Care in the Community (CiC) Welfare Response

Evaluation Synthesis Report

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Author

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Disclaimer

The views and interpretations in this report are those of the author and are not the official position of the Ministry of Social Development.

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Executive Summary

The Care in the Community welfare response used a locally-led, regionally-enabled and nationally supported approach to help people self-isolate during the pandemic and reduce the spread of COVID-19

The government introduced the Care in the Community (CiC) welfare response in the unprecedented context of the COVID-19 pandemic. Led by the Ministry of Social Development (MSD), the response involved a locally-led, regionally-enabled and nationally supported approach to enable people to safely self-isolate and minimise the transmission of COVID-19. This included community providers taking a leading role in the response, overseen by Regional Leadership Groups and Regional Public Service Commissioners (many of whom were also MSD Regional Commissioners), and with the support of central government. The welfare response connected people in need of assistance with a broad range of government and community supports, including supports available through trusted local providers.

MSD rapidly established new systems and processes in support of the CiC welfare response, including coordination, the triage of referrals, management of communications, and delivery of support. This required MSD to reassign Service Delivery staff to support the welfare response, while still ensuring the continuation of its business-as-usual (BAU) operations to assist individuals and households (e.g., through Work and Income services and supports).

During this time, MSD also maintained a strong regional presence with more than 140 service centres across 11 regions, each managed by an MSD Regional Commissioner. These Commissioners worked with MSD National Office, local Civil Defence, iwi, and NGOs to support the All of Government COVID-19 response.

MSD undertook an evaluation to understand implementation and outcomes of the welfare response and lessons for future ways of working

MSD designed a three-pronged evaluation of the CiC welfare response, including:

- a real-time evaluation
- a outcomes-focused evaluation
- a synthesis.

MSD undertook the real-time evaluation (RTE) in 2022 to produce rapid insights and inform ongoing decision-making. MSD then expanded on these findings through an outcomes-focused evaluation.

The outcomes-focused evaluation focused upon the innovative partnerships within the locally-led, regionally-enabled, and nationally supported model that enabled the delivery of the response. In particular, the contributions of Community Connectors, community providers, and regional leadership structures in the implementation process. It also explored the outcomes achieved through the CiC welfare response – in particular, for the individuals, families and whānau supported through the response. The evaluation did not aim to explore the role of MSD's range of regular supports and services (e.g., programmes and services provided through Work and Income, including income support, hardship assistance, and housing supports) in facilitating self-isolation.

The outcomes-focused evaluation involved:

- A survey workstream (undertaken by Allen + Clarke) consisting of interviews with central government stakeholders, and surveys of regional leaders, providers, Community Connectors, and households who received CiC welfare support.
- A case study workstream (undertaken by Kaipuke Consultants Ltd.) consisting of interviews with regional leaders across six case study regions.

All available evaluation evidence was synthesised to identify insights from the response and lessons learned for future work to support communities.

This report represents a narrative summary of the synthesised findings.

Findings show that the welfare response was successful in enabling households to isolate safely

The majority of households (83%) reported that the support they received through the CiC welfare response enabled them to isolate safely.

The scale of the welfare response was large. Households were supported to isolate through a range of services and mechanisms that were activated at local, regional, and national levels by community partners and government agencies. MSD reallocated considerable frontline resource to support the CiC welfare response while also continuing to meet the heightened demand for benefit and payment support.

Community providers and Community Connectors delivered over 770,000 food parcels for households in self-isolation, and over 560,000 food parcels for households otherwise affected by the impacts of COVID-19. Community Connectors also supported more than 300,000 households in self-isolation and/or impacted by COVID-19.

Local level efforts were critical to the success of the welfare response

While the evaluation was unable to capture insights from those who may have needed support but did not receive it, community providers, Community Connectors, and regional leads perceived that some priority groups may have struggled to access CiC support. However, of those who did receive it, most (65%) reported that it was easy to request CiC welfare support, with Māori and Asian households reporting the greatest ease of access (75% and 86% respectively).

Households most urgently needed and valued food support. The majority of households reported that food support arrived when they needed it (92%), enabled them to self-isolate without going hungry (84%), made them feel supported (90%), and reduced mental and financial stress (83% and 86% respectively). Food support helped develop relationships with households, increasing willingness to seek support for other needs, including among those who had not previously engaged with government or community supports.

Community Connectors were the 'face' of the welfare response and identified what each household needed to stay home through their isolation period. The majority of households agreed that their Community Connector understood their household's needs (92%), and that they had been respectful (90%), timely (86%), easy to talk to (87%), and built trust with their household (80%).

Evaluation participants attributed the success of the welfare response to local trust in community providers and Community Connectors. Their whānau-centred approach and understanding of local needs increased the reach of the response, especially for hard-to-reach communities.

Increased networking across the social sector during the response helped to build stronger regional relationships, but peaks in demand for support put significant strain on providers and Community Connectors.

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

The implementation and coordination of the CiC welfare response was enabled by two regional leadership mechanisms – Regional Leadership Groups (RLGs) and Regional Public Service Commissioners (RPSCs). RLGs oversaw the planning, alignment, and delivery of welfare in each region through existing partnerships with iwi, local government, community partners, and Crown agencies. RPSCs were given the mandate of supporting RLGs and leading the coordination of the public service contribution to the response.

RLG membership was expected to include representatives from local government, regional staff from central government agencies (including MSD), iwi, and other key regional partners. The evaluation found that RPSCs used their existing intersectoral relationships to assemble broad-based RLGs. In most regions, iwi were represented on RLGs or otherwise involved in decision-making, though representation was less consistently sought for Pacific peoples and other priority groups (e.g., disabled people, older people, ethnic 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.

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.

Existing infrastructure, investment in iwi participation, and joined up government collaboration provided national level support of the welfare response

The uncertain and rapidly changing context for implementation of the welfare response led to the model being stood up quickly. Existing cross-agency arrangements (including the Caring for Communities group, the Regional System Leadership Framework 2021, and the application of Social Sector Commissioning principles to contracts) gave MSD a foundation from which the CiC welfare response could be implemented.

The investment in resourcing iwi involvement at the regional leadership level was perceived as a commitment to Te Tiriti o Waitangi and a positive example of Crown/Māori partnership. It also enabled them to support their communities more than they might otherwise have been able to.

High trust commissioning and flexible contracts allowed providers and Community Connectors to be agile in meeting community needs and responding to changing circumstances. Providers' most highly rated aspect of the contracting model was certainty of funding, which enabled quick delivery of support. However, resourcing was not always sufficient to maintain provider workforces. The discretionary fund available to providers and Community Connectors was considered crucial in meeting immediate needs and mitigating against further financial hardship because of COVID-19.

All of Government collaboration developed a sense of collective responsibility for the welfare response, ensuring the delivery of joined up supports. The response's implementation was also expedited by MSD's robust operational workforce and infrastructure, which were rapidly redirected to facilitate coordination, triage referrals, organise communications while maintaining regular supports and services.

While the CiC model demonstrated a shift towards regional leadership, some RLGs felt that central government had not considered local and regional guidance in their decision-making. Incompatible IT systems and the lack of appropriate data sharing agreements also hindered triage of referrals between agencies at times.

While a few stakeholders signalled concern that the welfare response may have resulted in some duplication of funding streams, this was reported to have been managed by community providers ensuring that services and supports were not duplicated on the ground.

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

While the welfare response was developed and implemented 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.

1. Evaluation background

MSD designed an evaluation to understand the implementation of the Care in Community welfare response, the extent to which the response achieved its intended outcomes, and lessons learned for future work to support communities

The Care in Community (CiC) welfare response was part of the broader cross-government effort to assist individuals and households during the COVID-19 pandemic. The CiC welfare response utilised a locally-led, regionally-enabled and nationally supported model which involved: the local delivery of supports via community providers and Community Connectors; establishing Regional Leadership Groups to provide oversight over the implementation of the welfare response in the regions; and national-level collaboration across the wider public sector to enable a joined-up COVID-19 response.

MSD designed an evaluation with three key components:

- A real-time evaluation (RTE) to generate rapid insights about implementation of the welfare response and inform decision-making
- An outcomes-focused evaluation to assess implementation outcomes and outcomes achieved for individuals, families, whānau, and communities
- A synthesis weaving together findings from all evaluation components to identify lessons learned.

Real-time evaluation

MSD undertook the RTE between March and August 2022. MSD staff collected information across three cycles through a combination of document review and interviews. These captured perspectives and experiences of:

- six RPSCs and 11 RPSC Directors and Advisors
- two RLG members
- 38 community providers
- 15 Community Connectors
- 24 people who received CiC welfare support.

Each cycle of the RTE explored different aspects of the welfare response.

Findings are available here:
https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/real-time-evaluation-of-the-care-in-the-community-welfare-response/index.html

Outcomes-focused evaluation

The purpose of the outcomes-focused evaluation was to expand on the insights generated through the RTE.

The outcomes-focused evaluation also explored the extent to which outcomes were achieved for:

- individuals, families and whānau
- community providers and Community Connectors
- RPSCs and RLG members
- MSD and other agencies involved in delivering the response.

A set of key evaluation questions guided the evaluation (see Appendix 1). These were developed by MSD in consultation with internal stakeholders and a Reference Group of representatives from agencies and organisations involved in the response.

The outcomes-focused evaluation used a mixed methods approach and included two externally contracted workstreams – a survey workstream and a case study workstream. Additional interviews were undertaken in-house with MSD Service Delivery staff.

Survey workstream

The survey workstream was undertaken by Allen + Clarke in 2023. This workstream involved surveys of regional leads (including RPSCs and RLG members), Community Connectors, community providers, and households that received CiC support. Key informant interviews with 16 central government representatives were also conducted.[1]

In total, there were survey responses from:

- 53 RLG members
- 75 community providers
- 107 Community Connectors
- 255 households.

Please refer to Allen + Clarke's technical report for the survey workstream's methodology.

Case study workstream

The case study workstream, undertaken by Kaipuke Consultants Ltd. in 2023, involved six case studies to explore the role and contribution of regional leadership structures in achieving desired outcomes of the welfare response.

Selection of the case studies was informed in consultation with MSD and RPSCs, with the intention to include a cross-section of regions that provided a mix of characteristics (e.g., levels of economic deprivation, ethnic make-up, home agency of the RPSC). From the 15 public service regions, six case study regions were selected – Te Tai Tokerau, Tāmaki Makaurau, Waikato, Bay of Plenty-Waiariki, Greater Wellington, and Marlborough-Nelson/Tasman.

[1] Key informant interviews were undertaken with representatives from MSD, Treasury, Oranga Tamariki, Te Pūni Kōkiri, Ministry for Pacific People, Te Whatu Ora, and Whaikaha.

A total of 54 regional leadership stakeholders participated in case study interviews, including: RPSCs (and their support teams), RLG members from across departmental agencies, local government, iwi, and Pacific peoples' representatives.

Please refer to Kaipuke Consultants Ltd.'s technical report for the case study workstream's methodology.

Interviews with MSD Service Delivery staff:

In September and October 2023, the MSD evaluation team conducted interviews with MSD Service Delivery staff to examine the Ministry's role in delivering the welfare response.

Senior operational leads supplied the names of staff who led different elements of the MSD frontline response. Interviews followed a semi-structured interview guide and were audio-recorded and transcribed.

In total, interviews were undertaken with five participants (1x contact centre, 1x centralised services, 1x triage service, 2x regional coordination and case management response).

Thematic analysis of the transcripts was conducted to identify key themes emerging from the interviews.

Synthesis

A synthesis of findings from the RTE and outcomes-focused evaluation was conducted to identify lessons for future ways of working.

