networks) are outside of the scope of this Review. The Networks were established from 2013 with time-limited funding of \$4.5 million for a four year period.

Terms of reference

Purpose and rationale for the review

The purpose of the review was to identify potential improvements to the PPDF process and inform future investment priorities for the fund. The review findings will contribute to the Ministry of Health's ongoing work to support Pacific health providers and services.

Objectives

The Ministry set the objectives and scope of the PPDF review. The key objectives of this review are to:

1. describe the operational issues and pressures (challenges) faced by Pacific health providers and how they are dealing with these
2. assess the effectiveness of the PPDF for Pacific health providers
3. inform the types of provider capacity and capability development on which to focus the PPDF investment (eg, workforce, IT systems, governance etc).

Scope

The focus of the current review is providers' perspectives of the effectiveness of the PPDF. The Collective model component of the PPDF has been evaluated elsewhere by Allan and Clarke 2016 (as noted above).

The scope of the review includes:

1. funding used to implement Pacific Provider Development Fund Plans in contracts between the Ministry and the three Collective lead providers; and the Fono¹¹ from 2013; as well as two one-off contracts with individual providers (see Appendix 2 for contracts in scope)
2. providers:
 - that are currently receiving PPDF funding as outlined above
 - that had received PPDF funding since 2013 as part of a Collective but who are no longer members of a Collective (but would still be eligible for PPDF funding).

The list of eligible providers for the review was provided by the Ministry team that manages the PPDF¹².

¹¹ Contracts were signed with three Collective lead providers and the Fono, an individual provider. For the purpose of this review we refer to non-lead providers (including the Fono), and lead providers as "providers".

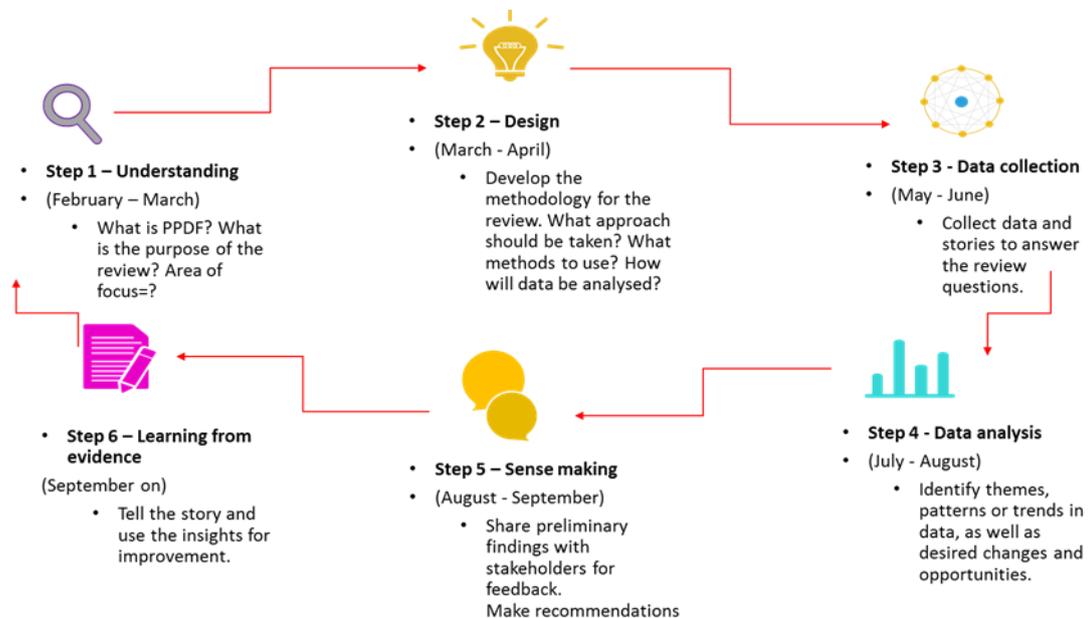
¹² There was consideration of interviewing Pacific health providers who are eligible but not currently receiving PPDF. These providers would be able to contribute to the knowledge about challenges faced by Pacific providers, and could inform some thinking about the future of the PPDF (for examples barriers to access) but could not contribute to the question of the effectiveness of the fund. These providers were therefore excluded from the review.

Methodology

The approach

Reflecting on the context and purpose of the PPDF, the review takes a three-pronged approach: participatory, talanoa, and strength-based. Feedback from interview participants on this approach has been positive.

Figure 1: Overview of the PPDF review process



The methods

Design of the review process – stakeholder workshop 1

In the early phase of the review, a workshop was held with stakeholder representatives to introduce the project and seek their input into the review design. Input and feedback was sought on: a draft programme logic model (PLM); areas on which to focus the key research questions; and providers’ views on what they would want to achieve from the review.

The workshop was attended by representatives from the Collective lead providers, South Island Pacific health providers and Ministry officials (Chief Advisor Pacific Health, lead Contracts Manager for the PPDF, Pacific Policy Team Manager, and the project team).

Data collection

The review used mixed research methods to gather a wide range of information, including:

- assessment of relevant peer reviewed and grey literature
- review of service documentation

- stakeholder interviews – face-to-face interviews with representatives from Pacific Health Collective lead providers and non-lead providers and other agreed stakeholders
- online survey to gather providers' assessment of changes to their capacity and capability overtime as the result of the PPDF
- Most Significant Change stories
- stakeholder workshops.

Literature scan

A literature scan was carried out to identify research results, frameworks, models, and tools, and other information relevant to government funding and capacity and capability development. The search included published journal articles, grey literature, and websites (government, academic, and professional, etc).

The full results of this literature scan are presented in a companion technical document (Ministry of Health 2018).

Service documentation review

To support the design of the review, a range of service documents were analysed to:

- gain an understanding of the background and context of the PPDF, including how the fund is administered
- understand the contract specifications, including activities specified, and the intended outcomes of the PPDF as communicated to contract holders
- develop a PLM to outline the theory of change of the PPDF
- determine if there was any existing objective data that could be used for assessing changes in capacity and capability over time (since the PPDF was contracted in 2013).

The service documents reviewed included:

- key Ministry strategies (eg, New Zealand Health Strategy, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing, 2014)
- previous evaluations of the PPDF (Ernst and Young 2009; Allan and Clarke 2016)
- an *Organisational Capability Self-Assessment Tool* completed as part of a Request for Proposal for "Pacific Health Provider Collectives Seeking Development Support (Ref 121300753), May 2013"
- a needs assessment tool completed by Auckland providers in 2012
- contracts between the Ministry and three lead providers signed in 2013 and the Fono signed in 2015 for implementation of Pacific provider development plans
- a sample of performance monitoring reports between 2013 and 2017 for the above contracts.

A draft PLM (see Appendix 3 for the final version of the PLM) was developed and used to facilitate discussion at a planning workshop with stakeholders. As a result of feedback from stakeholders, ten areas of capacity and capability development ("focus areas", see Appendix 4 for definitions) were finalised and used to guide the review (note, these are aligned with the areas contained in the Ministry of Social Development *Organisational Capability Self-*

*Assessment tool*¹³). This has been an iterative process, and the focus areas and exact wording were adapted as the review progressed. The focus areas are:

1. Strategic governance
2. Operational management
3. Workforce development
4. Financial resources and viability
5. Information technology (IT)
6. Responsive to different needs of the Pacific community
7. Deliver services in a Pacific way
8. Innovation
9. Performance management (including for outcomes)
10. Collaboration.

The PLM focus areas informed the questionnaire for stakeholder interviews, the analysis, and final report structure.

The project team was not able to establish a retrospective baseline of provider's capacity and capability in 2013 for all providers participating in this review from examining available service documents (needs assessments or reported outcomes data in contract performance monitoring reports). Reasons for this data constraint include: (a) the number of providers participating in this review, who were not recipients of PPDF in 2013 and/or for whom we did not have access to individual level needs assessment data (b) different needs assessment tools were used in Auckland compared with other regions making it difficult to compare (c) provider monitoring reports held by the Ministry did not contain outcomes data. These data constraints mean that the effectiveness of the PPDF on providers' capacity and capability development in this review is based on providers' online survey ratings of their capacity and capability across two points in time and qualitative interview data (on the type and extent of the PPDFs impact).

A summary of the service documentation review can be found in Appendix 5.

Stakeholder interviews

Stakeholder interviews were conducted with representatives from eligible Pacific providers and the Ministry. Interviews were semi-structured and designed with a Pacific context in mind. Where possible, interviews were face-to-face and took place at the venue of the interview participants. A total of 29 interviews were conducted across 27 out of 30 (ie, 90%)¹⁴ eligible Pacific providers (including representatives from Collective lead and non-lead providers and representatives from all regions¹⁵). In addition, five key Ministry staff were interviewed who had direct knowledge and experience of the PPDF within the scope of the review. A copy of the survey tools can be found in the companion technical document (Ministry of Health 2018).

¹³MSD Organisational Capability Self-assessment Tool. URL: www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-services-for-outcomes/organisational-capability-self-assessment-tool.html

¹⁴Two providers declined to participate in a stakeholder interview. One provider was not available during the period when the interviews were held.

¹⁵Breakdown by region is withheld to protect confidentiality.

Online survey

The online survey gathered information from the providers about changes in capacity and capability overtime through self-assessment – a quantitative information to supplement qualitative data. A total of 15 of 27 (56%) providers (from all four regions¹⁶) took part in the survey. See the companion technical document for a copy of the on-line survey questions (Ministry of Health 2018).

Most Significant Change stories

“Most Significant Change is a participatory evidence-gathering technique. It involves collecting stories of significant change, usually from a service or programme” (Davies and Dart 2005). Providers were encouraged to share their stories of change(s) that occurred with the contribution of the PPDF. These stories are valuable sources for understanding how changes take place (process and causal mechanisms), why change occurs and most importantly, why these changes are so important from the providers’ perspective.

The providers were given information and instruction on the Most Significant Change stories verbally during the face-to-face interviews and as part of the on-line survey. The instructions in the survey asked for providers to “describe a story that shows changes in mind set, behaviour, approaches in your organisation or your communities as the result of using the funding from the PPDF”. Specifically they were asked to describe:

- the story (what happened? who? where? how? when?)
- why is this story significant to you?
- how has PPDF contributed to this story?

The review team analysed the stories by theme and by following the causal mechanisms. A total of 13 organisations submitted Most Significant Change stories; 11 of whom consented for their stories to be shared (see Appendix 6).

Data analysis

Qualitative thematic analysis was used to analyse interview data and quantitative analysis was used to analyse online survey data. Preliminary results were sent to interview participants for their feedback (sense making process). Results were then cross checked and where possible triangulated to provide a more complete picture.

Sense making process

Feedback was invited from interview participants on the provisional findings as part of a sense making process. The original intention was to invite feedback through a sense making workshop with lead provider representatives. However to ensure all interview participants had an opportunity to feedback on the provisional findings, sense making was conducted via email. The Sense Making document was emailed with clear instructions to provide feedback on three questions (do the findings by and large reflect your experience; how meaningful are these findings for you and your organisation; what are the possible opportunities arising from these findings for informing future PPDF investment in provider capacity and

¹⁶ ibid

capability?). Interview participants were invited to email their feedback or phone the review team.

We received feedback on the Sense Making document from 11 interview participants (38% of all interview participants) (representing 10 (37%) organisations across all regions). This meant the project team may not have a true representation of interview participants' views on the provisional findings. Potential contributing factors to this response rate is the use of email and phone calls to invite feedback rather than face-to-face method; the timing for the sense making which coincided with a particularly demanding time for providers; and the fact that the sense making document did not contain recommendations.

All respondents confirmed that the provisional findings accurately reflected their experience. One respondent noted that the findings presented are very broad. The findings were considered meaningful. A number of respondents highlighted particular findings and described how they were meaningful for their organisation. This information was consistent with what they had shared in their interviews.

Providers shared a range of suggestions arising from their insights to the findings for future PPDF investment. A number of these were captured as part of the interviews and are reflected under Objective 3. The project team have considered these in developing the review recommendations. Some suggestions, while out of the scope for this review, have been shared directly with the Ministry Chief Advisor of Pacific Health.

Stakeholder feedback on the draft report recommendations

Providers were invited to provide feedback on the draft review report recommendations and discuss next steps.

Ethical considerations

The review methodology was assessed against New Zealand Health and Disability Ethics (HDEC) guidelines for conducting observational studies. Based on the HDEC criteria for observational studies, it was assessed that this review does not present more than minimal risk to participants (including because data collected did not include personal health information) (National Ethics Advisory Committee 2012; New Zealand Health and Disability Ethics Committees 2014). Based on this assessment, formal ethical approval from an approved ethics committee was not required. Ethical principles have been applied in the design and delivery of the review.

Findings

To inform potential improvements to the PPDF process and future investment opportunities, the review draws on providers reported experiences of operational challenges (Objective 1) and the effectiveness of PPDF (Objective 2) and identified key success factors (what works) and opportunities for improvement (Objective 3). It also takes into account other factors that impact on the success of the fund (broader findings).

This section presents the analysis of data from the qualitative stakeholder interviews, online survey results completed by providers, and the Most Significant Change stories.

The findings are presented under each of the review objectives. Within objective one and two, the findings are structured under each focus area for provider capacity and capability development (see Appendix 4 for broad definitions of focus areas).

Findings related to Objective one (operational challenges)

“to describe the operational issues and pressures (ie, challenges) faced by Pacific health providers (the providers) and how they are dealing with these”

The following section describes the operational challenges faced by Pacific providers and how they are dealing with these (where this information was shared), drawing on the qualitative data from stakeholder interviews. Providers noted that the PPDF funding support had assisted them to manage or mitigate some challenges to some degree.

