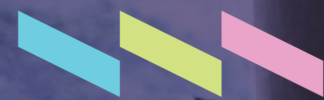

# Care in the Community

## Evaluation Pack

- Context
- Limitations
- Key findings

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Rautaki me Matawhānui
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insights ▸ decisions ▸ lives

# Context.

### The Care in the Community welfare response used a locally-led, regionally-enabled and nationally supported approach to help people in need during the COVID-19 pandemic

The Care in the Community (CiC) welfare response was designed to help people remain safe and supported while they were required to isolate because of COVID-19. MSD partnered with community providers, iwi and Māori, local government, and other agencies to deliver a locally-led, regionally-enabled and nationally supported response.

This included:

- enabling Regional Public Service Commissioners (RPSCs) and Regional Leadership Groups (RLGs) to oversee planning, alignment, and delivery of welfare support in their regions
- resourcing iwi to engage and participate in RLGs
- strengthening community providers' capability and capacity
- funding Community Connectors to provide short term support to self-isolating households, and later to households impacted by COVID-19 who could not access other supports
- directing funding to food providers as well as funding to boost the infrastructure, capacity, and efficiency of local and national food organisations.

### The welfare response was delivered at a time of great uncertainty and situated within a broader landscape of supports made available for people impacted by COVID-19

In October 2021, the government introduced the COVID-19 Protection Framework (CPF) to minimise the impact of COVID-19 and protect the critical systems that support people's health and wellbeing. People with COVID-19 were supported to self-isolate in the community under the CPF. The CPF was in place until mid-September 2022 but when it was first introduced it was not known how long the framework would be required.

During the CPF, CiC support was delivered by a range of health and welfare providers and overseen by multiple agencies. The Ministry of Social Development (MSD) was responsible for coordinating the CiC welfare response - an integrated package of welfare and community supports made available to isolating households. The overarching aim was to support people to stay safe at home for the duration of their isolation period, limiting the potential of further COVID-19 transmission. The Ministry of Health and MSD shared an expectation that health and welfare providers would coordinate their services as much as possible to achieve intended CPF objectives.

Projections of COVID-19 positive cases based on different scenarios were used to inform CiC responses. These projections recognised that some communities would be impacted by COVID-19 more than others due to lower vaccination rates, poor service infrastructure, and long-standing disparities in health and wellbeing access and outcomes. Projections estimated that without dedicated welfare support there would be more breaches of self-isolation, greater health risks to communities through increased transmission, and increased pressure on the health system.

The CiC welfare response was not delivered in isolation. Alongside this, there was a range of other support delivered by MSD and other agencies to address different COVID-19 impacts. This included temporary increases to eligibility for hardship assistance, the COVID-19 Wage Subsidy Scheme, and the COVID-19 Support Payment. The COVID-19 Leave Support Scheme and the COVID-19 Short Term Absence Payment were also designed to enable people to self-isolate while positive with, or awaiting test results for, COVID-19. These supports were provided on top of regular benefits and payments available via Work and Income (e.g., Special Needs Grants, Temporary Additional Support).

As MSD was responsible for managing the welfare component of the All of Government COVID-19 response, many new systems and processes were established at pace to facilitate coordination, triage referrals, organise communications and deliver support. MSD also redirected operational staff to support with the delivery of the welfare response while still maintaining BAU practices for supporting individuals and households (e.g., via Work and Income supports and services). These included:

- the Contact Centre Services team, which rapidly established and staffed a dedicated COVID-19 Welfare Line 0800 number
- the National Triage team, which facilitated and coordinated the triage response for referrals from the Ministry of Health and redirected referrals to regional case managers
- the Centralised Services and Operational Delivery team, which managed workforce coordination and assessed available resource across MSD and the amount teams could contribute without sacrificing core critical demand.

### A 'no wrong door' approach was used to ensure broad-based access to welfare support

People could receive CiC welfare support through multiple pathways, including via the Ministry of Health, via MSD (through MSD contact centres, the MSD website, and MSD Service Centres and case managers), or directly through community organisations. MSD set up a dedicated 0800 number staffed 7-days per week and new IT supports to share information and referrals. An assessment of need was conducted through all access pathways.