A narrative synthesis approach was employed to synthesise findings from each of the evaluation data sources (RTE reports, survey workstream report, anonymised qualitative responses to the household survey, anonymised key informant interview transcripts, case study workstream report, and MSD Service Delivery staff interview transcripts).

An evaluation crosswalk was developed (Appendix 1), which identified which data source provided findings for each of the key evaluation questions (KEQs). Using NVivo, findings from each of the data sources were extracted and clustered according to each KEQ.

Inductive thematic analysis was used to identify key themes across the data sources. Where possible, qualitative evidence (i.e., from the case study workstream, RTE, central government stakeholder interviews, or MSD Service Delivery staff interviews) was triangulated against quantitative evidence (i.e., from the survey data), increasing confidence in the findings. Instances of contradicting evidence (e.g., between survey and interview data or between different stakeholders) were identified.

A narrative summary of findings was then completed to highlight successes and challenges at local, regional, and national levels of the CiC welfare response.

There are several limitations associated with this evaluation

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 staff. The evaluation did not capture perspectives of households that contacted MSD Work and Income 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 did not share information on COVID-19 positive cases for the purpose of monitoring and evaluation.
    - This means 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.

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.

2. Context

The government introduced the Care in the Community welfare response in the unprecedented context of the COVID-19 pandemic

In October 2021, the New Zealand 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. When the CPF was first introduced, the timeframe for operation was unknown. It remained in place until mid-September 2022.

Under the CPF, people with COVID-19 and their households were provided support to isolate at home or in the community. The Ministry of Social Development (MSD) was responsible for leading the coordination of an integrated package of supports to meet people's welfare needs while in self-isolation.

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. Without support, there was likely to be more breaches of self-isolation, greater health risks to communities through increased transmission, and increased pressure on the health system.

Community organisations and government agencies swiftly developed a range of supports for individuals and households affected by the pandemic. Within MSD, there were several rapid developments to ensure timely delivery of support. On top of regular Work and Income supports, MSD also introduced new income support products, as well as the CiC welfare response. This evaluation focuses specifically on elements of support delivered through the CiC model.

The Care in the Community welfare response involved a locally-led, regionally-enabled and nationally supported approach to enable people with COVID-19 to safely self-isolate

From November 2021 until the end of June 2023, MSD delivered the demand driven Care in the Community (CiC) welfare response for people in COVID-19 positive households and other people required by government to self-isolate.

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 involved:

- enabling cross-agency Regional Leadership Groups (RLGs) and Regional Public Service Commissioners (RPSCs) to oversee planning, alignment, and delivery of support for the CiC welfare response
- resourcing iwi to engage and participate in RLGs
- strengthening community providers' capability and capacity
- re-directing Community Connectors, introduced in June 2020, to provide short term support to people self-isolating, and later to people impacted by COVID-19 who could not access other government supports
- directing funding to food providers as well as funding to boost the infrastructure, capacity, and efficiency of local and national food organisations.

The response was designed to enable relevant local agencies, councils, and providers to play key roles in delivering welfare support, based on what a region or community decided would work best for them. People, families and whānau were supported to connect with trusted local providers in their community who understood their circumstances and needs.

The CiC welfare response used a 'no wrong door' approach, with people able to receive support through multiple pathways, including via the Ministry of Health, via MSD or directly via community organisations.

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).

During the CPF, MSD maintained a strong regional presence with over 140 service centres across 11 regions, each led by an MSD Regional Commissioner. These Regional Commissioners collaborated closely with MSD National Office, local Civil Defence Emergency Management groups, iwi, and NGOs to support the All of Government COVID-19 response. While RPSCs were responsible for convening and leading RLGs to manage the regional delivery of the CiC welfare response, half of the RPSCs also served as MSD Regional Commissioners. The two roles were closely interconnected, with RPSCs and Regional Commissioners often working together to ensure a coordinated public service response in the regions.

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.

The government funded food support, Community Connectors, and regional leadership as key components of the welfare response

Government increased funding for the welfare response over time in response to demand for community services during the Omicron outbreak. Of the $407.9m allocated for the welfare response, the government appropriated $159.4m for food support and $178.6m for Community Connectors. An additional $18.1m was provided for regional service delivery, which included resourcing RLGs and RPSCs ($12.2m), and the resourcing of iwi participation in RLGs ($5.9m). The remainder of the funding was split between:

- provider capability ($12.6m)
- community resilience ($4.4m)
- disability support ($8m)
- personal protective equipment ($2m)
- housing – allocated outside of MSD ($15.5m)
- assessment and referral functions ($8.3m)
- data, analytics, and evidence services ($1m).

During the welfare response, community providers and Community Connectors delivered over 1.3 million food parcels – 770,000 for households in self-isolation, and over 560,000 for households otherwise affected by the impacts of COVID-19. 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.

Community Connectors were contracted by, and located within, MSD-funded community providers to ensure individuals and whānau who were self-isolating had access to the support and services that they needed. MSD's investment in the Community Connector workforce at its peak included funding up to 500 FTEs across 267 community providers. Between December 2021 and June 2023, Community Connectors supported over 300,000 households in self-isolation and/or impacted by COVID-19. During this time, Community Connectors also accessed $19.7m in discretionary funding to meet urgent households needs (e.g., food, general household items, utilities, medical needs, transport costs, rent arrears).

These costs do not reflect the total amount spent on supporting isolating households during COVID-19, including on regular income support or hardship assistance (e.g., Special Needs Grants), which were a significant component of MSD's support for affected households.

Investment in provider capability funding supported 116 providers with additional fixed-term FTEs, office space, personal protective equipment, and other operational needs. It also helped 476 community organisations to fund resources to establish and maintain community resilience as defined by communities.

MSD also provided funding to three national providers (the New Zealand Food Network, the Aotearoa Food Rescue Alliance, and Kore Hiakai – Zero Hunger Collective) to increase the supply of food to community food services, support local food rescue organisations, and support capability building for these organisations. Further items funded included community food infrastructure and food security planning and initiatives.

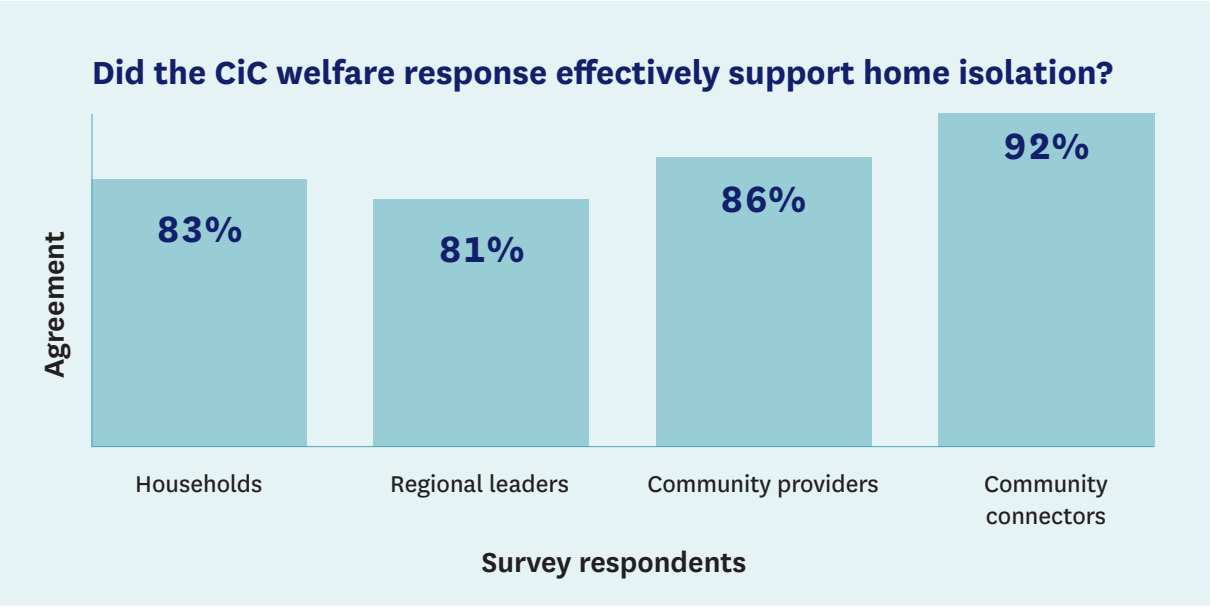
3. Findings at the local level

The Care in the Community welfare response was successful in supporting households to isolate safely across all ethnic groups and priority populations

On the whole, households who received CiC support reported that the welfare response made it possible to stay home and isolate, therefore achieving the primary objective of the response (RTE and survey workstream). Of those who responded to the household survey, 83% reported that the support they received made it possible to stay isolated during their isolation period, with no differences observed across ethnic or priority groups. Regional leaders (81%), community providers (86%), and Community Connectors (92%) also considered that the CiC welfare response effectively supported households to stay in isolation.

Figure 1:

Households', regional leaders', providers', and Community Connectors' views on whether the welfare response effectively supported households to self-isolate



Source: CiC household, RLG, provider, and Community Connector surveys; 2023 (survey workstream)

The necessity of this support was raised by many households, who considered it a lifeline during isolation.

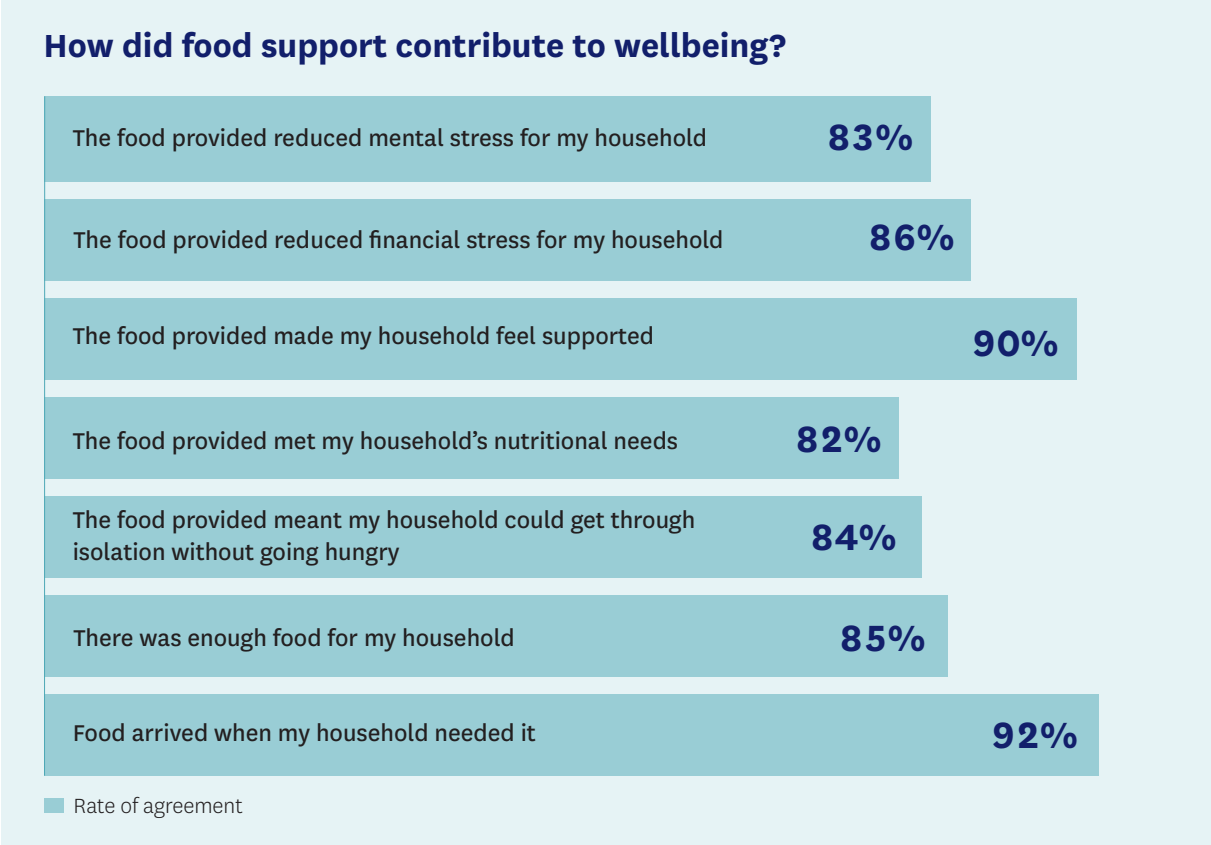
> *"If I didn't get the support I would have gone to the supermarket. And it wasn't a matter of wanting to go out, but I would have had to... We isolated from start to finish from the first positive test right through to the ninth negative test. We all isolated and just stayed at home the whole time and we could because we had that support there... I didn't need to go out and get anything that whole time"* (household - RTE).