Strategic governance

Providers face (or have in the past faced) significant challenges around strategic governance that can affect good governance and potentially the sustainability of their organisation. (See also *Financial resources and viability* section for a link between a perception that an organisation is “robust”, for example, through having a strategic plan, and securing funding).

Common themes identified include:

- **establishing an appropriate board membership and structure.** Finding community members who have governance skills or knowledge and/or who are willing to volunteer to be on a board.
- **operating a high functioning board.** Challenges included having inexperienced board members (eg, who do not fully understand their accountabilities); the amount of paper work, and other demands on members’ time especially as many board members are in full-time employment and have other commitments.
- **the role of governance and operations not being clearly separated**, especially for small providers due to pressure on staffing (eg, Board chairs are sometimes taking on some operational roles or Chief Executive Officers taking on multiple roles across the organisation).
- having the **capacity to undertake strategic planning.**

Operational management

A large number (more than two-thirds) of providers mentioned they had capacity and capability challenges related to operational management (ie, day-to-day management of the business, systems, policies, and planning and delivery).

Common themes identified include:

- **staffing.** By far the most common theme (from more than half of interview participants) was the operational challenge of securing and retaining the required number of staff with the necessary qualifications, skills, cultural competencies and experience.

Factors impacting on providers' ability to recruit and retain staff included:

- shortage of Pacific staff with the required qualifications and skills in the current competitive employment market
- inability to compete with the wages offered by larger and/or mainstream organisations
- short term contracts mean providers cannot guarantee ongoing employment
- insufficient funding to advertise for a full-time positions
- service contracts not covering funding for key management and administrative positions

As a result of these staffing challenges, some providers are using volunteers for service delivery, and acknowledge that their staff work hours that are unpaid. Some staff within the organisation take on multiple roles (eg, CEOs).

'because when I look at the staffing for instance if I pay for every hour of people working here this organisation will go out the door. There's doctors and nurses and social workers that part of their work is voluntary.'

Linked to this is succession planning where it is a challenge to grow leadership and management from within the organisation.

- **operational policies** having capacity and appropriate expertise to support the development and/or implementation of operational policies and systems including quality management systems, and health and safety systems and policies.
- **geographic spread of regional providers** puts pressure on providers because of the time and cost of travel, and having reduced access to other services.
- **compliance paper work** particularly for primary care providers
- **not having fit for purpose buildings** (eg, when organisations out-grow their premises or when buildings are not configured to best support service delivery)
- **communications/marketing** including letting communities know about their organisation and what it offers in terms of services.

Workforce development¹⁷

Common themes identified include:

- **lack of funds to support ongoing staff training and development**
- **lack of appropriately qualified Pacific people** who are available to recruit so providers train staff on the job.

Providers talked about the importance of workforce development not only for paid staff, but also the many volunteers and community members who are always keen to support and contribute to the services delivered by providers. Providers who talked about this, felt that it will not only build capabilities for community members themselves, but importantly the providers will then be able to recruit people directly from the community to use learned skills and knowledge for various projects.

Most providers received funding through the PPDF for workforce development in the early stage after the Collectives were set up. Amounts given were different depending on providers' needs assessments and strategic planning. Obtaining funding for ongoing staff training and development has been challenging for some providers in some regions (eg, due to the amount of funding available or Collective processes). As a consequence, staff are either trained on the job, or funding and free training is sought from outside the Collective.

Financial resources and viability

Providers continue to face challenges that impact on their financial viability and the long-term sustainability of their organisation.

Common themes identified included:

- **challenge of securing new contracts/funding.** Small Pacific NGOs (particularly when they are starting up) may be at a disadvantage when tendering for contracts where they have not built up a "track record" and do not have the resources or time to complete the tender documents. In addition, providers noted funders seem to prefer larger or national providers in the current market.

'...where you're seeing closed tenders, you're seeing preferred providers, and I think for the small to medium ones and with respect the non for profits [they] are sort of seen as a bit more of a risk and I think that's a challenging thing – because some of them probably are but it's that tension it's between having choice and diversity versus universal one-stop-shop kind of strategies. So that's probably more of a statement around what I perceive, so for us going forward as Pacific providers that's our barriers'

- **service contracts not adequately funded to cover operating costs.** Some contracts do not provide adequate funding to: cover overheads, support key staff positions (eg, CEO, administration) or enable providers to respond to additional or unforeseen pressures such as pay equity.

¹⁷ Responses about staff recruitment and retention issues are discussed in the *operational management* section of this report.

This is particularly a challenge for Pacific providers where at the heart of their service is a drive to meet the needs of their communities, whether this is within the contract specifications or not.

'... the challenges also that it's hard to find contracts that allow you to be responsive to the rising needs, you know, to the little things that happen that you can't find a place in the contract for where it fits'

- **short-term contracts** have impacts on ability to plan and develop services, and secure and retain staff
- **primary care funding models and system.** The income from the Very Low Cost Access (VLCA) scheme¹⁸ do not cover costs adequately. The increased pressure on services with government changes such as free appointments for under 14 year olds, puts pressure on practices. Another provider found it a challenge to establish clinics in areas of high need, as a physical presence is needed in these areas before funding can be secured.
- **competition from large mainstream or other providers**

Providers have different ways of managing challenges around *financial resources and viability* (also mentioned in the innovation section), including cutting services, delivering the service in a different way, or making things "user pays" (within reason as the community may not be able to afford services). A few providers made comments about having to generate their own income outside of their current service contracts.

Information technology (IT)

IT (including telecommunications) are continually changing and this creates a number of challenges for organisations to operate in the most effective, efficient and secure way. Many interview participants mentioned current or past challenges that were aligned with two closely linked themes:

- **not having a fit for purpose IT system** to enable providers to complete their day-to-day work in the most efficient and effective manner. This manifested in a number of ways. These included not having the required IT hardware, software or systems to enable timely access to data for client management; monitoring client and organisational outcomes; and generating timely purpose built reports.

A number of providers commented that in the past they did **not have the means to electronically input and/or access data when working outside of the office setting**. Reliance on paper based manual records was noted to result in inefficiencies (eg, through

¹⁸ Very Low Cost Access (VLCA) scheme supports primary care practices "with an enrolled population of 50% or more high needs patients where the practice agrees to maintain patient fees at a low level." <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/very-low-cost-access-scheme>

double handling of data) and potential confidentiality issues if paper based records were lost. Not having the ability to access client management databases in a timely manner when staff are mobile was also mentioned as a related challenge. These challenges have to some extent been addressed by PPDF investment.

- **costs associated with procuring, upgrading and maintaining IT hardware and software and license subscriptions (eg, Medtech)** were reported as challenges for the majority of organisations. This includes the associated costs of staff training if required with the introduction of new IT and telecommunication systems, equipment/hardware and software.

'Just like our IT last year was upgraded (our server) but now Medtech's come back and need to upgrade the version, we got the older version so sooner or later our system will not be compatible. So we have to find a dollar to help upgrade those, it's never-ending.'

There were some specific challenges for providers with primary care clinical services (eg, Medtech licences), and for organisations who were starting up or expanding; however most of the challenges were common across all types of organisations.

Responsiveness to different needs of the Pacific community

Providers recognise and understand that Pacific health issues are complex and diverse, and go beyond clinical issues. For many providers, managing these issues is often outside of their scope, such as New Zealand non-residents requiring significant social support.

Common themes identified included:

- **multiple health and social issues** faced by Pacific families. The majority of providers noted the many challenges facing Pacific families, such as unemployment, poor housing, and not accessing primary care services early
- **having someone from the same Pacific community deliver the service**
- **contract service specifications** restricts providers' ability to respond appropriately to Pacific health needs because solutions often require collaboration with other sectors and maybe outside of the scope of contracts
- **need to get people to be proactive around their health.**

Deliver services in a Pacific way

Delivering services in a Pacific way refers to how services are delivered; considering the diverse cultural and Pacific ways of being and the environmental and social elements impacting on Pacific families. For many Pacific providers this captures their point of difference.

Central to this is the Pacific family focused holistic model of care - explained by providers as *'not only treating the whole family's health issues but supporting or managing the family's social issues'*.

Many providers did not identify this focus area as a challenge, as they agreed that generally, delivering services in a Pacific way is inherent in the way they operate.

'You practice [as Pacific people] from your experience of knowing being in it'.

One common theme identified was the:

- **challenge to provide ethnic specific services for each ethnic group.** Providers struggle with having sufficient capacity to deliver services tailored for each ethnic group (eg, ethnic specific health promotion services). However, responding to this expectation of delivering services to specific Pacific communities is seen as being of value, as providers believe this will help build community trust, get buy-in and increase provider visibility.

Innovation

Common themes identified included:

- **lack of clarity about the scope of innovation**
- **sustainability of activities** that started out as being of an innovative nature. For example, one provider was able to use the PPDF to secure a short-term contract with a female doctor specialising in mother and child health care. However, the short term situation was not ideal for job security for the doctor or for the sustainability of the service for the community.

Innovation has been described by providers as new ways of thinking, new ways of working together, and new programmes and services. Providers commented that innovation could happen in many ways and was dependent on the priority of the organisation. In general, the PPDF has supported innovation to varying degrees.

The main drawback for using the PPDF for innovation is the short term nature of funding. This was especially so when the fund was used to employ staff that were in high demand or hard to source. Sustainability became an issue when the fund was not available. Providers would like to have a clear guideline on activities in scope for innovation PPDF funding from the Ministry.

Some providers mentioned the natural connection between the PPDF and the Ministry Pacific Innovation Fund¹⁹ in programmes and activities. In that regard, funding from any source could contribute to innovation. Providers see innovation as part of organisational growth and would welcome support in becoming more innovative.

'Innovation comes from the ability to keep the right things in front of you. One of the things that we identified in health of older people is ... isolation and the loneliness... We

¹⁹ The Pacific Health Innovation Fund was established in 2012, to contribute to reducing the prevalence of disease and injury to the Pacific population in New Zealand, through investing in a range of Pacific health initiatives that demonstrate innovation through the application of new strategies, models and methods of service delivery.

just started up a development centre for elderly care... we have four of them all (base) on ethnicity because they return to their first language'

Performance management²⁰

A few providers mentioned they are facing challenges around performance management. A common theme identified is the:

- **challenge to deliver on contractual volumes targets:** where providers are small and/or have high volumes to achieve.

Other challenges related to performance management included:

- managing performance expectations from community and other providers.

'what I'm thinking is that we've actually grown too fast ...that the likes of the DHB and the PHO is actually now expecting too much of an organisation that is only operating at this level of resources.'

- having access to research/data to better understand community needs
- having realistic and clear performance measures.

Collaboration outside of the Collective

Common themes identified include:

- **barriers to working in collaboration.** While providers value working in collaboration, they noted barriers to doing so. These partly arise due to the competitive funding environment in which providers operate, making providers cautious about sharing and trusting other organisations. The time and cost to collaborate is also a barrier, especially for smaller providers located in areas where providers are geographically dispersed. Collaboration was also noted to be a challenge amongst providers at different stages of organisational development and providers of different types and with different focuses.

'...started talking with other providers... around the region to see how we can do something better and that's actually a strength but it requires work. The relationships key, relationship is key. Our model's based on trust and simply chucking Pacific providers together again is asking for trouble ... it needs to start small and you've got to practice a relationship.'

- **challenges working with mainstream organisations.** These included the ability to have influence at DHB level in one region, and the challenge of working with organisations who approach Pacific clients as individuals without considering the wider family or context.

²⁰ While there are some overlaps between performance management and broader quality assurance activity such as audit and accreditation, these aspects were analysed as part of operational management.

Additional findings from Ministry of Health stakeholders on challenges associated with the PPDF

Ministry staff interviewed were aware of these challenges experienced by providers. Ministry staff did their best to work with providers to find solutions to the challenges. The main challenge for the Ministry internally relates to the demand on resources to administer the fund and to support Pacific health providers in general.

Findings related to Objective two (effectiveness of PPDF)

“to assess the effectiveness of the PPDF for Pacific health providers”

To assess the effectiveness of PPDF in developing Pacific providers' capacity and capability, this section presents data from the following sources:

1. stakeholder interviews – the extent to which the PPDF has been effective; examples of support from the PPDF; and the results of this support.
2. online survey – providers self-assessed ratings of capacity and capability across time
3. analysis of the Most Significant Changes stories.

Strategic governance

Most interview participants reported that the fund had supported their capacity and capability development in *strategic governance*. Many providers expressed that this investment should be ongoing to support new board members and to support existing members when new issues of governance arise (eg, new legislation).

‘PPDF has been probably about 80% of governance training, professional development for the board - has come from PPDF. If it wasn't for PPDF we wouldn't have been able to actually sustain any programme to develop the governance to ...to become an effective governance body.’

Common themes regarding the type or extent of the PPDF's contribution included:

- **governance training.** While a few providers had experienced boards, approximately half of all respondents described the PPDF's contribution to governance training. This investment was noted to increase knowledge of the board's legal responsibilities and support strategic planning.

‘So there was a lot of capacity building that was required for governance, so PPDF in that sense, that was pivotal, instrumental and actually growing that governance component’

- **strategic planning.** This included development or review of strategic plans and supported providers to be responsive to priority health issues and health determinants and inform prioritisation of activities.
- some **Collective leads provide mentoring/support** for providers around governance particularly for the board chair or CEO

- **moving to a more robust entity:** that is, funding to change from an *Incorporated Society* to a *Charitable Trust*.