The response required extensive efforts from community providers, Community Connectors, and MSD operational staff (who had to deliver the response alongside business as usual) to respond to surges in demand for support as COVID-19 case numbers increased.

During the time the CiC welfare response was in place, MSD allocated over

**$325m**

to partners, iwi, service providers and community groups across Aotearoa New Zealand.

This funding enabled

**500** Community Connectors *and* **233** Community food providers

to deliver the response.

Over

**1.3 million**

food parcels were distributed to people in self-isolation, while Community Connectors supported more than

**300,000**

households.

MSD also provided contributory funding to

**244** social service providers to enable them to pivot from their existing government contracts and deliver support to isolating households.

These costs do not reflect the total amount spent on supporting isolating households during COVID-19, including on Special Needs Grants, which were a significant component of MSD's support for affected households.

### The welfare response was adapted to respond to changing circumstances over time

Revisions were made to the CiC welfare response over time to respond to changing circumstances and needs. For example, a significant funding boost to sufficiently scale the welfare response was provided to address the Omicron outbreak. This was used to increase the Community Connector workforce, increase discretionary funding to meet non-food essential wellbeing needs, and provide further funding to foodbanks and other food organisations. When COVID-19 cases began to decline a plan was put in place to transition the focus from a crisis response to supporting communities to recover (while maintaining the capacity to shift back the focus if case numbers were to grow).

When demand for isolation support reduced, Community Connectors pivoted to providing short term support and connection with recovery and resilience supports for people impacted by COVID-19. This enabled them to respond to a broad range of emerging priorities, such as young people's engagement in education and youth crime.

### An evaluation of the welfare response was completed to identify lessons for future ways of working

A three-pronged evaluation of the CiC welfare response was conducted. This included:

- A **real-time evaluation** undertaken by MSD to generate rapid insights and inform real-time decision-making during implementation of the welfare response.
- An **outcomes-focused evaluation** to understand implementation and outcomes achieved through the welfare response. This included a survey workstream undertaken by Allen and Clarke and a case study workstream undertaken by Kaipuke Consultants Ltd.
- A **synthesis** undertaken by MSD to summarise findings from across the different evaluation activities and identify lessons for future ways of working.

# Limitations.

## The evaluation triangulated data from multiple sources to generate valuable insights about the CiC welfare response but findings are limited in their generalisability and representativeness

A mixed methods approach was used to collect a combination of qualitative and quantitative data. Data collection methods included document review, surveys of different stakeholder groups, regional case studies, and interviews. These methods were used to converge on evaluation findings and help to strengthen their validity.

The Ministry of Health was unable to share unit record information about positive COVID-19 cases with MSD. This meant there was no way for the evaluation to identify who needed support to isolate and the extent to which these needs were met through the response.

Findings reflect the perspectives of those who participated in the evaluation and cannot be considered representative or generalisable to those who did not participate. Participants included a selection of national stakeholders, community providers, Community Connectors, isolating households that received support from a community provider/Connector, and a small number of MSD Service Delivery. The evaluation did not capture perspectives of households that contacted MSD directly for support, despite this being a key referral pathway. Many participants were invested in the CiC model which may have biased their perspectives on the success of the response.

## The evaluation cannot determine whether reported outcomes are a direct result of the CiC welfare response

Comparison with a counterfactual is recommended to understand whether an initiative is responsible for outcomes. This involves comparing observed outcomes to those expected if the initiative had not been implemented.

However, in rapidly changing, complex situations it can be impossible to develop an accurate estimate of what would have happened in the absence of an initiative. This is because the absence would have affected the situation in ways that cannot be predicted, as in the context of the CiC welfare response.