Households considered food to be their most urgent need and highly valued the food support provided through the response

The most frequently requested form of support was for food, with 84% of households receiving food packages from community organisations (survey workstream). Māori households and those in rural areas were less likely to require food support, while Asian households and those with not enough money to meet their needs were more likely to require food support. The timeliness and appropriateness of this food support were highly rated by households.

Figure 2:

Households' views on the the contribution of food support to their wellbeing needs



Source: CiC household survey; 2023 (survey workstream)

As shown in Figure 2 above, the majority reported that food arrived when they needed it, that there was enough food for the household, the household could get through isolation without going hungry, and the food support met their nutritional needs. They also agreed that the food support made their household feel supported and reduced financial and mental stress for their household. Households expressed that food support *"help[ed] to relieve stress and anxiety"* and *"made isolating not so scary"* (survey workstream).

Providers put effort into making sure that the food support was tailored, and most households reported it met their household cultural needs (78%) and religious needs (70%). Some households noted the care put into their parcels, saying that food seemed to be selected with awareness of cultural requirements and preferences – *"[it was] food we usually eat not just cans of food but there was food that we Samoans can make meals out of so it didn't feel like we were eating different foods"* (survey workstream).

The provision of food support also instilled in recipients a sense of community care that extended beyond the food itself. Households expressed gratitude for this, commenting such things as:

> *"When I get the food box, I feel like 'oh I'm not alone' even though I'm isolating... like this country [is] looking after me"* (RTE).

> *"Having a food parcel delivered to the door when we were isolating was hugely supportive but along with that came care, concern, genuine checks on how we were"* (survey workstream).

Other supports were available and tailored to household needs

Households also received diverse and flexible support via Community Connectors. The most common supports they received were:

- information about the different supports available (47%)
- support for medical needs (35% [50% for those living in rural/remote households])
- support for education (28%)
- support for general household items (26% [33% for households with at least one resident of Māori ethnicity and 39% for rural/remote households])
- support with urgent expenses (20%)
- referral to other health or social services (20% [32% for households with at least one resident over the age of 65]) (survey workstream).

Households ranked food support as the most helpful, followed by general household items (e.g., clothing, blankets, beds), help with urgent expenses (e.g., utilities, rent arrears), information about other supports available in the community, and medical needs. Four of these five top supports were expense-related.

While meeting immediate needs was the top priority, follow up interactions with households began to address more enduring issues

Through the initial provision of food support, providers and Community Connectors were able to build on their relationships with the households they supported, therefore opening the door for broader needs to be discussed and met. Some noted that *"people come in with food support needs but often due to conversations we identify they need housing support, clinical support... then we refer them to appropriate places"* (provider - RTE).

Over half of households reported receiving support from a Community Connector after they finished isolating (58%), indicating a need for ongoing holistic support (survey workstream). As part of this follow-up support, households reported receiving:[2]

- support with mental health and wellbeing (48%)
- continued food support (45%)
- connection to Work and Income financial support (21%)
- support to reintegrate into school and education (20%)
- referral to other health or social services (19%)
- connection with employment support and opportunities (16%)
- support to reintegrate with family and friends (16%) (survey workstream).

They ranked continued food support as their top priority, followed by connection to Work and Income financial support, and then support with mental health and wellbeing.

Households highly valued ongoing check-ins from Community Connectors, expressing that this made it easier to seek support for ongoing needs.

> *"The odd check in phone call to see how we were doing both mentally and physically was a welcomed unexpected surprise and made the process of asking for help in the future much easier"* (household - survey workstream).

Most Community Connectors believed that follow up support helped households reintegrate after the isolation period (77%), though this was rated less highly by providers (59%) and RLGs (58%). While most Community Connectors agreed that there was a diverse range of services available to households during isolation (79%), the availability of these services after isolating was reported to be lower (52% agreed) (survey workstream).

Community Connectors played a critical role in increasing households' awareness of available support. Almost half (48%) of the households reported that their Community Connector told them about government support services they did not already know about and 40% reported learning about other community-based support services. Of this group, many went on to engage with new services (59% government services and 61% community-based). However, beyond initial engagements, people tended to continue seeking community-based support services (61%) rather than government support services (46%) after isolating (survey workstream).

A significant function of the Community Connector role, as outlined in a November 2021 Cabinet Paper, was to *"act as a conduit for individuals and whānau to government services that they may not access, such as through Work and Income"*.[3] In their community outreach, Community Connectors noticed that there were many households who were not engaging with the broader landscape of welfare support.

[2] Note that these percentages add up to more than 100% as respondents could tick more than one answer.

[3] Office of the Minister for Social Development and Employment to SWC (24 November 2021). *COVID-19: A whole-of-system welfare approach under the COVID-19 Protection Framework*.

> *"There's a lot of stuff that you don't know about that you can get and are entitled to... Because people don't tell you, like the right people in the right places, they don't tell you what you're entitled to or what you can get and you don't know... it's just being educated on what is there I suppose"* (Community Connector - survey workstream).

Ensuring households were aware of and accessing support needed through Work and Income became a focus for many providers and Community Connectors: *"I think it [the welfare response] helps people get in the door to their relevant grants and entitlements they should be able to access anyway"* (stakeholder interview – survey workstream).

Dedicated effort was invested in ensuring the accessibility of the welfare response through multiple referral pathways and a 'no wrong door' approach

A key design feature of the welfare response was creating multiple avenues through which households could seek CiC welfare support. Referral pathways (e.g., via government channels, community providers, social media, self-referral) were scaled up and simplified to enable ease of access.

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 about the perceived accessibility of the response were captured from RLG members, Community Connectors, and community providers. Survey respondents from these groups thought that some communities may have struggled to access support during the response, including Māori,[4] Pacific peoples,[5] older people,[6] people with a health condition or disability,[7] and low income households.[8] Nevertheless, the majority of community providers (81%) and Community Connectors (89%) felt they were able to increase the reach of support to everyone who needed it through the welfare response.

Of the people who did receive CiC support, there is some evidence that it was easy to request – with about two-thirds (65%) of household survey respondents agreeing that it was easy to ask for support for their needs while isolating. Households with at least one Māori or Asian resident reported finding it easier to ask for support (75% and 86% vs. 65% for the total sample) (survey workstream).

[4] 28% of providers and 33% of Community Connectors felt that whānau Māori may have struggled to access support; 11% of RLG members reported their RLG struggled to enable access for Māori (survey workstream).

[5] 23% of providers and 33% of Community Connectors felt that Pacific peoples may have struggled to access support; 11% of RLG members reported their RLG struggled to enable access for Pacific peoples (survey workstream).

[6] 28% of providers and 52% of Community Connectors felt that older people may have struggled to access welfare support; 17% of RLG members reported their RLG struggled to enable access for older people (survey workstream).

[7] 45% of Community Connectors felt that people with a health condition or disability may have struggled to access welfare support; 23% of RLG members reported their RLG struggled to enable access for people with a health condition or disability (survey workstream).

[8] 36% of providers and 34% of Community Connectors felt that socio-economically disadvantaged households were most likely to struggle accessing support; 14% of RLG members reported that their RLG struggled to enable access for socio-economically disadvantaged households (survey workstream).

When asked what made it easy for them to ask for support, numerous households reported the importance of relationships (survey workstream); in particular, having positive rapport with the provider, knowing the provider already, or the provider initiating contact with their household. This appears to have been particularly important for Māori and Pacific households, many of whom had pre-existing relationships with providers and Community Connectors or knew them through community networks (e.g., via church, family, friends).

Many households also found that the processes to request support were easy to follow, forms were quick to complete, and supplies were delivered by simply answering a few questions online or via email (survey workstream).

Fourteen percent of households reported that it was hard to request support. When they were asked what made it difficult, almost all of the respondents described a sense of whakamā (shame), which hindered their ability to seek support – *"embarrassed for needing help"* (household - survey workstream).

Households reported different referral pathways through which they accessed support, including:

- referral from a health or social service provider (29%)
- self-referral via the community provider they were already a client of (17%)
- self-referral via social media (13%)
- referral via Ministry of Health (11%)
- referral via the COVID-19 Welfare Line 0800 number (9%)
- referral via MSD (8% [4% via the MSD website])
- self-referral via MSD service centres or case managers (1.5%) (survey workstream).

Referral from a health or social service provider was the most common pathway for the total sample, but this was even more likely for households with at least one Māori resident (43% compared to 29% for the total sample). Some Māori providers described drawing on their existing knowledge of their clients to identify people who might benefit from CiC welfare support, which may explain the higher referrals from this source for Māori households (survey workstream).

There is indication of some discrepancy in experiences of support for priority groups

While the evaluation was not able to assess the scale of potential unmet need, survey data suggests that priority groups who did receive CiC welfare support may have experienced some inconsistencies when compared with the general population.

Households with at least one Māori resident were less likely to agree that support from the Community Connector met their wellbeing needs (80% vs. 86% for the total sample) and that the Community Connector built a relationship of trust with them (71% vs. 80% for the total sample).

Households with at least one Pacific resident were more likely to agree that the Community Connector understood the needs of their household (97% vs. 92% of the total sample), that the Community Connector checked in on their household regularly (77% vs. 65% for the total sample), and that their Community Connector told them about government support services they did not already know about (60% vs. 48% for the total sample) (survey workstream).

Asian households were significantly less likely to agree that the Community Connector checked in on their household regularly (46% vs. 65% for the total sample) or that the Community Connector told them about government support services they did not already know about (27% vs. 48% for the total sample). However, they were more likely to agree that the Community Connector told them about community-based support services that they did not already know about (44% vs. 39% for the total sample) (survey workstream).

No differences in experience of support from a Community Connector were observed for households with at least one resident reporting a health condition or disability. However, central government stakeholders frequently acknowledged *"lots of shortcomings"* in catering the welfare response to disabled people (stakeholder interview - survey workstream). But the design of a landing page for disabled people as part of the Unite for COVID-19 website was considered to have enhanced the accessibility of the response for this cohort. Government also created a dedicated disability fund for providers to ensure better support for disabled people.

Community Connectors were the face of the welfare response for many households

The work of Community Connectors was diverse, as enabled through their flexible contracts. The key aspects of their role were:

- ensuring the immediate needs of families and whānau were met by connecting them to relevant agencies, services, and supports
- serving as the primary point of contact for whānau needing additional wrap-around support once immediate needs were addressed
- completing ongoing follow-up and advocacy to empower whānau and communities and enhance their wellbeing.