Operational management

Common themes regarding the type or extent of the PPDF's contribution included:

- **development and implementation of policies and procedures.** Members of one Collective commented on the value of having access to shared Collective policies and procedures that are developed and regularly updated. Other providers noted PPDF has supported them to develop their own operational policies.
- **capital purchases** including equipment and refurbishment of buildings
- **expertise and support for operational issues** - particularly human resource professional advice and support for processes such as recruitment for key staff. Access to financial expertise and support has built internal capacity and confidence in this area.
- **effective communication.** PPDF investment has supported improved communication with the wider community and Pacific communities, including to promote health issues. The PPDF has supported rebranding and making organisations more visible.
- **staffing key positions** especially to enable the functioning of Collective lead providers
- **quality assurance systems and activity** including funding audits, and accreditation
- **operational planning sessions and organisational reviews.**

Workforce

Common themes regarding the type or extent of the PPDF's contribution include:

- **increased skills and knowledge through training**
- **staff circumstances improved through training** such as better salaries and more senior roles
- **identification of skills and talents**
- **backfilling roles with temporary staff** (eg, while permanent staff members completed their qualifications, such as Masters Degrees).

'The workforce have benefited from this earlier investment because they were able to get paid higher rates when the pay equity came in ...'

Financial resources and viability

Common themes regarding the type or extent of PPDF's contribution include:

- **making providers more attractive to funders** which was a direct result of providers being more seen as more financially robust and able to deliver on contracts, and indirectly through things like improving communication about the organisation to the sector and community.
- **funding the costs of running an organisation** (eg, contribution towards IT, workforce development, staffing)
- **investing in good financial systems**
- **completing needs assessments and implementing the results** in some cases has improved financial aspects of their organisation.

A couple of providers noted that they would have invested in capacity and capability building even if they did not have access to PPDF. However having access to PPDF, freed up their non-PPDF funding to support alternate aspects of their organisation. Other providers noted PPDF made them a more sustainable organisation.

Information Technology (IT)

Several providers stated as a result of PPDF investment their IT systems had "definitely", or "significantly" improved or that the PPDF had been a large factor in improving their IT system. Others qualified their response with descriptions of other areas of IT that still need improvement.

Common themes regarding the type or extent of the PPDF's contribution include:

- **IT as essential backbone infrastructure.** IT structures are described by providers as essential infrastructure to enable them to work in the most effective, efficient and clinically safe way. PPDF investment in IT has supported providers back-office functions (including performance management, operational management, financial management and viability and understanding of client population), and the work of frontline staff (eg, client management systems; off-site access to databases). It has also contributed to staff safety and supported internal and external communication (eg, smart phones, intranets, websites) – including increasing the visibility and profile of an organisation (eg, through a website).
- **PPDF has contributed to the ability to procure, upgrade and maintain IT** hardware, software, servers to support day-to-day business in most effective and efficient way
- **staff working outside of the office in the community** are able to work more effectively, efficiently and safely through the use of mobile telecommunications and mobile computer devices
- **improved reporting to boards and funders** enabled by easier and timelier access to data held electronically

- **ability to ensure compatibility of IT systems** across different parts of the health and social systems.

Responsiveness to different needs of the Pacific community

Pacific providers agree that they provide services based on an integrated model of care because they are aware that social and environmental determinants of health (eg, health, social, housing, education) impact on the health of the population.

Half of the providers who responded, were not sure if the PPDF contributed to how they respond to different needs faced by Pacific communities. This is because to understand and be responsive to the different needs of Pacific communities is their core business. However, the themes below illustrate what was able to be achieved with the support of PPDF.

Common themes regarding the type or extent of PPDF's contribution include:

- **community consultations** to identify priorities
- **Pacific specific and gender specific** staff were recruited (eg, female doctor in response to maternal health need)
- **Pacific specific board members** representing their respective community
- **Pacific models of care.**

Delivering services in a Pacific way

Interview participants found it difficult to respond to what extent PPDF had contributed to delivering services in a Pacific way. This is also because delivering their services in a Pacific way is inherent in how they work and is their point of difference from mainstream providers. However, the following two themes highlight providers' views of what PPDF has contributed to enable them to deliver services in a Pacific way:

- **policies and procedures** that supports staff training and improves knowledge and understanding about different cultural contexts
- increased staff numbers and access to equipment which allowed **providers to practice within the Pacific family focussed wrap-around model of care.**

Innovation

Common themes regarding the type or extent of the PPDF's contribution include:

- **helped develop thinking as well as actions.** This is especially the case in terms of governance and board leadership
- **learning and sharing within the Collective.** Providers credited this learning and sharing for becoming more innovative in their thinking and actions including preparing for request for proposals (RFPs) better and exploring new programmes and contracts.

Board members held and attended community meetings because they realised part of leadership is about 'doing something outside of our comfort zone'. Other examples of innovation included using the PPDF to fund a radio show to connect the community and reduce isolation or to fund a youth and families fitness programme to encourage families to get active.

'...always keep an element for innovation. So think about outside the box: is it currently there? Because I think that's about currency as well...There's a limit to what all of us have and are doing and specialising in, but sometimes something comes along that doesn't fit anything. So you've got to keep something innovative.'

Performance management

Only a few organisations talked about how the PPDF has supported them to improve performance management.

Common themes regarding the type or extent of the PPDF's contribution include:

- **improved performance management** via improved IT systems
- **a focus on Results-based accountability™ (RBA):** one Collective has a focus on RBA including having discussions and training around RBA as a Collective.

Collaboration

Common themes regarding the type or extent of the PPDF's contribution include:

- **supported providers to network, cooperate, coordinate, and collaborate** in a range of ways providers have found beneficial. These include: enabling them to increase their reach, to increase their influence within a region, to achieve outcomes that they would not be able to do alone because of resources or capacity; to work with other parts of the health and social system to better engage with, and respond to, the needs of their communities and supporting them to access appropriate services (to their own service or other providers such as primary care); to undertake joint programmes and submit joint proposals with a view to secure new contracts.

'...there is so much that we have to do and we cannot do it alone...and the reason why we can't do it alone, is that we don't have the resource base to do that. So we need to look at other people who are doing very similar things or who are able to do services where we don't cover'

- **lead provider or providers in the Collective in some regions have supported providers to collaborate** outside of the Collective.

Additional findings from Ministry of Health stakeholders on effectiveness of the PPDF

Ministry staff identified a number of challenges in assessing the effectiveness of the PPDF, including: lack of benchmark information, criteria to measure effectiveness, assessment tool, and data on outcomes.

Survey Findings

This section describes the data from the online survey. Just over half of the providers interviewed completed the online survey. Although the survey results show a good degree of consistency with interview findings, we do not know if providers who are not in the survey shared similar experiences to those who completed the survey.

Survey results (Figures 2 and 3) are based on an average rating for each area of capacity and capability development across three points in time (2013, 2016, and 2018). The results show that between 2013 and 2018 providers assess their capacity and capability has improved in all the PPDF focus areas. Areas that scored the lowest average rating in 2013 – IT, governance, and collaboration, are among the areas where the greatest improvement was seen by 2018. In the survey, workforce development capacity and capability has shown the smallest improvement between 2013 and 2018.

Figure 2: Providers' assessment of capacity and capability in the order of 2013 rating scores

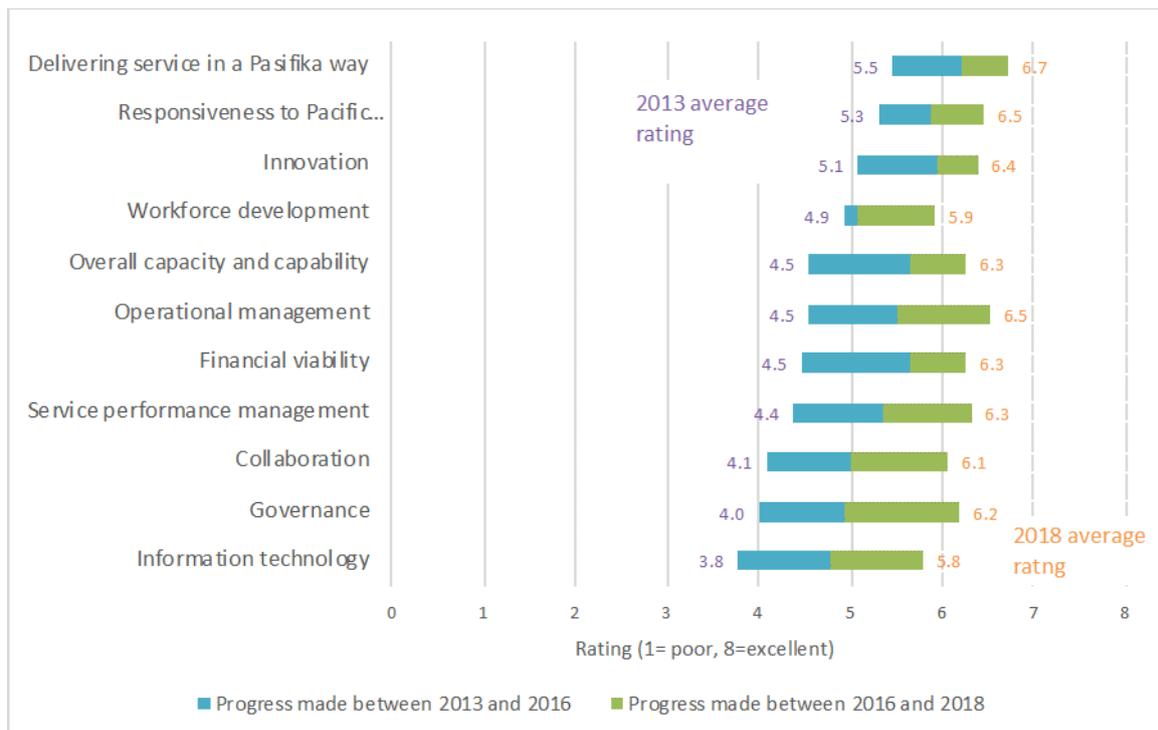
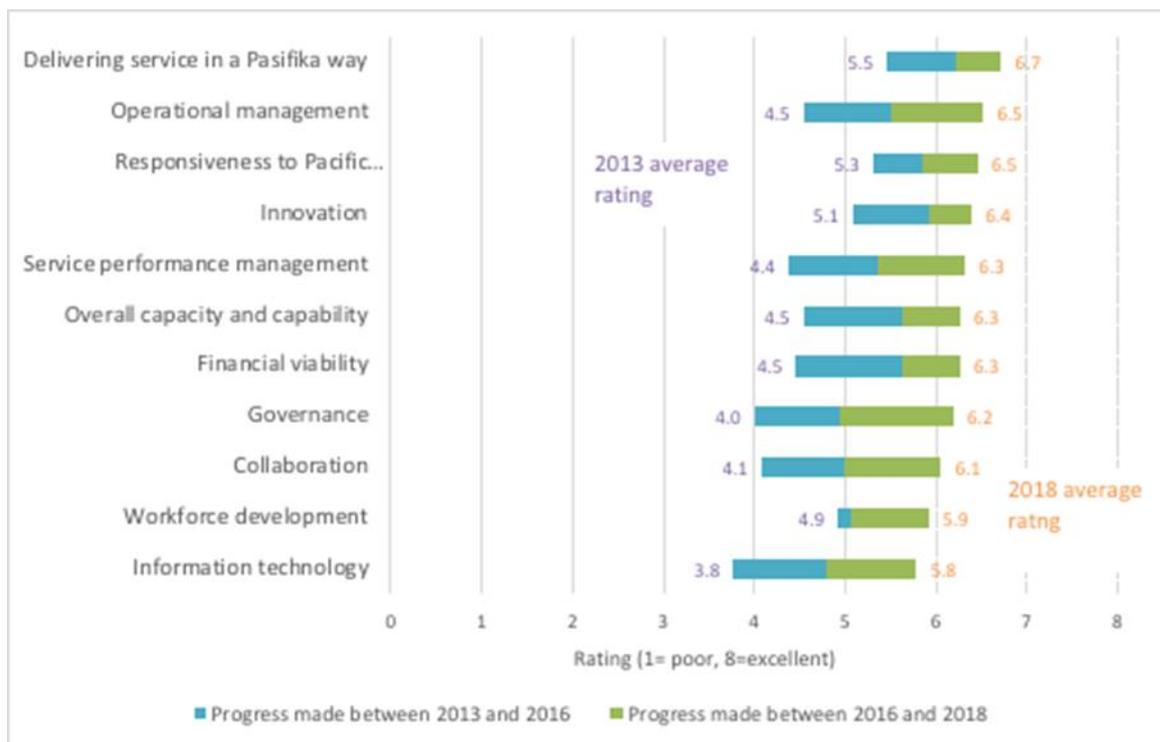


Figure 3: Providers' assessment of capacity and capability in the order of 2018 rating score