There were several other challenges to establishing a causal link between the CiC welfare response and observed outcomes through this evaluation:

- The primary challenge was the absence of information (data) on who was eligible for and who received welfare support (to be able to form a comparison group).
  - The CiC welfare response was designed to support people to self-isolate, and MSD was careful not to introduce barriers that may have disincentivised people from accessing support (e.g., through the use of personally identifiable information).
  - The Ministry of Health was unable to share information on COVID-19 positive cases for the purpose of monitoring and evaluation.
  - This meant it was not possible to identify the total population that received CiC welfare support. While community providers completed weekly estimates of the number of households they had supported, there was no expectation that providers capture personal details from households supported or that they share this information with MSD.
- Even with this information it would have been difficult to construct a comparison group because there would likely be differences on several key characteristics between those who accessed welfare support and those who did not.
- One data source that is commonly used for comparing outcomes between groups is the Integrated Data Infrastructure (IDI). If it was possible to identify those who were eligible for or who received support within the IDI, it would still not be possible to demonstrate a causal link between the response and any observed differences in outcomes like hospitalisation because of the difficulty separating the impact of the Omicron outbreak from the response.
- Another issue is that the IDI does not contain information on many of the intended outcomes of the response, including compliance with isolation requirements and the extent to which people felt adequately supported to remain isolated.
- The design phase of the evaluation did not consider qualitative approaches to inferring impact (e.g., theory-based, case-based, or participatory design approaches).

## The inability to attribute outcomes to the CiC welfare response precluded a value for money assessment

Understanding the extent to which an initiative resulted in outcomes (both intended and unintended) is critical to be able to calculate its total costs and benefits. Exploring value for money was not feasible because of the difficulty identifying how costs were allocated across the range of welfare response activities and the challenges determining the role of the welfare response in producing outcomes.

## We learned that there are opportunities to collect information that would enable a value for money assessment if a similar initiative or response is rolled out in the future

Ensuring that the right data collection systems are in place is important to be able to assess the outcomes, impact and value of any social initiative. To support future evaluation, particularly the collection of good outcomes data, it is recommended that:

- Diverse stakeholders are engaged to identify appropriate outcomes indicators (ways of knowing that change has happened) and data on these indicators is collected and available for analysis.
- Relevant agencies and community organisations share unit record information so that this can be matched to data within MSD source systems or other data within the IDI.
- Systems are in place to assure agencies and community organisations of how data will be protected and safely used. This could involve a trusted third party, such as Statistics New Zealand, having responsibility for the data and ensuring it is matched and anonymised before it is shared with MSD.

# Key findings.

**The welfare response enabled households to isolate safely which contributed to reducing the spread COVID-19**

**83%** of households agreed that they were able to successfully isolate because of CiC welfare support.

No significant differences were found for Māori or other priority groups.

**83%** of Regional leaders

**86%** of Community providers

**92%** of Community Connectors

expressed strong agreement that the welfare response was effective in enabling isolation.

Households, along with Community Connectors and community providers, reported that food support was the most used, helpful and important support provided as part of the response. The majority of household survey respondents reported that the food:

**92%** **was timely**

**84%** **was sufficient**

**90%** **made them feel supported**

**83%** **reduced mental stress**

**86%** **reduced finacial stress**

Following food, the most valued supports included general household items, help to meet urgent expenses and medical needs, and information about community supports. Household survey respondents appreciated the ability to access a range of supports which they reported mostly met their needs, including their:

**86%** **wellbeing needs**

**83%** **cultural needs**

**68%** **religious needs**

Evaluation participants attributed the success of the welfare response to local trust in community providers and Community Connectors. Many households that received support had never previously sought help from community or government services, viewing it as a *"last resort."* Providers and Community Connectors put significant effort into community outreach, targeted communications, and welfare checks, focusing on building relationships with hard-to-reach populations.

Community Connectors were the 'face' of the welfare response, with ***75%*** of households reporting that they were supported by a Community Connector. The majority of households reported that the Community Connector:

**92%** **understood their household's needs**

**90%** **was respectful**

**87%** **was easy to talk to**

**86%** **was timely**

**80%** **reduced finacial stress**

Community Connectors and providers both agreed that the most important aspect of the Community Connector role was their understanding of the needs of the community, followed by their flexibility, and their existing community networks. With four of the five top-ranked top supports being expense-related, Community Connectors' access to a discretionary fund also helped them meet urgent household needs (e.g., medical expenses, rent arrears, transport costs).

**65%** of households reported that CiC welfare support was easy for them to access.

**75%** of households with at least one Māori resident

***and***

**86%** of households with at least one Asian resident

were significantly more likely to find it easier to request support.