Community Connectors were the 'face' of the welfare response, with three quarters of households (75%) reporting that they were supported by a Community Connector. This assistance was crucial for many households, with 83% indicating that their support enabled them to stay home through their isolation period (survey workstream).

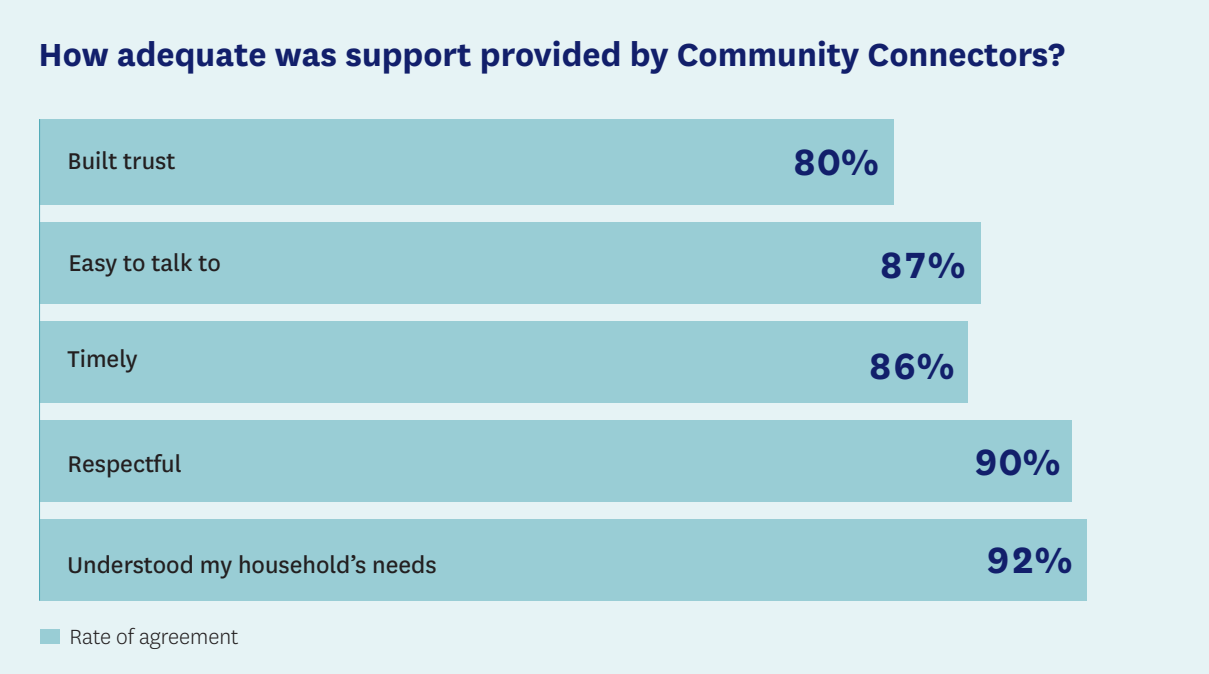
Community Connectors acted as a trusted interface for individuals, families and whānau to access community and government support and services. They also had a deep understanding of local need.

> *"Because the Connectors live and are from the community, their assessments weren't obtrusive, families were comfortable opening doors and sharing [their] situation open and honestly. All these conversations were had in a sensitive and uplifting way because it was with people they trusted and saw walking around the streets"* (provider - RTE).

They walked alongside and advocated for individuals, families, and whānau until they were connected to appropriate supports (survey workstream, RTE). Described by community providers as the *"glue"* holding the welfare response together (provider - RTE), Community Connectors drew on their networks, lived experience and relationship-building ability to meet the needs of communities in a timely and culturally appropriate way.

Figure 3:

Households' views on the adequacy of support provided by Community Connectors



Source: CiC household survey; 2023 (survey workstream)

As demonstrated in Figure 3, household surveys showed high levels of positive feedback for Community Connectors. Their ability to understand the needs of households was the most highly rated aspect of the role. The majority of households also agreed that support from the Community Connector was respectful and timely, that they were easy to talk to and built trust.

Households expressed gratitude for the compassion and wellbeing support that was woven into their interactions with Community Connectors.

> *"I was surprised that the Community Connectors offered me emotional and mental support at this time as I was expecting it to just be help with our practical needs. However, the odd check in phone call to see how we were doing both mentally and physically was a welcomed unexpected surprise and made the process of asking for help in the future much easier"* (household - survey workstream).

> *"The Community Connector we dealt with as a whānau was so kind & understanding. She helped make the experience less embarrassing for needing help. She was a pleasure to work with in a tough situation"* (household - survey workstream).

Community Connectors reported having helped households to access support (83%) and meeting households' wellbeing needs (86%) and cultural needs (83%). Both Community Connectors and providers ranked the most important aspects of the Community Connector role as:

1. understanding of the needs of the community
2. the flexibility of the role
3. existing community networks
4. understanding of community supports available
5. understanding of government supports available (survey workstream).

Providers reported particularly valuing their Community Connector colleagues for building relationships (82%), especially with socio-economically disadvantaged communities (83%) (survey workstream).

Some non-MSD central government stakeholders also praised the navigational prowess of Community Connectors, noting them to be of *"sensational value"* in the response (stakeholder interview - survey workstream). Most RLG members who reflected on the Community Connector role were highly supportive, stating that *"they were such a great support for us"*, and that they were *"the eyes and ears of this group out across the community"* (case study workstream).

Community providers mobilised to ensure that isolating households had their urgent needs met

Providers quickly developed multiple referral pathways through which people could receive welfare support (e.g., self-referrals, referrals through MSD, referrals through other community organisations) (RTE).

While some providers were involved in end-to-end food provision (from sourcing through to preparation, packing, and distribution), others focused on specific aspects of food provision such as the supply of food parcels. In order to meet demand, providers quickly pivoted to respond to rapid surges in case numbers, even when continuing to deliver 'business as usual' (BAU) services.

Providers drew upon their local relationships to meet demand and make sure that they *"never had to make whānau wait"*, even during workforce shortages (RTE). Several providers recruited assistance from within their communities to deliver food and other supports as quickly as possible. This included leveraging their relationships with local churches, marae, suppliers, and community groups (RTE).

Central government stakeholders lauded provider efforts under such intense circumstances:

> *"The success of CiC response and credit should be with community providers. They were the welfare response. We provided the resource, but they did the work... They are the unsung heroes for the whole response" (*stakeholder interview - survey workstream).

Despite urgency, especially under peak demand, providers did not compromise the quality of care they provided. Many households commented on the sense of awhi (care) and manaakitanga (generosity) evident in providers' engagements with them.

> *"I honestly think those people who were doing that work till all hours need a medal"* (household - survey workstream).

> *"I was grateful for the warm and humane treatment I received when I reached out to the [provider]. Thankful for the quick and efficient response"* (household - survey workstream).

> *"Excellent service, really helped so much knowing there is people to help and you [are] not alone" (*household - survey workstream).

Community trust in providers and Community Connectors was critical to the success of the CiC welfare response

To be equitable, the welfare response needed to reach those who may have previously been underserved by government supports and services or felt hesitant about seeking support. Through funding community providers and Community Connectors already embedded in communities, MSD gave effect to the locally-led model of working – a close working relationship that potentially enabled far greater reach of the response.

Engaging directly with government agencies (e.g., Work and Income) posed too great a hurdle for many households, whether due to lack of knowledge, discomfort requesting support, or a sense of mistrust or scepticism about government services and their capacity to meet more complex needs.

> *"They go 'I don't wanna be contacted by MSD, instead I wanna be contacted by a welfare provider.' What they don't realize is that those providers are all contracted through MSD anyway, but that's by the by... they didn't particularly want to engage with them [at] MSD"* (stakeholder interview - survey workstream).

Many households who were supported through the welfare response had never sought help from community or government services before, with some describing it as *"the very last resort"* (household - RTE). The sense of separation between MSD (as funder) and providers and Community Connectors (as key contacts) removed a barrier for many households accessing support.

> *"[We were] able to make headway that government agencies are not able to because there is a stigma attached to 'government'... we have the relationship and because we can talk those difficult conversations... we can get more information that they otherwise might not have been able to"* (Community Connector - survey workstream).

Providers and Community Connectors came from the communities they represented – *"trusted places, trusted faces"* (RLG member - case study workstream). With significant efforts devoted to community outreach, targeted communications and welfare checks, providers and Community Connectors invested in building relationships of trust with hard-to-reach populations.

> *"People didn't want to contact [the] MSD line. When they found out about us – they circumnavigated no matter how quick MSD referrals were. They knew Māori were on our line. We are a small community – everyone has a connection. You don't get that response when you go to the 0800 line"* (Community Connector - RTE).

Community Connectors and providers worked to establish trusting relationships through:

- food and care parcels carefully tailored to the needs of each household
- non-judgemental and respectful communication
- messaging designed to make people feel comfortable to seek help
- spending time on relationship-building
- making sure people had access to translation and interpreting services (RTE).

The broad reach of the welfare response was evident to many regional leaders and central government stakeholders. For example, Pacific representatives on some RLGs noted the emergence of a new cohort of Pacific families who had not accessed MSD support previously. This cohort was not comfortable reaching out for government welfare support and relied on providers to support them to connect with MSD (case study workstream). In this way, the welfare response revealed invisible communities with unmet need for greater welfare support.

> *"For MSD, CiC started a conversation about invisible communities – they're invisible to government because we put the wall up so that they can't walk through or don't want to walk anywhere near us – and MSD's responsibility in a welfare system. I feel like historically there is this question of the degree to which an organisation chooses to proactively reach the people who are in need"* (stakeholder interview – survey workstream).

Household trust in Work and Income and government stayed at similar levels after receiving welfare support, but trust in community providers increased

Around three-quarters of households (74%) reported that they trusted Work and Income and other government agencies (78%) about the same, with 18% trusting Work and Income more and 15% trusting other government agencies more. Around 9% trusted Work and income and 7% trusted other government agencies less (survey workstream).

Conversely, trust in community providers increased substantially, which may have resulted in hard-to-reach households having ongoing increased access to relevant community supports. Half (51%) of the household survey respondents were more likely to trust community-based support services more and almost half (46%) reported they trusted them about the same after receiving support from a Community Connector. Only 3% reported trusting them less (survey workstream).

The different contexts under which MSD Work and Income staff and community providers were operating may partially account for this difference. During COVID-19, MSD relaxed some operational policies to ensure financial support was available for isolating households (e.g., temporarily increasing the amount available for food grants). However, Work and Income staff still had to work within primary legislation under the Social Security Act 2018[9] when granting assistance. On the other hand, where MSD could not provide assistance, community providers and Community Connectors could access discretionary funding to support households' urgent needs, which was not bound by legislative requirements (e.g., maximum limits to how much a household could receive). The support available through providers and Community Connectors was therefore able to be more flexible and tailored to need, which may have contributed to increased trust and dependence on non-MSD supports.

[9] https://www.legislation.govt.nz/act/public/2018/0032/latest/whole.html

The welfare response improved relationships between providers, demonstrating progress towards a more networked community sector

At the local level, the CiC welfare response appears to have contributed to the emergence of new partnerships between community providers across the country. Households seeking welfare support were often referred by providers and Community Connectors to other specialised services (e.g., family violence, mental health, education, and budgeting/financial mentoring services) to address longer-term needs. This required providers and Community Connectors to have awareness of the broader landscape of community supports available in their region and forge closer relationships with these providers to effectively deliver the response.