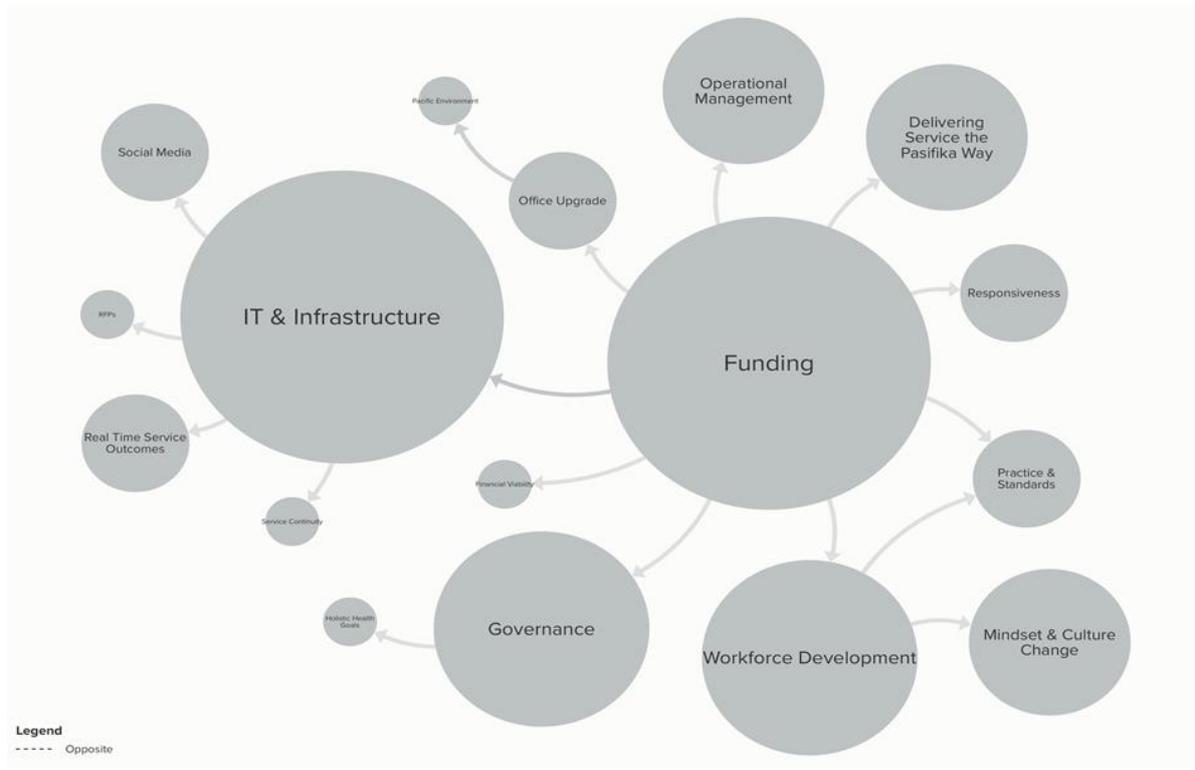


Analysis of Most Significant Change Stories

The analysis of the Most Significant Change stories by theme and by following the causal mechanisms is shown in Figure 4. There was no attempt to select the “most significant” story of those received. Instead, all the stories (for which we have consent to publish and attribute) are included in the providers own words (Appendix 6). It should be noted that Most Significant Change stories do not provide comprehensive information about the impacts produced by an intervention, as they have a focus on success stories.

Figure 4 shows where changes occurred through PPDF investment, based on the Most Significant Change stories provided by providers. The size of the circle represents the frequency of an area being mentioned. It suggests IT as the area where investment and change are most likely to have taken place. The analysis indicates changes in workforce has an impact on culture and practice change.

Figure 4: Areas where changes occurred through PPDF, based on the Most Significant Change stories from the providers



Findings related to Objective three

“to inform the types of capacity and capability on which to focus the PPDF investment”

As part of the stakeholder interviews, providers shared their perspectives on what aspects of PPDF works well and what could be improved (what doesn’t work well, what they would like to change). These findings will inform the future capacity and capability investment areas for the PPDF and are presented below.

Findings related to “what works” in relation to how the PPDF fund operates

Common themes include:

- **flexibility** of what funding can be used for

‘I think the permissiveness ... to be able to do with the fund what we want to do subject to acting within the terms of the fund because we do know well obviously ourselves as a provider but we also know our community we know what the needs are so that’s not necessarily usual of you know contracts ...you’ll be told you must deliver A B and C and here it’s like well you can do this within this which has been an amazing way to operate’

- just the fact of **having extra funds**.

'The best part I think having PPDF is the best part. And we value that because as a small provider we don't have capacity resources to do this so I value having that as a resource.'

A broader consideration of "what works" includes how PPDF investment has been able to benefit providers in specific focus areas, as noted in *Findings related to Objective two*.

Findings related to "what could be improved" in relation to the PPDF investment

Common themes include:

- **better tailoring of support from the PPDF based on the capacity and capability development needs of providers** which vary by the size, geographic location, and maturity of the organisation and the type of services it delivers
- a **needs assessment tool** that is specific for a New Zealand Pacific health context and appropriate to the stage of an organisation's development
- **increased amount of PPDF invested** in individual providers (in relation to need)

'we've got to be wise and to look at being more effective at what we do and more efficient at what we do. But you know we can only cut ourselves, we can only cut our fingers so far...but what I would say is this – if there is a possibility to slightly increase that to do our work much more effectively, then I think it is a great investment.'

- **increased clarity for provider eligibility criteria to access the PPDF and for being part of a Collective.** There were a range of views expressed including whether or not providers who are for-profit privately owned, or Pacific-led rather than Pacific per se, or within a mainstream organisation should be eligible. Some providers also request there are transparent agreed criteria and process for joining a Collective.
- **increased transparency around criteria and process for allocation of funding** by the lead to individual providers. Some providers would like to change the way the fund is allocated so it isn't competitive which they note as undermining collaboration and contributing to conflict and mistrust.
- **clear documented guidance for what the PPDF can be used for** supported by training (and **balanced with flexibility** on a case-by-case basis)
- development of **agreed measureable outcomes**
- **future PPDF investments need to be aligned** with:
 - cross agency intelligence and planning to better align investment across agencies. This included intelligence and planning at regional and national levels to support stronger alignment of investment in provider development and service contracts
 - the nature of the more holistic and wrap-around approach to service delivery by Pacific providers (including appropriate Pacific models of care)
 - the assessed needs of providers

- investment in Pacific workforce development through Pacific provider specific scholarships.

'we do need an end-to-end strategy on Pacific health ... that is customised for each of the [geographical] areas ... we need to get out of the silos and the Ministry and DHBs and the Providers and the community need to sit around and think about what that looks like. And it might be a high level roadmap for Pacific health'

- many providers would like to **keep or enhance investment in existing types of capacity and capability**. For example:
 - greater investment in workforce including backfill for staff on professional development
 - ability to use the PPDF to address critical staffing issues (eg, support critical FTE; offer better remuneration to aid recruitment and retention)
 - IT
 - innovation.

Additional findings from Ministry of Health stakeholders related to “what could be improved” in relation to the PPDF investment

Areas of improvement mentioned by Ministry staff interviewed reflected the findings from the interviews with providers. In addition, Ministry staff would like to see adequate resourcing for both the administration of the PPDF in the Ministry and to support the Ministry playing a stronger strategic leadership role in Pacific health. They would like to see the Ministry systematically consider the potential impact on Pacific health providers of any planned changes to strategies and policies (eg, changes to commissioning policy and practices).

Summary of findings from Objectives 1-3

Table 2 summarises the key themes under each objective and highlights some of the inter-relationships (including commonalities and points of difference) between areas of capacity and capability development. Commonalities include the fundamental importance of delivering services in a Pacific way to meet the needs of Pacific communities and the linked need for Pacific workforce capacity (staffing) and capability (workforce development). Having functional IT infrastructure and strong governance are also cross-cutting themes.

Table 2: Summary of key PPDF review findings - Objective 1-3

Focus areas Capacity & capability	Key PPDF review findings		
	Objective 1 Operational challenges	Objective 2 PPDF effectiveness	Objective 3 Future investment & improvements
1. Strategic governance	<ul style="list-style-type: none"> Board membership and structure and function Separating role of governance and operations Capacity to undertake strategic planning 	<ul style="list-style-type: none"> Governance Training Strategic Planning Mentoring and support by Collective leads Changing type of entity 	<ul style="list-style-type: none"> Ongoing investment in governance training (turnover of board members; new governance issues eg, new legislation) Support for strategic planning
2. Operational management	<ul style="list-style-type: none"> Funding staff Business compliance Suitable facilities Operational policies Geographic location Communications/ Marketing 	<ul style="list-style-type: none"> Operational policies Facilities / infrastructure Operational support & expertise Business communications Sufficient staffing Quality management Operational planning and reviews 	<ul style="list-style-type: none"> Using PPDF to backfill key staffing gaps to aid operational management and the recruitment and retention of staff Invest in Pacific provider workforce capacity building Value of access to shared policies
3. Workforce development	<ul style="list-style-type: none"> Funding staff professional development Recruitment of appropriately qualified Pacific people 	<ul style="list-style-type: none"> Training Improved staff salaries and more senior roles as a result of training Identification of skills/talents Backfilling with temps. 	<ul style="list-style-type: none"> Using PPDF to backfill key staffing gaps, aid recruitment and retention of staff Invest in Pacific provider workforce capacity building
4. Financial resources and viability	<ul style="list-style-type: none"> Securing new funding Service contracts not covering operating costs Short term contracts Primary care funding models Competition from larger providers and mainstream providers 	<ul style="list-style-type: none"> Providers more attractive to funders Contributing to operational costs Investing in financial systems Completing needs assessments and implementing results 	<ul style="list-style-type: none"> PPDF contributes to organisations financial viability. Caution for organisations not to be too reliant on PPDF for their long term sustainability. Funders to be an advocate for Pacific providers around national and local policies and practices that impact on Pacific health providers.
5. IT	<ul style="list-style-type: none"> Not fit for purpose Funding to upgrade and maintain IT and telecommunications 	<ul style="list-style-type: none"> Funding upgrades and maintenance of IT and telecommunications Enabling staff to work more effectively, efficiently and safely outside of office 	<ul style="list-style-type: none"> Given the ongoing evolution of IT and need to have secure, functional IT infrastructure - continue to invest in IT

		<ul style="list-style-type: none"> • Data availability for reporting • Compatibility of IT systems 	
6. Responsiveness to different needs of Pacific community	<ul style="list-style-type: none"> • Multiple health and social issues • Having someone from same Pacific community delivering service • Constraint of contracted services vs actual need • Proactive about health 	<ul style="list-style-type: none"> • Fund contribution to community consultations • Recruitment of Pacific specific and gender specific staff • Pacific specific board members • Pacific models of care 	<ul style="list-style-type: none"> • Benefit of investing in Pacific health providers • Invest in Pacific models of care • Using PPDF to aid recruitment and retention of staff • Invest in Pacific provider workforce capacity building
7. Deliver services in Pacific way	<ul style="list-style-type: none"> • Provide ethnic specific services 	<ul style="list-style-type: none"> • Cultural competencies and practices supported by organisational policies and procedures • Increased staff and equipment to support Pacific model of care 	<ul style="list-style-type: none"> • Benefit of investing in Pacific health providers • Invest in Pacific models of care • Using PPDF to aid recruitment and retention of staff • Invest in Pacific provider workforce capacity building
8. Innovation	<ul style="list-style-type: none"> • Lack of clarity about scope • Sustainability of activities 	<ul style="list-style-type: none"> • Governance and board leadership • Learning and sharing within Collectives supporting innovative thinking and actions 	<ul style="list-style-type: none"> • Continue to invest in innovation and provide clarification of scope of what can be funded under this area • Working collectively to support innovative practice
9. Performance management	<ul style="list-style-type: none"> • Delivering on contractual volumes 	<ul style="list-style-type: none"> • Improved performance management through improved IT systems • Focus on RBA 	<ul style="list-style-type: none"> • Continue to invest in IT • Development of agreed outcomes to aid accountability and quality improvement
10. Collaboration (outside of Collective)	<ul style="list-style-type: none"> • Barriers to collaboration (competitive environment; time/cost; geographical location) • Working with mainstream organisations 	<ul style="list-style-type: none"> • Supported providers to network, cooperate, coordinate and collaborate – increase reach and influence; access wider resources; improve access for communities. • Lead providers or providers in Collective have supported collaboration 	<ul style="list-style-type: none"> • Support regular national and regional forums for networking and collaboration. • Flexibility around different ways of working together

Findings that are broader than the three objectives

Many providers shared their experiences working as a Collective, including around the allocation of funding. While this topic is not a focus of the review (as it was covered in the previous evaluation undertaken by Allan and Clarke in 2016), the review team felt that excluding this data would risk the data collected from the interviews not having broader context and being incomplete. Therefore, data relating to the 'Pacific Collectives' was collected as part of the interviews and analysed.

Findings related to what works around Collectives:

Common themes:

- **networking and coordination:** some providers commented on the benefits of coming together as a Collective to meet and share ideas, discuss their work, as well as discuss the allocation of funding (a way of working that can be described as networking and coordination²¹). One interview participant particularly liked the Collective meetings when Ministry staff were present.

'Have conversations around ...what else is coming up in the Ministry of Health. Having [Senior contracts manager] as part of our meetings I feel is very effective as it gives an insight into ... what the government wants. Also having [Chief Advisor Pacific] there ... to give us a sense of belief in the work that we do ... she is you know part of the Ministry of Health she is our advocate as Pasifika people so having her there ... it really means a lot to my organisation.'

- **cooperation and collaboration:** There are other ways of working together that the review team observed, that are more beneficial and include: mentoring of providers' staff; mutual support for Collective members; working together to secure funding; and having a shared vision (ways of working that can be described as cooperation and collaboration¹⁷)

'We are genuinely not about a provider in particular, we are about the collective wellbeing of Pasifika. If one provider is struggling that means that the Pacific community not going to be able to access services so we need to get in there and do what it takes to support that provider because they are working with our families'

²¹There are different ways to define how providers work together. The review team has chosen to use the following definitions to describe how Collective members work together:

- **Networking:** an informal relationship in which information is exchanged for mutual benefit.
- **Coordination:** a more formal linkage in which information is exchanged and activities are altered in pursuit of mutual benefit and achievement of common purpose.
- **Cooperation:** an exchange of information, altering activities and resource sharing for mutual benefit in pursuit of a common purpose. Formal agreements can be used.
- **Collaboration:** this is distinctive, as it involves a willingness of the parties to enhance one another's capacity – helping the other to "be the best they can be" for mutual benefit and common purpose. In collaboration, the parties share risks, responsibilities and rewards, they invest substantial time, have high levels of trust, and share common turf (O'Flynn 2008)

- **development and dissemination of shared** policies was a theme for providers from one Collective

'One of the things we are forever thankful for, is the shared policies and procedures that have been developed across the Collective. That has been significant in a day to day audit, review process from every kind of entity. That document... which was produced from our lead provider and is utilised right across the Board, so we all have consistent policies, consistent approaches'

- **support from lead providers and approach to funding allocation:** some non-lead providers noted the benefits of the support they receive from the lead provider and the approach to the allocation of funding
- **expertise; their approach to allocation of funding; relationships:** from the perspective of lead providers, what works best and some of their successes as lead providers included: the value they add through their expertise (including through the corporate and/or accountancy backgrounds of their staff, their business expertise, and understanding of governance, Public Finance Act); their approach to allocation of funding; relationships with providers and with the Ministry.