It is important to note that the evaluation did not capture information directly from those who may have needed CiC welfare support but did not receive it. Perspectives on access to the response were captured from regional leaders, Community Connectors, and community providers who thought that some communities had struggled to access support during the response, including Māori, older people, disabled people, and low income households.

Nevertheless,

**83%** Community providers ***and*** **89%** Community Connectors

felt they were able to increase the reach of support to people who needed it through the welfare response.

### Regional leadership mechanisms mostly worked well in providing coordination and oversight of the welfare response in the regions

The majority of RLG members reported their RPSC's existing relationships were:

**87%** crucial for enabling an effective regional welfare response

***and***

**100%** for connecting with other cross-agency stakeholders

RPSCs used these relationships to form broad-based RLGs, with 87% of RLG members agreeing that all relevant organisations were included. While iwi representatives were successfully recruited onto most RLGs, representation for Pacific peoples and other priority groups (e.g., disabled people, older people, and ethnic communities) was less consistent.

Iwi participation in RLGs was considered instrumental in ensuring the welfare response delivered for whānau Māori. However, the absence of RLG members representing other priority groups may have impacted the extent to which the welfare response was tailored to support these communities.

Harnessing local level 'intel', RLGs successfully worked to identify and resolve issues in the regional delivery of the welfare response (e.g., ensuring access to community facilities for local providers). Where necessary, RLGs escalated barriers to local delivery to central government. Providers acknowledged the value of RLGs in aiding local level delivery, with 86% agreeing that they were well supported by their RLG to deliver the response.

RLGs also channelled national level communications out to their regions. Messages were adapted to ensure they would resonate with communities, helping to increase awareness and access to available supports.

### National level priorities, systems and processes generally supported regional and local level efforts

The uncertain and rapidly changing context for implementation of the welfare response led to the model being stood up quickly. Existing cross-government arrangements provided MSD with a foundation from which to implement the CiC welfare response.

The All of Government collaboration fostered a shared sense of responsibility for the welfare response, with MSD's existing robust operational infrastructure and efforts enabling its implementation. However, incompatible IT systems and the absence of suitable data-sharing agreements occasionally hindered effective coordination of referrals between agencies.

Several iwi RLG members noted that the investment in resourcing iwi involvement at the regional leadership level demonstrated a commitment to Te Tiriti o Waitangi and a positive example of Crown/Māori partnership.

Although the CiC model marked a shift towards regional leadership, some RLGs felt they were not adequately consulted on broader decision-making.

With regard to the contracting and commissioning models:

**82%** of providers found them flexible enough to tailor support to community needs

***and***

**85%** of providers found them flexible enough to adapt to changing circumstances

Stable funding allowed providers to focus on delivery but was not always sufficient for maintaining workforces.

Limits to CiC funding meant that:

***only***

**28%** of providers could recruit skilled personnel

**33%** of providers could retain them with CiC funding

***and***

**71%** of providers relied on volunteers to meet demand

Providers and Community Connectors considered the discretionary fund to be crucial for addressing immediate needs and alleviating COVID-19-related financial hardship.

A few stakeholders expressed concern that the welfare response might have led to some duplication of funding streams. However, some central government stakeholders argued that community providers managed this issue effectively by ensuring that services and supports were not duplicated on the ground.

### The evaluation identified implications for future efforts to support and strengthen communities

While MSD developed and implemented the welfare response in a crisis context, there are several lessons for the design and delivery of social supports that require cross-agency collaboration and coordination going forward. These lessons include:

- The locally-led, regionally-enabled and nationally supported model worked well to deliver the CiC welfare response and could be a useful model for future situations that require the delivery of quick, coordinated and comprehensive support for communities.
- Communities are best supported by trusted local providers who understand their context and remove barriers for people who are reluctant to engage with government supports.
- Regional leadership structures should proactively recruit representation from priority groups to advocate for the needs of their communities.
- High trust responses enable support to be quickly distributed to impacted households in crisis situations.
- There is an opportunity to maintain the momentum and appetite for cross-agency collaboration that resulted from using an All of Government model.
- Flexible contracting models make it possible for community providers to tailor support to meet community needs.
- There is a need to assess whether providers and regional leaders have adequate resources and funding, particularly for delivery of future locally-led and regionally-supported initiatives.