Providers reported increasing their engagement with each other and *"leaning on each other"*, expanding their networks, and increasing their learning across organisations (RTE). Most community providers reported that they were able to build positive relationships with other providers delivering the response (74%) and other social, health and wellbeing service providers (71%). When asked what factors facilitated them building positive relationships with other stakeholders in their region, providers highly rated MSD Regional Relationship Managers (76%), ad hoc/informal meetings with other community providers (70%), and formal meetings with these groups (64%) (survey workstream).

Overall, most community providers agreed that the welfare response facilitated the development of new networks within their region's community sector (68%), strengthened existing networks (71%), and that the community sector in the region became better able to respond to community priorities (67%) (survey workstream).

Community Connectors leveraged their local relationships to strengthen provider networks

Relationships were at the heart of the work of Community Connectors, who expertly facilitated relationships between families and relevant agencies and services. While often working within existing provider structures, they also shared resources with other organisations and groups who might be better placed to meet the needs of a particular family seeking support. Unlike other roles, there were no limits around who Community Connectors could support, and which agencies and services they would collaborate with to meet need (RTE). There was no allegiance to one agency because, for them, whānau were at the heart of the matter. Unsurprisingly, Community Connectors reported positively on their ability to build relationships with other Community Connectors (83%), other community providers delivering the welfare response (84%), and other social, health and wellbeing service providers (81%) (survey workstream).

The factors that Community Connectors reported as enabling the building of these positive relationships were formal meetings with other Community Connectors in their region (79%), ad hoc/informal meetings with these groups (76%) and MSD Regional Relationship Managers (73%) (survey workstream).

While providers did not highly rate their own ability to build relationships with Māori and Pacific groups and organisations (56% and 48% respectively), Community Connectors reported this at a higher rate (81% and 67% respectively); this may demonstrate the significance of this role in supporting providers to forge strong connections with more diverse regional stakeholders.

The majority of Community Connectors also agreed that the welfare response facilitated the development of new networks within their region's community sector (85%), strengthened existing networks (89%), and that the community sector in the region became better able to respond to community priorities (87%) – significantly higher rates of agreement than providers reported (survey workstream).

Limited staffing and high demand affected community providers' and Community Connectors' ability to respond to household need

As case numbers rose, providers and Community Connectors dealt with huge demand for their services. By the conclusion of the CPF, over 308,000 households had received provider and/or Community Connector support. With so many incoming requests, many providers felt that they did not have sufficient capacity to meet demand – an issue that was further exacerbated as staff also fell sick and workforce capability became more stretched (RTE). At times, providers and Community Connectors had trouble accessing provisions for households that were in high demand, including medicine, hygiene products, and pet food.

To ensure households received timely support, providers mobilised their networks to meet demand, recruiting assistance from churches, marae, sports groups. Nearly three quarters (71%) of providers reported that they relied on volunteer workers to deliver the CiC welfare response often or always – *"There was a lot of pressure on our organisation to deliver a 24/7 service with the majority of our staff being volunteers"* (survey workstream).

Providers also relied heavily on Community Connectors to triage requests, carry out community outreach, deliver food parcels, and provide regular check-ins on households. This high level of demand was particularly challenging to manage early in the welfare response when Community Connectors first started responding and were required to define their role in action. The unprecedented volume of requests could be overwhelming, with Community Connectors feeling that *"we weren't prepared for the level of need"* (RTE).

Pressure to meet demand during peak times also had repercussions for some Community Connectors who needed time to *"establish personal relationships with families to ensure their needs were met"* (survey workstream). Ensuring that households received same day deliveries needed to take precedence over time spent on less urgent but more holistic support for households. This may explain why some RLG members reported that Community Connector engagements could be considered *"transactional"* in nature and focussed on delivery of essential supplies rather than holistic care (case study workstream).

4. Findings at the regional level

Regional Public Service Commissioners' existing relationships helped to establish broad-based Regional Leadership Groups

Under the CPF, Regional Public Service Commissioners were tasked with the mandate to:

- Convene: Bring together, coordinate, and align central government decision-makers as it relates to regional leadership, planning, and delivery of wellbeing outcomes for communities.
- Resolve: Coordinate with officials to resolve barriers to outcomes (can include collaboration with iwi/Māori, local government, and regional stakeholders).
- Escalate: Identify and raise issues with relevant CE Groups where resolution can't be achieved at regional, work programme or single agency level.[10]

The groundwork for regional cooperation was already laid. Before the arrival of COVID-19, Public Service Regional Leaders, as they were then known, were already *"docking in"* to existing leadership groups in their regions, where they existed (e.g., Regional Intersectoral Forums, Auckland Social Sector Leaders Group) (RPSC - case study workstream). Many of these groups existed with the objective of strengthening the leadership objectives outlined in the Public Service Act 2020.[11] Around half of RPSCs also held dual roles as MSD Regional Commissioners, which increased connection with existing partners across MSD National Office, Civil Defence Emergency Management groups, local iwi and NGOs. With the onset of the CiC welfare response, the intersectoral networks and relationships forged through such groups were instrumental for RPSCs to manage regional-enablement and the recruitment of members for their RLGs.

The majority of RLG members (87%) reported the value of their RPSC's existing relationships in enabling an effective welfare response in their region. All RLG respondents (100%) also agreed that these relationships were important for them building relationships with other cross-agency stakeholders (e.g., MSD, iwi, Ministry of Health, other central government agencies, community organisations, community providers, Care in the Community hubs, and the Department of the Prime Minister and Cabinet [DPMC] COVID-19 Group) (survey workstream).

To best support their region, it was expected that RPSCs would ensure the representation of diverse regional leaders on their RLGs. By and large, RPSCs managed to recruit sufficient membership on their RLGs. There was substantial local government representation in RLGs across the country. In some regions, local government was represented by their mayors, and in others council Chief Executives sat on the RLGs. Departmental agencies were also well represented (e.g., Police, MSD, Oranga Tamariki, Ministry of Education, Ministry of Health, DHBs, Civil Defence, Te Puni Kōkiri and Ministry for Pacific Peoples and others). RPSCs also requested that organisations nominate appropriately senior leaders who had the authority to make decisions on behalf of their agencies – *"You have to have people around the table that have the delegation to be able to move"* (RLG member - case study workstream). The majority of RLG respondents (87%) agreed that all relevant organisations were represented on their RLG (survey workstream).

[10] https://www.publicservice.govt.nz/assets/DirectoryFile/Cabinet-Paper-Joined-up-Government-in-the-Regions-report-back-Strengthening-a-regional-system-leadership-framework-for-the-public-service.pdf

[11] https://www.legislation.govt.nz/act/public/2020/0040/latest/LMS106159.html

During the CPF period, RPSCs were also expected to collaborate closely with DHB Chief Executives and MSD Regional Commissioners to facilitate effective engagement between the public service and iwi and Māori, local government, and major service providers.

RPSCs also worked to set a standard of conduct for their RLGs, emphasising the urgency of their work. Senior leaders were expected to prioritise their attendance at hui, rather than delegate to others. RPSCs convened frequent meetings (sometimes twice daily early in the CPF period), and it was common for RLGs to convene outside core working hours and on the weekends if necessary (case study workstream).

Seventy percent of RLG members agreed that their RPSC was sufficiently resourced (survey workstream). However, the significant workload of some RPSCs was noted, with one RLG member indicating that their *"RPSC was spread very thin"* (survey workstream). The workload of RPSCs was also acknowledged in interviews with some central government stakeholders, who noted that RPSCs had to juggle BAU work from their home agency while also acting as directors of the public service within their region. One central government stakeholder noted:

> *"I don't believe that they are funded to the capacity that they should be and if we are truly talking about authentic collaboration in an All of Government perspective, that really does need to be taken quite seriously"* (stakeholder interview - survey workstream).

Regional Public Service Commissioners succeeded in enabling iwi engagement in most Regional Leadership Groups

The role of iwi representation on RLGs was important, in part, for advocating for their hapori (community), and most RPSCs put significant effort into actively engaging with iwi leaders to encourage their participation. This could be difficult at times due to differing levels of trust in the Crown (case study workstream). Nevertheless, persistence from RPSCs and RLG Chairs was a key motivator for some iwi representatives agreeing to participate. One iwi RLG representative noted the significance of this on their decision, stating:

> *"You had believers of the time... They were very loud and very clear across the region saying that if vulnerable communities were our concern, our regional COVID response must be iwi led... And so that was a game changer"* (case study workstream).

Their involvement was also enabled by a dedicated Iwi Partnership Fund, which resourced iwi to participate in RLGs.

In one region where iwi representatives did not participate directly in the RLG, the RPSC ensured iwi engagement in decision-making by meeting marae leaders to discuss the specific needs of whānau Māori. Iwi leaders who participated in the RLGs decided how they wanted to be represented. For some iwi, this looked like one person consistently participating in the RLG. For others, representatives rotated in and out of RLG discussions depending on evolving circumstances and the focus of agenda items (case study workstream).

Of the regions that responded to the RLG survey, 91% of RLG members agreed that iwi were members of their RLG, and most agreed that iwi were involved in the design of the welfare response for their region (71%). Just over half reported that iwi led their RLG (56%). The majority stated that iwi were involved in disseminating communications about the welfare response within their region (87%) (survey workstream).

Representation of Pacific peoples and other priority groups was less consistently sought for Regional Leadership Groups

With awareness of the potential vulnerability of Pacific communities to COVID-19, over half of the RPSCs recruited RLG members from the Ministry for Pacific Peoples or Pacific Trusts. However, Pacific representation on RLGs was less consistently established than that for iwi. Fifty nine percent of RLG survey respondents reported that Pacific peoples were members of their RLG, and 52% reported that they were involved in the design of the welfare response for their region. However, 64% reported that Pacific peoples were involved in disseminating communications about the welfare response – perhaps indicating some reliance on a wider pool of Pacific organisations to assist with this messaging.

Other priority groups who were expected to face unique challenges during the pandemic were less consistently enlisted, with most RLGs lacking such representation. In particular, individuals representing older people, disabled people, rural communities, migrant communities and culturally and linguistically diverse communities were absent from most RLGs. RLG members offered possible explanations of this, including the need to *"manage numbers"* on the group, uncertainty about whether representatives would have the capability to participate in the group and questions about the mandate of potential representatives (case study workstream).

However, it is also worth noting the relative infancy of the Ministry for Ethnic Communities and Whaikaha as RLGs were being set up – Ministry for Ethnic Communities was established in July 2021, and Whaikaha was established in July 2022. While representation could have been sought from community organisations, the newness of these ministries may have impacted the ability of RPSCs to recruit representatives from ethnic and disabled communities.

The forging of strong intersectoral relationships through Regional Leadership Groups with a common purpose was fundamental for mobilising a successful collective response to COVID-19

Regional Leadership Groups were a key mechanism for delivering sector wide collaboration. The majority of RLG survey respondents (90%) agreed that the formation of the groups strengthened existing networks across the social sector (survey workstream). Through their united focus on a *"common enemy"* (RLG member - case study workstream), RLGs worked to override the siloes of their individual agencies. This common purpose and accountability to serving their regions was observed to have resulted in a stronger commitment to action than previous cross-agency forums had achieved (case study workstream). Concentrating on the bigger picture, RLG members set aside their organisational accountabilities to function as a collective. As one RLG member from an RPSC office noted:

> *"We appreciate through COVID, that if we all work together, we all collaborate – we have more power. So just as a single agency, we may...[be] bound by limited budgets. As we go forward, we have more power if we can actually bring all our budgets and our resources, other resources together"* (case study workstream).