Some themes related to challenges and areas for improvement around Collectives included:

- providers would value **increased organised opportunities to meet together** (both within the Collective and nationally) to share information, share stories of success and learnings, work on shared goals and generally support each other

'How can we as a Collective come together and share that body of knowledge and be able to help each other, support each other on our journey'

- providers shared some ideas about **ways of strengthening the Collective partnership**. Examples include: having joint outcomes for the Collective, with individual providers contributing to these; collective decision making about a joint pool of funding for shared training/purchases; and better ways of using the Collective to strengthen their ability to secure funding and to influence the wider system.
- the **need for increased transparency:**
 - around the criteria and process of allocation of funding within the Collectives
 - of Ministry expectations and requirements of the lead providers
- **flexibility around different ways of working together** (ie, one size does not fit all)

The relationship between the Ministry and the lead providers has been described as responsive, supportive, and flexible. Some non-lead providers would prefer to have a direct contractual relationship with the Ministry and some would like the PPDF to be administered directly by the Ministry. This is noted by these providers as likely to support neutrality, reduce competition and potentially increase the amount of funding available to providers (as don't have the overheads of an intermediary agency). A number of providers suggested there does not need to be uniform approach. Some providers suggested a direct contractual relationship

with the Ministry for the PPDF could be offered to providers considered capable to manage the fund without the support of an intermediary agency. Two providers would like the South Island Collective to be re-established.

'you can't apply a uniform sort of approach across the country um just because it's actually working well in Auckland or working well in Christchurch doesn't necessarily mean it will work well in Wellington'

Conclusions

This section sets out the review conclusions to inform potential improvements to PPDF and future PPDF investment (Objective 3) and discusses the evidence on which these conclusions are based.

Importance of understanding the unique and important strengths of Pacific health providers and the complex environment in which they operate

Pacific health providers have a unique point of difference in being Pacific for Pacific; having strong connections to the communities they serve; and in the way they deliver services to diverse Pacific communities with complex health and social needs through a wrap-around family focussed model of care.

The environment in which Pacific health providers operate is complex and dynamic and involves relationships and accountabilities to multiple stakeholders (including the communities they serve). Fiscal constraint and "bigger is better" procurement practices in the health system over the last few years have resulted in contract losses and funding changes for some providers.

Provider's capacity and capability development is variable and they experience ongoing operational challenges (Objective 1)

The qualitative interview findings indicate that there are ongoing operational challenges for the providers across all areas of capacity and capability development, and these vary by the size, type of organisation, its geographic location, and its stage of organisational development. Small organisations are particularly challenged by limited organisational capacity and greater financial vulnerability (Copestake, O'Riordan, and Telford 2016). Providers interviewed noted the challenges of securing contracts as small not-for-profit entities in the current fiscal environment.

The operational challenges for the Pacific health providers interviewed across these dimensions of organisational capacity and capability reflect those reported in the literature from New Zealand for the NGO sector and other similar jurisdictions (see literature scan for details) and are consistent with the findings of the Allan and Clarke evaluation of the PPDF (Allan and Clarke, 2016). It is noted that many of the challenges identified have solutions which require a wider health sector response (including that providers are supported by their DHBs and PHOs) (personal communication, Ministry of Health staff).

PPDF is an effective contributor to provider capacity and capability development and supports provider viability and sustainability (Objective 2)

Overall, the qualitative interview and on-line survey data indicates that the PPDF has contributed to improving provider capacity and capability across all focus areas. Providers' capacity and capability development was particularly supported in the areas of IT; strategic governance; operational management; and financial resourcing and viability.

Evidence from previous evaluations of the PPDF (CBG Health Research Ltd 2007; Ernst and Young, 2009; Allan and Clarke 2016) and of the New Zealand Ministry of Health Māori Provider Development Scheme (CBG Health Research Ltd 2009) highlight the positive impact of investment in provider capacity and capability in New Zealand. International literature confirms positive effects of capacity and capability across a range of measures including organisation development (governance, human resources, systems, policies and procedures), service delivery, and workforce development (Genat 2016; Mandeville 2007; National Audit Office 2009; Sobeck 2008; Takahashi, Candelario, Young, and Mediano 2007).

Provider development funds have wider economic, social and health benefits to Pacific communities, including by supporting the sustainability of Pacific providers as employers of Pacific peoples (CBG Health Research Limited 2007). As described in the qualitative interview data in this review, investing in Pacific provider development also has wider sector benefits through influencing the cultural competency of services for Pacific peoples (CBG Health Research Limited 2007).

We acknowledge there are multiple interrelated factors that impact on provider capacity and capability and the described changes in qualitative interviews and Most Significant Change stories may not be solely attributable to PPDF (CBG Health Research Limited 2009). There is also potential for provider's self-assessment of effectiveness of PPDF to be biased, as additional funding is beneficial to organisations. However strengths of the review approach was the richness of information shared as part of talanoa, and that providers are able to make judgements about the impact of the funding, and were able to contribute to an understanding of what might have caused any improvement in their capacity and capacity.

Optimising the operation of the fund

The strategy for future investment must also be cognisant of factors that could improve the operation of the fund itself – drawing on providers' perspectives and literature about what works (success factors) and what could be improved.

Increased clarity on the PPDF model – vision, purpose, outcomes, eligibility criteria

Providers interviewed as part of this review, requested increased clarity and transparency around the PPDF fund. This included clarity on the fund: vision and purpose; criteria for eligibility to access PPDF; the process and criteria to join a Collective; what PPDF can be used for (balanced with some flexibility) and development of measurable outcomes for PPDF investment.

The literature emphasises the need for capacity building funds to have a clearly stated purpose (Sapere Research Group 2018) and linked criteria (Impact Investing Australia 2018; Ruben & Schulpen 2008) and outcomes. Outcomes are often clustered around increases in

credibility, skills and confidence and effectiveness (Institute for Voluntary Action Research (IVAR) 2010). The evaluators of the Māori Provider Development Scheme (2009), note that funds should clearly identify which recipients can apply for funding (provider type, annual turnover, types of activities (inclusion and exclusion criteria), and any cost-sharing requirements (usually a percentage of activity cost) (CBG Health Research Limited 2009).

To enhance providers understanding of the criteria and requirements, funders and/or intermediaries should work with providers to clarify funding processes and criteria (ie, what funding can be used for) (Abt Associates Inc. 2010). This might include additional guidance on funding categories and annual priorities, and inclusion and exclusion criteria (as for the Māori Provider Development Scheme) (CBG Health Research Limited 2009).

PPDF funding allocation

Strengthening the process and transparency of the allocation of funding to support the best use of limited resources and the fairness and equity of the allocation, were strong themes from the stakeholder interviews.

There are two levels that could be considered, the allocation of funding from the Ministry to the regions and then within the Collective to members.

At both levels, it is suggested that the funding approach will work best if it is flexible, responsive and multi-year as it allows providers to engage in longer-term planning (Internal Affairs 2011). Many evaluations of capacity building funds call for longer terms for funding, for example, three-year cycles (CBG Health Research Limited 2009).

At the level of the Collective, the funding application process will be assisted by having nationally agreed criteria for what PPDF can be used for. The literature indicates that simplified, clear and consistent application and proposal assessment processes can contribute to better quality funding proposals, and reduced administrative effort and costs for providers and funders (Impact Investing Australia 2018; Institute for Voluntary Action Research (IVAR) 2010; National Audit Office 2009; Ruben and Schulpen 2008; Sapere Research Group 2018).

Development of a Pacific specific needs assessment tool that is appropriate for providers of different sizes and at different stages of organisational maturity.

Providers were clear that a Pacific specific needs assessment tool would assist improved identification of priority capacity and capability investment for their organisations. Provider capacity building needs assessment (called diagnosis in some literature) requires providers to critically assess their strengths and weaknesses (Te Puni Kokiri 2009) and is central to successful and effective capacity building (University of Birmingham 2014; Cram 2006).

Monitoring and reporting

Strengthened monitoring and reporting allows opportunities for good data to be collected at fund level, which can be shared with providers, intermediaries and other funders (Sapere Research Group 2018). This review has highlighted current data limitations including the need for increased visibility at all levels of the outcomes achieved through PPDF investment.

Fit for purpose data is required for effective monitoring and demonstrating accountability for PPDF and to identify opportunities for future quality improvement.

The importance of having a functional Collective

Collectives play a key role in the success of the PPDF. The Collective model (established in 2012/3) is, arguably, still a relatively young model and its ongoing evolution is likely to require continuous learning and adaptation, given the complexity of the environment in which Pacific providers operate, including the many interdependencies and factors that impact on provider development (Pacific Perspectives 2012).

The model itself is not uniform in its structure or implementation both across and within regions - with different management structures, leadership, processes and member compositions (provider maturities, size, type, services). Given these differences, it would seem appropriate that the Ministry supports some flexibility and adaptability in the approach to working collectively in order to best meet the different and evolving partnership needs of providers (recognising that there is no "one size fits all"). The Ministry also needs to consider the best approach for administering PPDF, if providers leave the Collective.

There is value in understanding and sharing the characteristics of Collectives that providers (leads and non-leads) experience as working well and their views on what could be improved. Currently, providers' experiences of working as part of a Collective and the quality of relationships are variable. These findings are reflective of the results of the Allan and Clarke Evaluation of the Collective Model undertaken in 2016. The literature highlights the importance of positive relationships between funders and providers for the success of capacity building (Sapere Research Group 2018; University of Birmingham 2014) and the benefit of networking, partnerships and collaboration to assist organisations to expand their capacity (Cram 2006) through information sharing and practical support (Ministry of Social Development Te Manatu Whakahiato Ora). Leadership style, skills and expertise of Collective lead providers appeared to be an important determinant of the extent of networking, coordination, cooperation and collaboration opportunities.

To be a successful vehicle for allocation of funding and support for providers, the Collective needs to be functional and based on trust, transparency and seen to be equitable (Allan and Clarke 2016). These characteristics are fundamental to the success of PPDF investment.

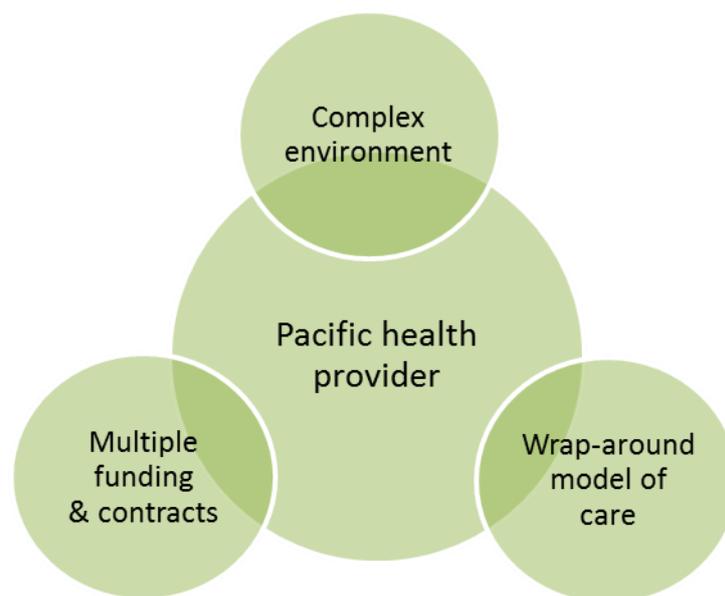
Recommendations

Two considerations underpin the following recommendations, and they are first of all, to **build on the strength** of the PPDF discovered during the review, and secondly, to **acknowledge the three significant features** (Figure 5) of the Pacific health providers who receive PPDF, which are:

- the complex environment the providers work in
- the family-focused wrap-around model of care providers operate
- PPDF is one of the many funding that providers have and utilise.

Some recommendations are accompanied by suggested actions. It is noted that many of these actions will require leadership from the Ministry, working alongside Pacific providers (lead and non-lead) and other key stakeholders.

Figure 5: Viewing PPDF providers from a system level perspective



1. **Continue to invest in capacity and capability development for Pacific providers.**
The review has found this to be needed and an effective way to increase capacity and capability for these providers.