In some regions, improved working relationships resulted in more direct collaboration with colleagues from different organisations. To ensure timely responses to emerging challenges, RLG members realised they could *"pick up the phone, make a phone call and sort of resolve issues"*, as opposed to working through traditional cross-agency commissioning and consultation pathways (RLG member - case study workstream). This flow of information between members was considered effective by most RLG members (89%) (survey workstream).

Additionally, the trust established through these relationships enabled the sharing of more sensitive information about the welfare response that otherwise might not have been disclosed between agencies (e.g., changes in CPF traffic light settings and local protection/lockdown boundaries) (case study workstream).

Regional Leadership Groups worked as a team to gather local level 'intel', identify issues, and resolve them

RLG members understood their place in the welfare response as enabling the locally-led delivery of the welfare response and supporting community leadership (case study workstream). To best support the local-level response, RLGs worked hard to identify and resolve barriers that were impeding the delivery of the CiC welfare response. As one RLG member noted:

> *"The best thing the RLG did was stay in their lanes and let the operational folks get on with it. We were there to remove barriers if they arose and keep everyone above operational level connected"* (survey workstream).

One key activity prioritised by RLGs was the gathering of local level intelligence regarding how providers were operationalising the welfare response across their region. This was undertaken to ensure that RLGs had sufficient insight into when and where blockages were occurring and for whom, the services most in demand, and which cohorts of the population were most in need. Through their networks, iwi and Pacific RLG members offered crucial insight in the specific needs of their communities – intel that local and central government RLG representatives acknowledged they would have been unable to collect (case study workstream).

Where intel identified emerging issues, RLG members harnessed the specific expertise and resources of their home agencies to achieve quick solutions so that households received timely and appropriate support. The ways that support was mobilised varied across regions. In several regions, local government RLG members assisted local providers with accessing the facilities they needed to deliver their services (e.g., warehouses for food storage, carparks for drive-throughs, libraries for RAT collection points). In one region, an RLG member contacted MSD regional managers after hearing households were having trouble navigating certain operational processes. This advocacy resulted in the immediate removal of this barrier. In another instance, RPSCs from two neighbouring regions worked to ensure that their MSD regional offices were aligned in how to best support households. For example, if a Māori community spanned two MSD boundaries or was affected by different lockdown delineations, then one MSD office would be responsible for servicing the whole community (case study workstream).

Where necessary, agencies and organisations also pooled their resources to support frontline providers. This included:

- iwi allowing for MSD to operate out of their rūnanga (council) offices
- council staff collaborating with Police and District Health Board staff to support tourists to isolate together in a secure campervan park
- departmental agency RLG representatives working together to identify staff in rural areas to conduct welfare checks and deliver supplies to particularly isolated households (case study workstream).

The value of RLG support for local level delivery was acknowledged by providers, the majority of whom (86%) agreed that they were well supported by their local RLG to deliver the response. The majority of RLG respondents also agreed that their RLG had strengthened existing networks within the community sector (90%) (survey workstream).

Regional Leadership Groups provided a valuable communication channel between central government and communities

During COVID-19 surges, it was crucial that central government conveyed clear and consistent messaging to communities under tight time restrictions (e.g., about what was expected of them under the CPF, when and how to isolate, local lockdowns). Bridging the national and community levels, RLGs were intended to act as a channel for two-way communication flows between the central government and local communities – a *"clearinghouse for good information"* (RLG member - case study workstream).

To ensure the timely dissemination of up-to-date advice, RLG members would engage directly with regional leaders (e.g., mayors) and update them with emerging information from the national level. Mayors worked particularly hard to engage with local media to convey messages about CPF settings and information communities needed to keep themselves safe. With an 'ear to the ground', they were considered by RLGs as a particularly valuable resource. As one RLG member noted:

> *"We regularly got key messages and updates from the Centre. You're able then to transport that across to mayors... You've got the Prime Minister standing out doing the press conference. Then you get local mayors on the radio or in press, being quizzed about that and they could then trot out the key message as well. So a very effective way of amplifying your message"* (case study workstream).

Iwi leaders were also helpful in amplifying messaging to their hapori (case study workstream).

In at least one region, hui between the mayor, the RPSC, and DPMC representatives occurred weekly, which was an important mechanism for aligning national and regional communications (case study workstream).

While the majority of RLG members agreed that there was an effective flow of information between RLG members to support the response (89%), there was less consistent agreement about the effectiveness of the flow of information to RLGs from central government (71%) and the DPMC Response Group (61%) (survey workstream).

RLGs were also responsible for facilitating messaging from the community level upwards to central government. At times, this involved community providers reaching out to RLG staff to escalate concerns about centralised decisions, and the potential impact on affected communities. Reflecting on this, community providers were in slightly less agreement (70%) about RLGs' ability to effectively share information with central government (survey workstream).

Regional Leadership Groups helped with tailoring of messages to suit regional contexts

Another function of RLGs was ensuring communications were appropriately targeted for a region's population. Both RLG members and central government stakeholders commented on frequent confusion resulting from the constant flow of messaging from individual agencies to providers and the public (case study workstream and survey workstream). It was therefore important that RLGs aligned their communications capacity to simplify the sheer volume of messaging that was circulating throughout the CPF period. In at least one region, an RLG established a sub-function of communications experts from all relevant agencies to facilitate quick sharing of messaging (case study workstream).

In some regions, communications advisors would rewrite messages to ensure they would be accessible and digestible for all communities. As an RLG member in one region recalled:

> *"We spent a lot of time discussing and redoing the communications for our region. We didn't think that they were pitched at the right level or for people to really understand. So we did a lot of work... making sure people were getting ready, understanding what they needed to do to get ready, knowing where they could get help"* (case study workstream).

RLGs also worked to guarantee that messaging was available through a range of local-level channels (e.g., social media, print media, radio).

An important element of tailored messaging was the translation of communications to make sure that no population sub-group was left behind. RLGs harnessed the translation services of representatives from priority group agencies (e.g., Te Puni Kōkiri, Ministry for Pacific Peoples, Ministry for Ethnic Communities), iwi, and other community organisations to socialise communications more widely. They also relied upon trusted providers and key community leaders to circulate messages to harder-to-reach cohorts.

> *"I think we were able to prove how connected we were with communities... People trust the Pacific providers that they deal with but they need to hear... the consistent message 'If we do this, we'll save lives, if we do this it's a good thing for you, it's a good thing for your family'... give it to them in their own languages"* (RLG member - case study workstream).

Investment to secure iwi representation in Regional Leadership Groups was important in delivering for whānau Māori

The involvement of iwi at a strategic level was considered a crucial enabler for ensuring that the welfare response was responsive to Māori.

When the pandemic began, iwi across the country rapidly mobilised to ensure prompt support was available. Before central government had activated any formal welfare measures, iwi and Māori organisations were assembling Māori Wardens,[12] establishing distribution networks through marae, organising vaccination drives and delivering holistic clinical care delivered through Māori health services. With reach into their communities, iwi leaders quickly identified unmet need within their hapori and initiated the delivery of welfare support (case study workstream, RTE). As one iwi RLG representative recalled:

> *"We started using iwi investment pūtea [funds] to just front foot a huge CiC welfare response. Bring in all of our marae, training, development, PPE, resource, all of that – we just start spreading it out across our rohe [region]"* (case study workstream).

Once RLGs were formally established at the start of the CPF, iwi were already considered *"trusted faces"* delivering from *"trusted places"* (RLG member, case study workstream). Their involvement in RLGs meant that they were well-placed to enable the response to be operationalised within their region. The majority of RLG survey respondents reporting that iwi were members of theirRLG (91%).

Iwi leaders had a clear line of sight to their communities, and with the RLGs' proximity to central government, they could escalate concerns if service delivery was leaving gaps for Māori. As one iwi RLG representative noted, RLG hui gave them a platform to *"openly talk about things that weren't working"* (RTE). Their unique insight also informed RLG decisions on the most effective placement of Community Connectors within regions and identified opportunities to better serve Māori communities (e.g., through the funding of new providers) (RTE). Alongside the efforts of Māori community providers, the work of iwi on RLGs is therefore credited for the CiC welfare response reaching whānau who otherwise may not have engaged with MSD for welfare support.

[12] https://www.tpk.govt.nz/en/o-matou-mohiotanga/maori-wardens/maori-wardens-continue-whanau-support-in-tamaki-co

The extent to which Regional Leadership Groups enabled tailored responses for other priority groups within their regions was less consistent

While iwi involvement in RLGs was considered important for the response supporting Māori, the lack of involvement of priority groups on RLGs may have had implications for the response reaching those communities.

Without individuals representing older people, disabled people, and rural communities participating on RLGs, members acknowledged that they were uncertain about the extent to which their needs were met. Without systematic monitoring of outcomes for these priority groups, oftentimes RLGs perceived the lack of complaints as an indication that these groups were faring sufficiently. Many members noted that *"we had no negative feedback, so we took that as a good sign"* (case study workstream). While there is anecdotal evidence that agencies in some regions undertook welfare checks on priority groups, it does not appear that these groups were of significant strategic focus (case study workstream).

The majority of RLG members agreed that their RLG enabled a tailored response for Māori (88%), socio-economically disadvantaged people (81%), and Pacific peoples (71%). However, this decreased for other priority populations. Only 62% of RLG members agreed that a tailored response was enabled for older people, 45% agreed for ethnic communities, and 41% agreed for disabled people (survey workstream).

When regions did have RLG members from the Ministry for Ethnic Communities and Whaikaha (or the Office for Disability Issues, as it was then known), the benefit of their perspective was significant.

> *"My colleague from Ministry of Ethnic Affairs [Ministry for Ethnic Communities], he was very good... he made the point early on that we can't forget our new migrant communities and because they are often English as a second language. He was a great connection into those communities... There was a risk if he wasn't at the table that we may have inadvertently missed out some communities"* (RLG member - case study workstream).

However, population agency RLG representatives were often working under stretched capacity. Te Puni Kōkiri, the Ministry for Pacific Peoples and the Ministry for Ethnic Communities had single staff members assigned to several RLGs at one time. Some of these RLG members felt that they could not provide in-depth advice to RLGs when they did not reside in the region they were representing (case study workstream).

Interviews with RLG members suggested that rural communities were thought to be self-sufficient and resilient, and therefore potentially would need less than those in urban populations. RLG members also expressed wariness about the ability of older people to access welfare support, whether due to isolation, lack of awareness or lack of digital literacy skills. There was also an assumption amongst some RLG members that the needs of disabled people *"would be covered by Health"* (case study workstream). As one RLG member reflected:

> *"Disability sector [was overlooked] in a big way... But that voice... should have been at the table... And also, ethnic communities – although we did have that representation, it's not strong enough... Throughout the country it's only regarded in a big way in Auckland, Wellington, and Christchurch. Well, that's not good enough for other ethnic communities"* (case study workstream).

Iwi, Māori and Pacific providers in some regions reported that they took it upon themselves to ensure the welfare of older people, disabled people, and rural communities; however, this was not necessarily activated by RLG involvement (case study workstream). This was acknowledged by a central government RLG member, who recalled an interaction with a rural household who said, *"Well actually you guys forgot about us but the iwi down the road didn't - they fed us'"* (case study workstream). Some local government representatives also rallied the support of councils, who held relationships with Age Concern and Meals on Wheels. Leveraging off these networks, some RLGs felt more satisfied that the needs of older people were being met (case study workstream).