Future investment in PPDF needs to be guided by:

2. **Strengthened strategic and operational alignment for the PPDF across-social sectors and within health.**
 - a. **Greater cross government collaboration around supporting Pacific providers across all of the social sector (health, education and social**

development) (eg, between Ministries of Health, Pacific Peoples, Education and Social Development, Housing)

- b. **Ministry, DHBs and Pacific health providers will benefit from a stronger articulation of the alignment between the government’s priorities (eg, equity in health), the NZ Health Strategy, ‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–18 and local DHB priorities.**²² This will guide investment in the PPDF and provide a longer term strategic vision and roadmap for the Pacific health providers and for Pacific health sector.
 - c. **Systems view of investment in Pacific health providers** – Pacific health providers work in a complex environment with multiple stakeholders. The PPDF is one of many funding sources for Pacific health providers. Taking a systems view of investment in Pacific health providers will help maximise the outcomes achieved from the PPDF. Funders should consider the interdependencies of funding and the impact of future changes to strategies, policies and practices that impact on Pacific providers. Suggestions for actions include:
 - i. strengthen the relationship with DHBs/PHOs to better align PPDF investment with other sources of funding important for provider development and financial viability. Support planning and data intelligence sharing amongst national and regional health services with a role in Pacific provider development (Ministry of Health, DHBs, Collective leads and Pacific health providers) to inform the Pacific provider needs assessment process and strengthen alignment of the PPDF investment with service contracts and with other provider and workforce development initiatives.
 - ii. investigate the closer alignment between the PPDF, the Ministry of Health Pacific Innovation fund, and Ministry of Health Pacific Workforce Development fund. There are synergies between provider development and building and developing the Pacific workforce.
 - iii. explore the connection between funding for Pacific populations between Health (including Ministry of Health and DHB funding), Ministries of Education, Social Development and other government agencies.
3. **Increased clarity and transparency of PPDF investment parameters**
- a. **Clearer criteria for: (i) provider eligibility to access PPDF (ii) eligibility and process for Collective membership (iii) the types of activities qualify as investment in capacity and capability development.**
 - i. The Ministry should develop a PPDF guide that includes standard definitions of key concepts (eg, provider capacity and capability development) and clearly outlines: the areas of provider capacity and capability funded by the PPDF; criteria for receiving funding for each

²² And any future updates (eg, Pacific Health and Disability Action Plan)

- b. As part of the needs assessment process, Collective lead providers to collate data on provider profiles (eg, size of provider in terms of FTE and client population; number of current contracts and level of funding; amount of PPDF funding provided; what areas of capacity and capability funded, type of entity etc). This data is to be reported to the Ministry.
- c. Support providers to complete this needs assessment process
- d. Consider DHB input into the needs assessment process (given their understanding of Pacific providers within their region).

Types of capacity and capability development for future investment

- 6. PPDF future investment should continue to fund all the focus areas outlined in this review document. **Some specific suggestions for investment to support the following focus areas for provider capacity and capability are set out below:**
 - a. **IT** – as this is essential infrastructure, work with funders of service contracts to ensure adequate set-up and maintenance funding as part of service contract overheads. Support joint planning and purchasing of IT services for Pacific health providers at regional or national level to increase economies of scale and to support integration of IT systems across health sector, while balancing any specific operational or reporting requirements.
 - b. **Supporting workforce development:**
 - i. consider packages of training administered funded and administered at a national level (eg, governance training for boards that is tailored for a pacific cultural context and pacific provider environment). This could be delivered online or by one provider that may be repeated when there are new board members or changes to board requirements (eg, with new legislation)
 - ii. to support a stronger pipeline of Pacific workforce, encourage PPDF funded training placements for Pacific students /new graduates (eg, health, business) in provider (lead and non-lead) organisations or secondment opportunities for providers within Collective lead organisations, District Health Boards or Ministry of Health
 - iii. ensure Pacific health providers are aware of professional development opportunities that can be assessed at no or low cost elsewhere (eg, the Certificate in Public Health which is funded by the Ministry of Health).
 - c. Consider funding time limited **staffing for key positions** on case by case basis in small and/or start-up organisations including CEOs and admin staff. Note however the scarcity of appropriate staff.
 - d. **Innovation** - Once providers are past developmental stage consider funding to move the organisation into innovation including ways they can better address the needs of their Pacific communities. Sometimes this will naturally have to move into the area of service delivery.

- e. **Growth and scale** - Consider a collaborative project (with providers) exploring ways to support growth and scale for mature providers.
 - f. **Sector level influence through collaboration** - Many Pacific health providers provide an aiga/family-focused holistic wrap-around approach to service delivery that is different from mainstream primary care approaches that tend to be more transactional and focused on the individuals. The Pacific approach to service delivery service aligns with the government goal of achieving equity in health. To support Pacific approaches to service delivery,
 - i. the PPDF can focus on greater collaboration amongst all Pacific providers (within a collective or across the country) to enable mentoring, support, and sharing of experiences, knowledge, practices, systems, and skills. Through shared learning, the PPDF can also contribute to strengthening mainstream services response to Pacific health needs.
 - g. The PPDF needs to **invest more in activities that contribute to process change** and less in business as usual activities and costs. Investing in areas that are more fundamental to capacity and capability development is more likely to have a greater impact on improvements in related areas.
7. **Increase the profile and accessibility of information on PPDF**
- a. Develop and maintain a PPDF webpage on the Ministry website to profile the fund (including purpose, goals and outcomes, eligibility criteria for accessing PPDF, criteria for what the PPDF can be used for etc) so key information is transparent and easily accessible. Could have different levels of access and include a provider specific portal for sharing information.
8. **Explore the next steps to best support the sustainability and development of Pacific health providers.** It is suggested that this includes a more in-depth discussion on supporting providers' different and evolving development and partnership needs.
9. **Post-review implementation plan**
- a. We also recommend that the Ministry establish a **post-review implementation plan** to follow up on the recommendations in this review and the previous evaluation of the Collective model (ensuring adequate capacity to support this work).

Glossary

Term	Definition
Capability	For the purpose of this review “capability and capacity” is defined as human capability and capacity including governance (both corporate and clinical), leadership, management and delivery. Organisations ability to deliver its service based on ability knowledge skills of staff and structural resource capabilities (IT) etc.
Capacity	The conditions needed to be able to effectively, efficiently, and sustainably deliver functions. For example, an adequate and qualified human resource, appropriate policies and processes, functional governance and IT systems and effective collaborative partnerships.
Community of practice	A group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly."(http://wenger-trayner.com/introduction-to-communities-of-practice/).
Collective	Pacific Providers named in agreements between the Ministry of Health and lead providers who are working together to deliver joint services (implementation of the Pacific Provider Development Plans).
Lead provider	Single provider holding contract with the Ministry of Health working on behalf of the collective members to implement the Pacific Provider Development Plans.
Contract holder	Single provider holding contract with the Ministry of Health to implement the Pacific Provider Development Plans.
Most Significant Change stories ²³	Most Significant Change stories approach is a participatory evidence-gathering technique. It involves collecting and analysing personal accounts of significant change, usually from a service or programme ²⁴ . Most Significant Change can be a useful tool to explain how change comes about (processes and causal mechanisms) and when (in what situations and contexts). It is used to support the development of programme theory of change. ²⁵
Non-lead provider	Members of collective who are not the lead provider, or those contract holders who are not part of a collective (ie, the Fono).
Focus areas	See Appendix 4. These are areas of capacity and capability development and the areas used to collate and analyse information collected through the review process. For some collectives it is the structure of their PPDF Pacific Provider Development Plans.

²³ For more information on Most Significant Change Stories please see Davies, R. and Dart, J. (2005) The 'Most Significant Change' Technique - A Guide to Its Use. URL <http://www.mande.co.uk/wp-content/uploads/2005/MSCGuide.pdf>

²⁴ Davies R and Dart J. 2005. The Most Significant Change (MSC) Technique: A Guide to Its Use.

²⁵ https://www.betterevaluation.org/en/plan/approach/most_significant_change

Participatory research	"Participatory evaluation is an approach that involves the stakeholders of a programme or policy in the evaluation process. This involvement can occur at any stage of the evaluation process, from the evaluation design to the data collection and analysis and the reporting of the study." ²⁶ This ensures that the project is responsive and accountable to the research needs of the participant research population.
Providers	For the purpose of this review, lead and non-lead organisations.
Talanoa ²⁷	A Pacific term to describe a formal or informal conversation between two or more people. Talanoa produces relevant knowledge and possibilities for addressing Pacific issues.

²⁶ https://www.betterevaluation.org/en/plan/approach/participatory_evaluation

²⁷ Vaileti TM. 2006. Talanoa research methodology: a developing position on Pacific research. *Waikato Journal of Education* 12:2006

Appendices

Appendix 1: PPDF Collective membership 2018

Region	Lead provider	Pacific Providers
Auckland (14)	Alliance Health Plus	Alliance Health Plus Trust (lead provider) Alliance Community Initiative Trust Bader Drive Healthcare Cavendish Doctors Health Star Pacific Trust Mt Wellington Integrated Health Centre Pacific Homecare Penina Health Trust South Seas Healthcare Southpoint Family Doctors TOA Pacific Tongan Health Society Vaka Tautua Ltd
	West Fono Health Trust trading as the Fono	West Fono Health Trust trading as the Fono
Midland (7)	Aere Tai Collective	K'aute Pasifika Trust, Hamilton (lead provider) Pacific island Community Tauranga Trust South Waikato Pacific Islands Community Services Inc, Tokoroa Rotorua Pacific Islands Development Charitable Trust Pacific Islander's Community Trust, Gisborne Vaimoana Pasifika Charitable Trust, New Plymouth Kings Force Health Charitable Trust, Hawkes Bay
Wellington (6)	Central Pacific Collective	Central Pacific Collective (lead provider - umbrella organisation) Atamu EFKS Inc, Porirua Pacific Health Service Hutt Valley, Lower Hutt Mitikulena Family Healthcare Limited, Wellington
	Previous members of Wellington Collective	Pacific Health Service Porirua Taeaomanino Trust, Porirua
South Island (3)	No South Island Collective currently	Tangata Atumotu Trust, Christchurch Pacific Islands Advisory and Cultural Trust, Invercargill Pacific Trust Otago, Dunedin

Appendix 2: Scope of the review

- Funding used to implement Pacific Provider Development Plans in contract between Ministry of Health and the three Collective lead providers and the Fono²⁸ from 2013 as well as two one-off contracts with individual providers (see Table 2)
- Providers:
 - who are currently receiving the funding outlined above (PPDF) as part of a Collective
 - who had received PPDF since 2013 as part of a Collective but who are no longer members of a collective (but would still be eligible for PPDF funding).

The scope of the review is funding under the Purchase Unit Code COPA0004 used to implement Pacific Provider Development Plans from 2013 (PPDF). However a number of other contracts are purchased with the same code but sit outside the review scope.

The review excluded the following contracts under Purchase Unit Code COPA0004:

- Pacific innovation contracts
- any one-off contracts apart from those in Table 3 (as these supported the implementation of Pacific Provider Development Plans)
- Pacific Regional Provider Networks contracts
- contracts sitting outside the implementation of Pacific Provider Development Plans which aim to “increase the Pacific health workforce” for example through scholarships and mentoring of health workforce students.

Funding in scope for the review was funding for contracts between Ministry of Health and the three collective lead providers and the Fono from 2013 as well as two one-off contracts with individual providers (see Table 3). This list of contracts was confirmed by the team managing the PPDF contracts.

Providers who were in scope and so eligible for interviews were those who are currently receiving PPDF as outlined above, as well as those providers who had received PPDF since 2013 as part of a Collective but who are no longer members of a Collective (but would still be eligible for PPDF funding).

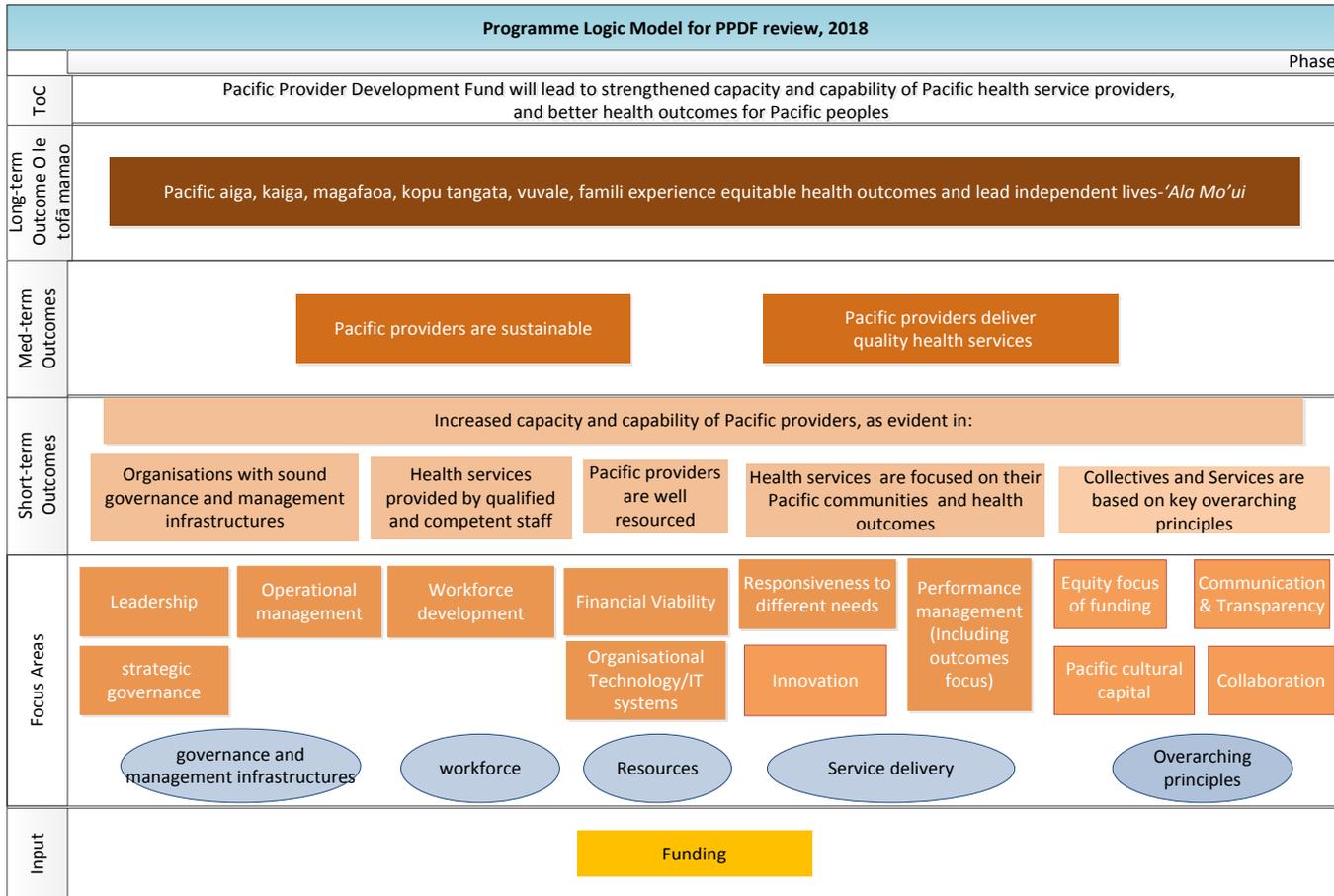
The team managing the PPDF contracts at the Ministry of Health determined the final list of providers to be interviewed.

²⁸ Contracts were signed with three Collective lead providers and the Fono, an individual provider. We refer collectively to non-lead providers (including the Fono), and lead providers as “providers.”

Table 3 Contracts containing the funding in scope for the review

Contract	Provider	Notes
347322-00	Alliance Health Plus Trust	Implement their Collectives Pacific Provider Development plan
348624	K'aute Pasifika Trust	Implement their Collectives Pacific Provider Development plan
348578	Pacific Trust Canterbury	Implement their Collectives Pacific Provider Development plan
352804-00	The Fono	Implement their "Collectives" Pacific Provider Development plan
348568	Taiaomanino Trust	Implement their Collectives Pacific Provider Development plan
351969	Mitikulena Family Healthcare Ltd t/a Kilbirnie Med	Workforce development and IT system overhaul. One-off but in scope
352627	Pacific Health and Social Services Development Trust	Deed of novation. Transfer of Wellington Collective lead contract.
352628	Pacific Health and Social Services Development Trust	Deed of novation. Transfer of Wellington Collective lead contract.
354639	The Fono	Dental clinic development. One-off but in scope

Appendix 3: Programme Logic Model for the PPDF review



The PPDF PLM was developed based on relevant documents as described in the methodology section of this report.

Note: The PLM focus areas of “equity focus of funding”, “communication and transparency” were informed by the Alan and Clarke evaluation.

Appendix 4: Definitions of focus areas of capacity and capability development

Below are the broad definitions ²⁹ the review team used for each focus area.

Capacity and capability focus area		Working definition
1	Strategic governance	<i>Strategic governance</i> refers broadly to strategic planning, capacity and capability around leadership, and the way the board operates including in an accountable and transparent way to manage risk and legal compliance.
2	Operational management	<i>Operational management</i> includes: day-to-day management of the business, systems, policies, and planning and delivery, and that these documents are well aligned to the strategic direction.
3	Workforce development	<i>Workforce Development</i> looks at organisation's strategies and plans around professional development, staff qualifications and experience, for example, professional development, and in service training.
4	Financial resources and viability	For this review the <i>financial resources and viability</i> focus area includes having effective financial systems and processes, for example, planning, budgeting, and monitoring/managing assets and liabilities, and maintaining a healthy level of liquidity.
5	Information technology (IT)	<i>Information technology</i> for the purpose of the review includes the organisations internal technical structures and processes and communication platforms (eg, websites).
6	Responsive to different needs of the Pacific community	<i>Responsiveness to different needs of the Pacific community</i> is to deliver effectively to diverse people and communities whilst recognising the true extent of the term Pacific diversity. As well as being aware of the diverse Pacific cultures, religion, heritage and other characteristics that form a Pacific person's identity, it's about understanding the factors that underpin Pacific values and affect the way they see and engage with the world.

²⁹ Unless otherwise stated, the descriptions of focus areas in this document have been drawn from the MSD *Organisational Capability Self-Assessment Tool* completed as part of a Request for Proposal for "Pacific Health Provider Collectives Seeking Development Support (Ref 121300753), May 2013

7	Deliver services in a Pacific way	<p><i>Delivering services in a Pacific way</i> is referring to how services are delivered; considering the diverse cultural and Pacific ways of being and the environmental and social elements impacting on Pacific families. What is the point of difference for a Pacific provider?</p> <p>The Pacific way means different things to different people. Examples include: tailoring programmes and services that are appropriate to each Pacific ethnic group; or having staff with appropriate cultural competencies, understanding of values, context and language.</p>
8	Innovation	<p><i>Innovation</i> has been described by providers as new ways of thinking, new ways of working together, and new programmes and services.</p>
9	Performance management (including for outcomes)	<p><i>Performance management</i> refers broadly to systems methods and tools to improve service/contractual performance measures and outcomes (including managing outcomes such as via Results Based Accountability™ (RBA). While there are some overlaps with broader quality assurance activity such as audit and accreditation, these aspects can be found in the <i>operational management</i> section of this report.</p>
10	Collaboration.	<p><i>Working in "collaboration"</i> as described by lead and non-lead providers has taken a number of different forms. These sit along a continuum of working together and could be characterised as networking, coordination, cooperation, through to collaboration³⁰ in a true sense of the word.</p>

³⁰ O'Flynn 2008: 185-186 <http://www2.curtin.edu.au/research/jcipp/local/docs/wilkins-et-al-working-together-report.pdf>

Appendix 5: Summary of service documentation review

A document review was conducted in order to determine if these contained any data such as outcome measures that could be used as baseline data (for 2013), and which could then be compared with the same data relating to the current time period (2018), in order to show any change over time for the period of the review.

Performance monitoring reports (PMRs)

A selection of Performance Monitoring Returns (PMR) corresponding to the four 2013 contracts between the Ministry and the contract holders were scanned to look for outcome data relating to the short-term or medium-term outcomes in the PLM (see Appendix 3).

A minimum of two PMRs were scanned per contract to determine if they contained relevant outcome information, or any information around focus areas that could be useful in determining to what extent the PPDF has supported individual providers to increase their capacity and capability.

The PMRs scanned were for periods from July 2013 up to December 2014, in order to move beyond the initial set-up period of the Collectives in 2013. A further random section of PMRs from each of 2015, 2016, and 2017 was scanned in case there was a move to reporting for outcomes across these years.

There was no outcome data available in these or any of the other PMRs scanned. PMRs mostly contained deliverable information that related to the outputs required of them as contract holders. There was also information about outputs delivered across focus areas by non-lead providers. While this output data for Collectives and non-lead providers might have been useful for the review, they were just one snap-shot in time for providers, and so did not give a picture of the change over time period 2013-2018. The information was also reported via a third party (the lead providers) rather than from the providers themselves. The Ministry does not routinely have access to the contracts nor access to PMRs between lead providers and the non-lead providers.

A decision was made that these reports were not useful for the review objectives and the information needed to be collected directly from providers.

Needs assessments:

The data from two needs assessment tools was analysed to determine if they could be used as base-line data for the review. These are:

1. An Organisational Capability Self-Assessment Tool (the MSD tool)
2. A diagnostic tool used by an Auckland "consortium" in 2012 (the diagnostic tool).

The MSD tool was completed in 2013 as part of a RFP process by three Collectives (K'aute Pasifika Trust for the Midland Collective, Taeaomanino Trust for the Wellington Collective, Pacific Trust Canterbury for the South Island Collective). It is based on a tool developed by MSD. It identifies "10 capabilities that are characteristic of organisations working to become stronger, more adaptable, more integrated and therefore more sustainable."

The MSD tool has a scoring system for each of the focus areas. It uses a Likert scale from 1. aspirational, to 4. transformative.

Only seven of the 29 providers in scope had completed the MSD tool in 2013.

Alliance Health Plus Trust undertook a project in 2013 to identify organisational development needs and development plans for six Auckland providers in the "consortium".

The diagnostic tool was a visual tool indicating where providers sat across the following levels: high level of performance and capacity in place; opportunities exist to make improvements which will enhance and strengthen the organisations performance; and urgent action required to manage risk. Scores were given for: governance, management, integration, business/financial systems, and quality. The diagnostic tool had been developed using the Baldrige criteria, NZ Institute of Directors, previous work done on the 'excellent Pacific providers' project' and had used Pacific expertise.

The review team had access to completed assessments for four of the 29 providers in scope for the review.

Due to the diverse nature of the two needs assessment tools and the small number of providers undertaking the assessments in 2013, this data could not be used as a baseline.

However the MSD tool was used to determine what activities applied to which focus area, and to aid the project team during interviews and analysis.

Appendix 6: Most Significant Change Stories

The providers were asked to share a story that best illustrates improvements in the last few years with the support of PPDF, as a way of helping the Ministry to understand what changes are desirable, and how they happen.

In the survey, the providers were asked:

- What's the story?
- Why is this story significant to you?
- How has PPDF contributed to this story?
- Anything else to share?

These are their stories (in their own words and shared with their permission).

Story 1: Mitikulena Family Healthcare (Kilbirnie Medical Centre)

What's the story?

In November 2010, our clinic was a 'coming together' of 3 separate clinics with a varied mix of ages and ethnicities. We brought a real Pacific family culture in to this new practice, with 3 of 4 siblings being GPs and our parents who are also in the health profession, so our foundation was set. Consequently, we needed an overhaul of our computer systems and this all needed upgrading and we had to upskill staff and further their professional development and so we sought assistance from the Ministry of Health. We were blessed to get some assistance in 2015 which saw us overhaul our IT system and assist staff training. I am proud to say that one of GPs is now a Fellow of the NZ Royal College of GPs thanks in part to help from PPDF.

Why is this story significant to you?

I think it highlights how important PPDF is for the upskilling of staff and further development of an organisation's infrastructure. So long as these things are able to be shown to help improve outcomes for its Pacific patients and their families.

How has PPDF contributed to this story?

It helped our organisation to upgrade its IT system (computers upgraded) and assist staff upskilling and professional development.

Anything else to share?

PPDF is vital for organisations like mine to sustain and improve their capability and capacity such that they can continue to do the great work that they do and more. I think there needs to be a strong and concerted effort within the MoH to ensure PPDF targets Pacific Primary care providers, particularly organisations like mine to extend and enhance their reach within the Pacific community, and that there needs to be a focus not just on enhancing provider capability to deliver services better but to help them in educating and training the next

generation of Pacific health professionals so they are better equipped to serve the Pacific community. Thank you for the opportunity to share our story.

Story 2: Rotorua Pacific Islands Development charitable Trust (RPIDCT)

What's the story?

Last year we were granted PPDF funding to refurbish/upgrade our office space. We needed to assure our communities that we existed and that they had a place where they could come and meet the team currently working in the office. Our community required support with funding applications, we have computers now to do this and current software, we have developed three spaces that can be used for small meetings with clients, we have created a warm Pasifika environment. We have utilised a portion of funds to support with governance training. Workplace development that allowed some of our ECE teachers and office staff to view a Pasifika centre that valued health and education and how the two connect and are a strong base to building healthy strong families and children. We have accomplished all that we aimed to do and look forward to stepping up and onto another level of PPDF support for staff.

Why is this story significant to you?

We had a shell of a building but no sense of Pasifika or a place that our communities could come to comfortably.

How has PPDF contributed to this story?

Funding to support the refurbishment and workplace development.

Story 3: Pacific Trust Otago

What's the story?

PPDF has enabled the organisation to establish an information technology infrastructure fit for purpose and relevant for the 21st century. While PPDF provided the financial means to enable physical changes, the opportunities to change the work place thinking first, was also critical. It was important for all the staff to analyse their practices and align these with the new technology in order to simplify and improve practices. The existing technologies were a miss-match of hardware and software which caused many issues of data collection, storage and reporting.

PPDF enabled the following:

- having an external organisation with the knowledge and skills to undertake the work
- procurement of new hardware for the organisation
- updating of the internal infrastructure to wireless
- procurement of relevant online software fit for purpose
- allowing staff to be mobile
- online storage systems (cloud, off-site backups)

- greater collaboration among staff
- standardising of practices and expectations
- improved maintenance and support system

PPDF funding meant that the changeover, from planning to implementation was achieved in two months with minimal disruption to the work of the organisation.

Why is this story significant to you?

This story is significant as it demonstrates the importance of planning, design and implementation involving the staff. The importance of change thinking in the workplace and ownership, is vital for any organisation considering making changes to the work place culture and environment.

How has PPDF contributed to this story?

The funding provided much needed impetus to implement the much needed changes.

Story 4: Pacific Health Service Porirua (PHSP)

What is the story?

Sunday around 7.30am on 23 August 2015, a fire ripped through the PHSP Community Outreach Services at 12 Bedford Court Cannons Creek, Porirua. PHSP lost all of its computers, printers, cultural and spiritual artefacts.

Why is this story significant to you?

3 hours later, and there would have been massive casualties because FETU Tuvalu church and youth groups use the hall for its Sunday school and services from 9.30am. It's significant to me because while the fire was massive and we lost everything at these premises, community, youth and Porirua Council support and loyalty was shown in the form of offers of venues, and church halls to run Outreach Services. Not only this, there were also offers to help clean up. We took this as a huge and positive tick of approval for the tireless giving of our time when working with our people and Porirua in general. It was like an excellent performance appraisal of sorts. One other very humbling experience was the resilience of PHSP staff to be able to come in the very next day and work out of the GP kitchen and from other small spaces available. There was no holiday!