5. Findings at the national level

Prior groundwork helped central government to rapidly stand up the Care in the Community model

Much of the success of the implementation of the welfare response depended on relational conditions at national, regional, and local levels that were emerging or had already been activated prior to the CPF. This granted MSD a launching point from which the CiC model could be set in motion.

In mid-2020, the Caring for Communities (C4C) group was established, which convened Chief Executives across central government to enable an All of Government response to COVID-19. C4C focused on gaining a greater understanding of communities who might be disproportionately affected through the pandemic and ensure their access to sufficient support services.[13] The group's broad welfare purview helped ensure that services across agencies, NGOs and providers, Civil Defence Emergency Management Groups, iwi, and community organisations were aligned and delivering results to communities. Central government stakeholders reflected positively on the ways in which the C4C governance structure supported positive cross-agency collaboration – *"we built quite a good rapport with one another and a level of trust"* (stakeholder interview - survey workstream). As the CiC welfare response was introduced, C4C's ongoing consultation ensured All of Government oversight and national support for the response.

At the regional level, several formative acts and frameworks set the standard for ensuring the joined-up public service in the regions. The introduction of a new Public Service Act in 2020 aimed to effect a more modern, joined-up, and citizen-focused public service. Two key aims of the Public Service Act were enabling greater integration of regional government within the public service and entrenching more cohesive partnership with iwi and Māori.

In 2021, the Regional System Leadership Framework was introduced, which aimed to address *"continued fragmentation and duplication cross agencies on cross-cutting issues"*.[14] The Framework proposed strengthening the role and mandate of Regional Public Service Leads (now called Regional Public Service Commissioners) to lead the public service contribution for a COVID-19 welfare response – specifically, the mandate to convene, resolve, and escalate. With the onset of the CiC response, RPSCs quickly established momentum; they had existing cross-agency networks and were primed to lead the regions in navigating the response.

The CiC welfare response applied Social Sector Commissioning[15] principles to working with providers and the wider social sector. Just before the outbreak of the pandemic, MSD had convened a hui with providers, iwi, and community organisations to explore *"a fundamental transition in how we commission alongside and with the community sector to achieve better social outcomes"* (stakeholder interview - survey workstream). Social Sector Commissioning principles were put *"straight into play"* as part of MSD's COVID-19 welfare response (stakeholder interview - survey workstream).

[13] CAB-20-MIN-0271

[14] CAB-21-MIN-0273

[15] https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/social-sector-commissioning/index.html

The design of the CiC welfare response demonstrated an innovative way of working with the social sector to achieve more equitable outcomes. In particular, non-prescriptive contracting arrangements allowed for the welfare response to be delivered in a way that was tailored to local needs. Of the funding allocated for the response, some was also ringfenced to bolster provider capability. By the time the Social Sector Commissioning Action Plan was released in 2022, the CiC welfare response was upheld as an example of how the government was beginning to embed relational commissioning.

The welfare response demonstrated commitment to Crown/Māori partnerships

Central government's mandate that RLGs recruit iwi as members demonstrated a positive commitment to partnering with Māori.

Iwi representatives felt that their contributions to RLGs were acknowledged and appreciated, and that they were *"genuinely treated as equals at the table and our voices [were] heard"* (survey workstream). Feedback from iwi representatives also suggests that the government's commitment to strengthening the Crown/Māori partnership was advanced through the welfare response. As several iwi RLG representatives noted, it was *"a commitment to Treaty partnership"* (RTE).

In particular, the Iwi Participation Fund resourced iwi to engage at this level. The investment in ensuring that more iwi were granted strategic regional leadership opportunities demonstrated the government's commitment to partnering with Māori. Some iwi RLG members suggested that this has formed a solid foundation for future collaboration.

> *"There was a period of time where we as iwi felt quite valued at the decision-making table... It's a shame that it takes a crisis for that to happen, but it was positive because it created an opportunity to show a better way of working together. So the silver lining of COVID is to demonstrate the power of working together collectively with local government agencies and iwi. You know, keeping whānau at the centre of our decision-making"* (RLG member - case study workstream).

While iwi would have mobilised to support their hapori regardless of the CiC welfare response, this funding demonstrated the government's recognition and acknowledgment of their efforts. It also enabled them to provide more support than they might otherwise have been able to.

RLGs and RPSCs unanimously supported continuing such partnership with iwi Māori to deliver outcomes for communities – *"the CiC response... has shown there's a model of working we need to retain, particularly the involvement of iwi"* (RLG member - RTE).

High trust commissioning and flexible contracts allowed providers and Community Connectors to be agile in meeting the needs of their communities and respond to changing circumstances

As discussed earlier, MSD moved towards a high trust model for the response and took a more flexible and non-prescriptive commissioning and contracting approach to funding providers and Community Connectors. MSD developed a COVID-19 Provider Funding Framework which outlined principles regarding certainty of funding for BAU services affected by CiC welfare response funding. In this framework, MSD committed to:

- give as much certainty on future funding as possible
- not hold back funding because of under-delivery against contract volumes
- work smartly with NGO social service partners
- support NGOs to be flexible to the differing needs of their communities, including relaxing contractual requirements so that NGOs can work outside of contractual requirements if needed
- support NGOs wherever possible to remove barriers to people receiving assistance.

With the onset of the CPF, these principles were activated in a variety of ways to ensure that providers and Community Connectors could quickly mobilise and deliver support to households in urgent need. The contracting model was considered to have struck the right balance of flexibility and accountability. It enabled providers to get on with service delivery without excessive administration, tailor their response to the specific needs of their communities and extend their reach (survey workstream).

The flexibility built into the CiC welfare contracting model was rated as the second most valuable aspect by the community provider survey respondents, with:

- 82% agreed that contracts were sufficiently flexible to enable their organisation to tailor the support to community needs
- 85% agreed that the contracts were sufficiently flexible to enable their organisation to respond to changing circumstances
- 77% agreed that they had flexibility to use funding to meet community need (survey workstream).

Providers valued the implicit trust demonstrated through this contractual adaptability, and the sense of central government's faith in the knowledge of their own communities.

> *"Providers who have very prescribed contracts were suddenly being given leniency around how they delivered on those contracts. 'Forget about what you're contracted to deliver. You do what you need to do for the community', and it was awesome... I think that was a real key enabler to let community just get on and do what they needed to do, and the agencies needed to... have some trust and then just be able to mobilise those things that community couldn't access"* (RLG member - case study workstream).

As previously discussed, flexibility was rated as the second highest enabler for Community Connectors and their ability to provide support, and this was actively enabled by contract design. A Community Connector reflected, *"I think the beauty of the Community Connector is you don't get a fixed criteria and so you have that little bit of flexibility and that's where I see you kind of really put the client in the centre"* (RTE).

Certainty of funding was a crucial enabler for ensuring quick delivery of support, although it was not always enough to acquire or retain staff

Providers' most highly rated aspect of the contracting model was the certainty of funding. While traditional contracts require providers to frequently report on specific metrics, KPIs and outputs to sustain funding, CiC providers were confident in the security of ongoing funding. Providers worked overtime to respond to incoming requests, and the fact that they had confirmed budget was essential.

> *"Having the financial means to make decisions based on what was needed without having to look for funding took one variable out of the equation. It meant less stress for our organisation to be able to respond adequately"* (provider - survey workstream).

Central government stakeholders also acknowledged that certainty of funding was the only way to ensure that support for people isolating would get out the door. However, creating a costing and funding model that could withstand demand uncertainty was a complicated task. At times, this necessitated seeking short bursts of funding from Treasury *"every two or three weeks"*, as one stakeholder recalled. This was considered *"not sustainable and put a lot of uncertainty around your operating model, from a business continuity and safety perspective"* (stakeholder interview - survey workstream). Central government stakeholders were wary also of the impact of drip-fed funding for provider sustainability.

> *"...From the perspective of those providers and their workforces, their own business continuity planning and making sure that they had the equipment that they needed and the safeguards to operate in an appropriate way"* (stakeholder interview - survey workstream).

Community provider survey results provide additional information on funding and contracting arrangements:

- Most providers (79%) agreed that their organisation was adequately funded to deliver the welfare response.
- Most providers agreed that CiC funding enabled their organisation to meet people's needs more effectively than traditional funding model (68%).
- Iwi/Māori organisations reported higher rates of agreement that funding was adequate (86%) and that the funding enabled meeting needs compared to traditional funding models (85%).
- Only 28% of providers reported that CiC funding allowed them to recruit skilled personnel; while 33% agreed funding facilitated retention of skilled staff.
- Most providers (71%) relied on volunteers to bolster their workforce in their efforts to keep up with demand (survey workstream).

Access to a discretionary fund supported Community Connectors' and providers' efforts to meet household needs

Another important aspect of the funding was providers' and Community Connectors' access to a discretionary fund which enabled them to *"move in spaces where other agencies can't"* (Community Connector - RTE). This fund helped subsidise urgent costs faced by households (e.g., transport, rent arrears, urgent accommodation, utilities), and gave providers and Community Connectors room to meet needs more flexibly and with more agility. Oftentimes, discretionary funding was employed to help reduce the impact of the cumulative hardship that the pandemic exacerbated; for example, supporting households to pay rent and avoid homelessness while unable to work due to sickness.

In November 2021, MSD's funding model allowed for an average of $300 per household to be made available in discretionary funding. However, it was only relied upon as a *"last resort"* (Community Connector - RTE) when other avenues had been exhausted, and Pulse Check Survey responses reported that discretionary funding spend per household was actually lower than expected (RTE). The funding model was adjusted accordingly over time to match the cost to spend reported by providers and Community Connectors. By the end of welfare response in June 2023, around $19.7million had cumulatively been spent on discretionary funding to support households.

With one fifth of households reporting receiving support with urgent expenses (20%), access to the discretionary fund was considered a lifeline of support (survey workstream). Ranked as the second most valuable household priority by both Community Connectors and providers (survey workstream), their ability to assist households with urgent expenses was appreciated, with some commenting that the discretionary fund *"allow[ed] us to treat people like people"* (provider - RTE).

Collective focus and the joined-up response from government was an important enabler of the CiC welfare response

The delivery of a streamlined welfare response was contingent upon unified public sector relationships and collaboration. While central government stakeholders noted that *"Government is good at doing things in their own lane"* (stakeholder interview - survey workstream), the CPF served to unify agencies by holding communities at the heart of the All of Government response. Rather than responding as specific agencies, the public sector worked in innovative ways to maintain a collective focus and ensure a joined-up response that was delivered together.

Care Coordination Hubs are an example of this joint approach at the community level. During the CPF, MSD and Te Whatu Ora co-located frontline regional staff alongside Community Connectors and health and welfare support providers in Care Coordination Hubs. Fifty-three Care Coordination Hubs were placed across the country as joined-up sites for the provision of information, resources, and wrap-around care to households, spanning health, public health, social, and welfare sectors. Insights from Hub staff, collated by Te Whatu Ora, demonstrate the unprecedented value of this partnership in enabling greater transparency and trust between agency staff. The Hubs were significant for the sharing of information and systems, therefore reducing the number of interactions a client needed before receiving necessary support. MSD Service Delivery staff reflected on leveraging relationships within Hubs to ensure quick responses for households – *"people were engaging, always someone who could do it, maybe not MSD, but there was always someone I could tap into to do what was needed"* (MSD Service Delivery staff interview).

Through participation in RLGs, regional agency representatives adopted a collective sense of accountability to the region they represented. Members from diverse agencies and organisation sought out opportunities to collaborate and resolve emerging problems that were impeding an effective response. With their broad-based memberships and escalation pathways back to their home agencies, RLG members reported building positive relationships with MSD (93%), Ministry of Health (82%), and other government agencies (80%) (survey workstream). They reflected positively on the cross-agency networks forged through RLG participation and recommended that:

> *"This is definitely an area of combined and integrated agency supports that we need to explore further and continue to develop. It has led on to further networking opportunities and supports for communities"* (survey workstream).