How has PPDF contributed to this story?

Our original PPDF enabled us to look at and upgrade our whole IT infrastructure. Meetings with IT vendors prior to 2013 under the guidance of our IT Advisor to the board enabled us to implement a secure, reliable and responsive IT infrastructure based on an outsourced and externally hosted server, with appropriate support and backup and disaster recovery options. Network connections to our sites were established and local thin clients installed to allow connection over the networks to the server and our applications and data. This meant that when the fire occurred and we no longer had access to the building, our IT operations were only affected within that building as the servers were hosted remotely. Relocating the staff to the GP practice was a simple exercise of purchasing a Wireless Router (earlier than planned),

configuring it and connecting it to the GP Practice switch. This allowed our laptops to wirelessly connect through to the server and thus the community team were able to continue working.

The reconfiguration was undertaken within three hours and the community team were operating at the GP Practice with no data loss.

Anything else to share?

PPDF is very important to building capacity and capability of Pacific Health Providers. It is also very important in terms of staff training and development as well as systems, tools and equipment upgrades. These funds ensure we are keeping up with political changes by having the best people and the best systems to meet changes. PPDF in our view should come straight from the Ministry to eligible providers just like in the early introduction of PPDF by MoH [Ministry of Health].

If the Ministry decides that PPDF should go through a Collective, we suggest that these funds should be sent to the PHO (these are Collectives too) that this provider belongs to. It should not be top-sliced but earmarked for that particular provider. If the provider were to move from that PHO to another, the PPDF funds should follow the Pacific Provider to the next PHO they join. This will be similar to patient capitation. When a patient moves from one GP to another, the funds are clawed back from previous GP and is paid to client GP of choice.

Ideally though, payment from the Ministry to the Provider cuts out the middle-man and let providers get on with what they need to do with the community. PHSP Outreach is back in the premises after 18th months of working from a kitchen and small spaces. We have been able to add heat pumps to the hall through community feedback.

Story 5: Alliance Health Plus (AH+)

What is the story?

One of the improvements made was integrating the CRM data from two of our PPDF Providers into our AH+ Data Warehouse. The CRM data were from an AH+ CRM customized database system that both the Providers and AH+ can use for one of AH+'s main Pacific contracts with the ADBH & CMDHB known as Integrated Services. Our Providers and AH+ IT systems were upgraded to fit to the CRM specifications and development with the support of the PPDF. The CRM system and the AH+ Data Warehouse has enabled the linking of social data captured as part of the Integrated Services Contract in the CRM to clinical data extracted from providers Practice Management Systems, as well as hospitalisation data from the DHBs. This data was then displayed via a dynamic dashboard using Microsoft PowerBI. This has been useful as it has enabled the team to assess outcomes across cohorts, and see the difference made to families. The tool shows obesity related measures (weight loss, BMI changes), diabetes related measures (Hba1c), and heart related measures (blood pressures, cholesterol changes) as well as hospitalisation measures (length of stay, number of admissions) over time. The activities done with the family that were captured in the CRM, such as diabetes education, or parenting education can also be used to drill down to look at specific outcomes.

Why is this story significant to you?

It has enabled our providers and us to collect data that has been quite challenging to collect in the past. The system has helped our providers to get real time data on their employees' work, e.g. the types and numbers of health activities that they have delivered to their high needs enrolled patients, and how long have the employees have engaged with each family. Our Funders are also are pleased by the data that we have been able to present to them. This is seen as a great development for both our Providers and our Funders, it has added value to all stakeholders.

How has PPDF contributed to this story?

Our providers IT system upgrade and development and also the training on the CRM system was funded through PPDF. And also a contribution from PPDF to AH+ Data Warehouse development costs.

Anything else to share?

A focus on the Pacific business workforce of the Pacific Health Providers especially the ones who have a vision of 'Pacific for Pacific'.

Story 6: Tangata Atumotu Trust (TAT)

What is the story?

There are many significant things that have happened in the 6 months since Tangata Atumotu Trust started receiving PPDF funding. Two of these relate to IT and Communications. Prior to receiving PPDF funding, the nurses who are part of the mobile nursing service were recording patient data by hand at the time of a patient's consultation. This information would then be transferred into an Excel spreadsheet when the nurse returned to the office. This resulted in double-handling of patient information and increased the likelihood of mistakes being made. The PPDF funding has enabled the purchase of tablets which the nurses now take out into the community when they are doing consultations. Patient data gets entered immediately and is securely stored in the Cloud. Information that is required by the funder (e.g. smoking status) is also collected at the time of consultation as data is entered into a pre-populated template document.

As part of the IT upgrade, TAT will soon be able to link in with the PHO IT systems which will lead to sharing of patient between TAT and general practice. TAT has also engaged a communications firm to help promote TAT and its work. We now have a new Facebook page and website - both of which contain up-to-date information of relevance to our communities. The TAT website contains a beautiful story about the work of our mobile nursing service from the perspective of one of the patients and the difference that the mobile nursing service has made to her life.

Ideas for future stories include:

- Story on a 'young, enthusiastic Cook Island Medical student'. He is keen to rally some fellow medical folk together to stress the importance of having more young Maori and Pacific people working in medicine.

- The need to educate the community on the importance of getting vaccinated and addressing shingles.
- Fijian doctor - looking into the connection to TAT here.
- Lisa Suapopo (mobile nurse) supporting a Samoan man to learn English. The benefit of having an active and relevant FB page cannot be underestimated, as they are important vehicles for getting information out and improving social connectedness amongst our communities.

Why is this story significant to you?

Reaching out to our communities in whatever ways we can is critical and the Facebook page, website and our community radio show are different mediums that allow us to connect to our communities.

How has PPDF contributed to this story?

Without the PPDF funding, there is no way that TAT would have been able to update our IT or our communication platforms.

Story 7: Pacific Island Homecare Services Trust

What's the story?

In 2017 we have used PPDF funding to support 20 of the 40 support workers who gained Level 2 and Level 3 national certification qualifications. This empowers our workforce. They are better paid through Pay Equity to look after their families and the quality of supports to the clients/customers we serve in the community improves. They learn Level 2 and Level 3 through Pacific Homecare, they are assessed while they are working and out in the homes of clients/customers. This adds significant value firstly to the workforce as well as the customers directly and continue to grow a stronger health workforce in a cultural diverse communities we serve in South Auckland.

Why is this story significant to you?

Two of our major Strategic Goals are simply about "Looking after our customers better" and "Supporting and empowering our staff" which we achieve both with this contribution of funding.

How has PPDF contributed to this story?

Through supporting and contributing to the cost of training staff and facilities and qualifications fees through our health sector ITO and a small part to training resources.

Anything else to share?

PPDF has contributed to the development of a Pacific for Pacific organisation. What is important for us going forward is sustainability, and (managing) capacity and capability challenges (so that we can be) responsive to the needs of our customers.

Story 8: Pacific Health Service Hutt Valley

What's the story?

A culmination of 3 years of PPDF funding for community engagement and development project resulted in the development of a community engagement model. This model was then applied to implement the Faith Led Wellbeing project. A cluster made up of 6 different churches based in Wainuiomata was formed and the Faith Led Wellbeing project focus on the four pillar approach of Family, Fitness, Food and Faith underpinned the project. The 6 months implementation phase resulted in approximately 600 to 800 people participated throughout the programme for 6 months. The project received an excellent award from the Hutt Valley District Health Board for the best community programme.

Why is this story significant to you?

Because it brought 6 churches of different denominations together for a common purpose for 6 months to improve health and wellbeing for individuals, families and community as a whole.

How has PPDF contributed to this story?

PPDF funded this project.

Story 9: Pacific Island Community (Tauranga) Trust [PICTT]

What's the story?

Within the first month of my tenure as CE the board members at that time (November 2016) took me out into the community to meet with Kiribati families in Te Puke. This Pasifika community were meeting for the weekend to have a fono on how to address family violence that had been increasing in their Kiribati community. The fono had in attendance approx. 180 people which included children and adults. Te Puke is still a small rural township in the Western BOP region that is known for the kiwifruit industry and a big employer of seasonal workers who are Pasifika.

Why is this story significant to you?

PICTTs presence by the CE and Trust Board members at the Kiribati fono that weekend started a chain reaction that had not been seen in this organisation previously. Our organisation had not engaged with this Pasifika community before. It is significant to me because from then to now PICTTs relationship with this community has grown and developed. From that one opportunity to introduce myself and the services that PICTT had and wanted to develop was that key to open a revolving door of mutual engagement. Today, we have Kiribati families engaging in many of programmes and services from our health services, education, Whanau Ora programme, but most importantly, Kiribati now hold a position on PICTTs Board of Trustees and on our Pasifika Community Development team as a volunteer representing youth.

How has PPDF contributed to this story?

PPDF plays a pivotal role in developing, progressing and implementing the holistic health goals of our Pasifika families in Tauranga City and the Western BOP region. With the PPDF

PICTT has been able to improve its capacity by investing in personnel who are experienced in Operations, specifically in the areas of governance, senior management, financial management and administration.

The value added to the story above is that by one presentation at a fono does not mean that something will come from it. It is our capacity and capability to be able to follow through as a reputable organisation, to do what we say and to be able to deliver on what we promote in the Pasifika communities. The PPDF has allowed PICTT the ability to change, adapt and improve its services to walk along side the Kiribati community and their families to be able to access health and social services where before they were not and to help them find their own solutions.

PICTT is grateful for the investment MOH [Ministry of Health] has made available to us through this fund. It has allowed us to build an organisation that can respond and adapt to the needs of the Kiribati community. I highly recommend that 1. the PPDF continues for another 5 years. Investing in us and our Pasifika communities means better health outcomes for them as well as the wider community and 2. that a greater amount of financial investment be made available to provide sustainability, continuity of service and a consistency of a quality of service to one of the most marginalised demographics in our region.

Anything else to share?

Thank you so much for the opportunity to speak on behalf of PICTT and the Pasifika communities residing in Tauranga Moana.

Story 10: South Waikato Pacific Islands Community Services

What's the story?

One of our significant challenges is around 'access' within a rural setting. PPDF has assisted us in removing these barriers by proactively engaging with our Pacific community to:

1. get feedback
2. design service requirements
3. inform our strategic direction.

We have successfully been able to do this through an initiative entitled - Aiga Taokotaianga which brought together close to 800 people in a safe, communal space where activities were had and had very much a family atmosphere. It is from these levels of engagement which provide us with the evidence on how to enhance the service and best practice that we aspire to. It has become an annual calendar event and with the support of PPDF enables us to have this very comprehensive approach to how we engage effectively with our Pacific community.

Why is this story significant to you?

It demonstrates the approaches that we would like to have, but how its implementation can be a challenge if the appropriate resources are not readily available.

How has PPDF contributed to this story?

As noted in the example.

Anything else to share?

PPDF has been very important to all areas of our organisation - it provided the capacity for our governance to have regular reviews, operationally for staff to have a retreat space to plan, prepare and coordinate annual service and promotion initiatives, it provided resourcing for ensuring that we have the right 'tools' and software to be relevant within an IT space, and has enabled us to invest in our workforce to have quality and skilled staff. As a small pacific NGO any other discretionary funding is contestable and we are not always successful in that space. PPDF has provided us with that leverage to invest in the continued robustness, transparency, and sustainability that are our outcomes.

Story 11: K'aute Pasifika

What's the story?

Prior to PPDF, there were no clear management structures in place and the governance clearly needed strengthening. There was a CEO who practically did everything from an operational perspective and then the staff who delivered the services. Through the PPDF, we have been able to invest in good governance training and strategic planning to the point where our vision and mission and strategic plan inform and permeate everything we do. We have developed clear management structures with accountability processes etc. With strong governance and operational management in place, we have been able to develop and maintain a pacific voice at local and national government level and regionally through the Collective vehicle. We have achieved ISO 9001 accreditation which necessitates a significant body of work.

Why is this story significant to you?

It is important because it reflects the growth of the organisation and that we have made prudent and optimal use of the funding that has been made available to us.

How has PPDF contributed to this story?

See above.

Anything else to share?

There remains room for improvement and capacity and capability development.

Appendix 7: The review project management

The review of the PPDF was undertaken by an internal multi-disciplinary project team comprising of members from two Ministry of Health directorates (Population Health and Prevention and Health System Improvement and Innovation)³¹. The project team has some independence as they sit outside the team that manages the PPDF contracts.

Review team members are: Jo Wall (Project Lead, Public Health Physician), Rebecca O'Connell (Public Health Physician), Sene Kerisiano (Senior Advisor), Laupepa Va'a (Public Health Registrar; left the team after the completion of the interviews³²), and Sonia Chen (Evaluation Lead, Senior Advisor Research).

The project governance includes: business owner, Grant Pollard (Group manager, Population Health and Prevention); the sponsor, Matafanua Hilda Fa'asalele (Chief Advisor Pacific Health, Population Health and Prevention) and the manager of the team leading the project, Te Miha Ua-Cookson (Manager Infrastructure team, Population Health and Prevention).

In addition the review has been supported by an internal Ministry of Health Advisory Group at key decision making points during the review. The Advisory Group currently³³ consists of Matafanua Hilda Fa'asalele, Danilo Coelho de Almeida (in his former role as Senior Contract Manager for PPDF, Operational Excellence), Christopher Carroll (Disability Policy, Disability) and Mathew So'otaga (Pacific Health, Population Health and Prevention).

³¹ The Ministry of Health adopted a new structure in October 2018. The position titles listed here have been updated accordingly.

³² Marlene Williams (Senior Portfolio Manager, Population Health and Prevention) has worked from August onwards on completing the literature scan.

³³ The Advisory Group also had initial representation from the Māori Health Service Improvement Team.

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