This sense of collectivism was also activated at the national level – a challenging task at times, when *"each agency has different relationships and priorities of ministers"* (stakeholder interview - survey workstream). Cross-agency senior management arrangements (e.g., C4C) maintained a collective focus on achieving outcomes for communities through the All of Government COVID-19 response, while maintaining agency accountabilities. Central government representatives looked beyond their individual agency and liaised in diverse ways to extend their line of sight to the wider public sector.

The progress in Cabinet papers from the start of the pandemic to the end exemplified this commitment to All of Government collaboration. Initially, agencies presented separate Cabinet papers in 2020. However, by 2023, MSD was ensuring significant cross-agency consultation for the development of Cabinet papers concerning the use of Community Connectors and providers to also support the Cyclone Gabrielle response.[16] These Cabinet papers included clear roles and functions for agencies, and clarity about where funding would go and to whom.

While, as one central government stakeholder commented, *"this was never going to be the thing that broke the camel's back in terms of fixing... 100 years of doing things in a siloed way"* (stakeholder interview - survey workstream), the pressures of the CPF accelerated the need to break through agency segregation. Such partnership has also built momentum for continued cross-agency work – there is now *"far more of an appetite to collaborate and do things differently... We are totally seeing that level of collaboration now, which we wouldn't have seen before"* (RLG member - case study workstream).

MSD rapidly reconfigured operational roles to support implementation of the welfare response

MSD Service Delivery staff described the implementation of the welfare response as *"building the plane while in-flight"* and *"baptism by fire"* (MSD Service Delivery staff interviews). With the arrival of the CPF, MSD was required to rapidly stand up a suite of new systems and processes to facilitate coordination, triage referrals, and organise communications. These new operational mechanisms also needed to be managed without sacrificing core critical demand for BAU MSD services, including those available through Work and Income.

An MSD stakeholder reflected on how the Ministry is uniquely placed to support such work, noting *"we do have people and systems and processes that we can surge to respond"* (stakeholder interview - survey workstream).

To match Contact Centre hours and the hours that the COVID-19 Welfare Line ran, many MSD Service Delivery teams worked seven days a week, up to 12-14 hours a day, including public holidays; as one staff member commented, *"I remember thinking, I've been here 35 years... It was the most insane time of my career, it was out of control, it was so busy"* (MSD Service Delivery staff interview). MSD teams managing provider and Community Connector contracts experienced similar strain, matching hours to ensure they were available to provide timely support to community organisations.

[16] CAB-22-MIN-00023. Office of the Minister for Social Development and Employment (13 February 2023). *Support for Communities and Community Providers Significantly Impacted by Flooding.*
EWR-23-MIN-0010. Cabinet Extreme Weather Recovery Committee (7 March 2023). *Continuing to Respond to Immediate Needs of Communities and Community Providers Impacted by Recent Flooding and Cyclone Gabrielle.*
SWC-23-MIN-0060. Cabinet Social Wellbeing Committee (7 June 2023). *Confirming the Scope of Community Connectors Beyond 1 October 2023.*

Under the urgency of the CiC welfare response, the level of demand placed on MSD Service Delivery staff and other operational teams placed them at high risk of burn-out. Some teams implemented overtime blockers to enforce pauses for staff who were working long hours for prolonged periods. One staff member noted the necessity of these, *"because as much as people wanted to help, roll their sleeves up and do what they can for people, we had to force them to have a break"* (MSD Service Delivery staff interview).

Overseen by huge staff effort, the internal architecture that was set-up within MSD worked efficiently and effectively to support the welfare response. Central government stakeholders reflected positively on MSD's back room and frontline functions, commenting that they were not *"overly bureaucratic"*, and that they worked well to understand *"what was happening on the ground"* (stakeholder interview - survey workstream).

There was concern that local and regional advice was not adequately considered in 'big picture' national decision-making

In theory, central government involvement in the welfare response was designed to aid the locally-led, regionally-enabled functions – i.e., taking direction from the local and regional levels, and supporting their leadership and guidance in operationalising the response. With the seat of decision-making having traditionally been with agency head offices, the transition to a more auxiliary role saw some challenges.

One way that this new model was enacted was through central government seeking RLG input and advice on decisions regarding the CPF (e.g., traffic light settings and geographical boundaries). This involved communicating insights from local level intelligence about the situation on the ground up to the national level. While this was considered by some RLG members to be a useful pathway for influencing decision-making, others felt that their input was not sufficiently heard or acknowledged. This resulted in some RLG members feeling that their efforts collecting local intel had no impact, especially when centralised decisions were made despite RLG concerns about the impact on affected communities (case study workstream).

Despite a general shift to high-trust relations with providers and Community Connectors, a couple of central government stakeholders reflected on an element of *"unbalanced trust"* from central government (stakeholder interview - survey workstream). One stakeholder reflected on this pattern of discrediting community insights, noting:

> *"We trust them to deliver certain aspects and do the good work they were doing, but when they feed back to us on what they were doing and what they could see, they were treated as though they were not credible"* (stakeholder interview - survey workstream).

Similarly, some central government stakeholders suggested that when RLGs presented their local intelligence to the national level, government agencies ended up reporting more diluted findings. As one central government commented:

> *"We're giving all this intel, this evidence, and we're pushing it up. And what's actually coming back... through the likes of DPMC and MSD is a very what I would like to call a diluted sense of what our... communities actually need"* (stakeholder interview - survey workstream).

In some regions, MSD consulted with RLG members to 'sense check' the allocation of Community Connector resource to ensure that distribution corresponded with areas of need. Ultimately however, RLG guidance appeared to be neglected, with MSD instead largely managing it independently (case study workstream).

Some RLG members also expressed frustration at their lack of oversight over investment in their regions. With multiple agencies investing in different elements of the All of Government COVID-19 response, some RLG members did not feel that decisions about resource allocation were always transparently communicated with them. Occasionally, they perceived inequity of funding for smaller providers who *"don't have infrastructure in place to either bid for funding or get that resourcing"* (RLG member - case study workstream). In particular, a few iwi RLG representatives were concerned that some providers were being funded that did not have the mandate to serve iwi. They saw the potential value they could have added had central government more actively sought their advice over intended investment in their region (case study workstream).

IT infrastructure and lack of appropriate data sharing mechanisms hampered agency efforts to operate cohesively

The incompatibility of technological systems was frequently flagged by central government stakeholders and MSD Service Delivery staff as a barrier in implementing and overseeing the welfare response. Non-aligned operational models and platforms between agencies presented challenges for staff when managing referral processes, sharing information and reporting.

As one central government stakeholder commented regarding MSD and Ministry of Health IT systems:

> *"A significant challenge to our ability to work with one another was our two systems not being able to talk to one another. There was a major technological capability problem between our two Ministries that meant that we couldn't quickly operationalise something"* (stakeholder interview - survey workstream).

This lack of inter-operability required that agency staff develop workarounds, which created extra work during times of peak demand.

Information sharing limitations meant households were required to repeat their case details as they were referred between MSD, Ministry of Health, and providers. The ability for agencies to quickly respond to demand was impacted, with MSD Service Delivery staff commenting that *"they often had to dig for information when that would've been better upfront"* when triaging referrals from Ministry of Health (MSD Service Delivery staff interview).

Investment in shared infrastructure was raised as an important mechanism for future All of Government responses. Central government stakeholders flagged this as a key component of *"stitching together"* the wider public service, and a mechanism to ensure *"everything [is] aligned from top to bottom"* (stakeholder interview - survey workstream). MSD Service Delivery staff suggested that inter-operability between agencies would be enable quick delivery of support. Better All of Government IT infrastructure was suggested as an important step in mobilising a joined-up public sector, with a central government stakeholder commenting:

> *"If government does really believe in holistic service and wellbeing provision, we need to do things differently within government to make that a reality"* (stakeholder interview - survey workstream).

There was some contention about whether the CiC welfare response duplicated or complemented other funding streams and service delivery models

With so many agencies investing in the different components of the broader public sector's COVID-19 response, it was suggested that there was the possibility that the CiC welfare response duplicated existing funding or service delivery.

With different funding channels, some RLG members raised the possibility that the same providers were being resourced for similar services; in particular, that MSD funding duplicated funding from the Ministry for Pacific Peoples and Te Puni Kōkiri. However, other RLG members, including iwi representatives, did not (survey workstream).

Central government stakeholders offered a different perspective – that, while the different streams risked duplication of funding, this did not necessarily equate to duplication of services. These stakeholders suggested that, due to high demand and need, any duplication of funding going to community providers was generally resolved through providers ensuring that resources were delivered without duplication (survey workstream).

> *"I think the problem of duplication was mostly mitigated at their [community providers] end because they knew who they were serving and who was doing what. And I don't think there's any reasonable argument that anyone was duplicating. They might have had some similar contracts for similar things from different agencies, but we know they would have been delivering those to different people"* (stakeholder interview - survey workstream).

The question of duplication was also raised about MSD's decision to fund the new Community Connector Service model, as opposed to upscaling the existing Whānau Ora Navigator Service funded through Te Puni Kōkiri. While the Community Connector role was explicitly designed to be supplementary to existing navigator roles, some central government stakeholders expressed frustration at this decision. A few stakeholders also flagged concern about the impact of these dual navigational roles in fostering competition amongst Māori providers. As one stakeholder reflected:

> *"... like you're getting resources from MSD now to do effectively the same thing, you don't need our resources anymore, and we can redistribute them to the areas that most need it, and it just kind of pulled providers apart"* (stakeholder interview - survey workstream).

It is worth noting, however, that neither providers nor Community Connectors themselves raised concern about the role replicating the Whānau Ora Navigator model, or this resulting in increased social sector competition.

Nevertheless, central government stakeholders reiterated the urgent need for navigational support for households, whether via Community Connectors or Whānau Ora Navigators. As the same stakeholder who reflected on competition also noted, *"what it speaks to... is the inability of the mainstream welfare system to reach a bunch of Māori whānau and an inefficacy to deliver the support they need to improve their wellbeing"* (stakeholder interview - survey workstream).

6. Implications for future practice

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

The success of the model in delivering the CiC welfare response indicates its potential value for future initiatives that require quick implementation.

In particular, the locally-led component of the model was considered to have increased priority groups' access to support services and trusted providers to lead the response. The regionally-enabled component of the model effectively supported regional coordination of local delivery. And finally, the nationally supported component managed resourcing of the response and provided clear escalation pathways for issue resolution (survey workstream, case study workstream).

> *"This model of delivery is one of the best models I have seen coming from central government. We have never ever seen any central government agency come down to community level. And then not only that, there's resource coming through. And it is reaching the doorsteps of the community who have never accessed those services"* (provider - RTE).

The model has been adopted in subsequent emergencies, including the North Island severe weather events in early 2023. Having seen the effectiveness of these practices during COVID-19, central government mandated that these functions be urgently scaled-up to support the response. RLGs in affected regions swiftly organised hui oriented to cyclone response and recovery, and community food distribution networks strengthened through CiC funding were deployed to support impacted households. Additional Community Connector FTE was also funded to provide navigational support to households.

> *"When the cyclone in particular happened, you know, our Auckland providers were like 'we're just a well-oiled machine now, we know how to stand up. We know what we need to do in response. We know who we need to talk to' and all of that muscle memory about what mechanisms you put in place"* (stakeholder interview - survey workstream).

The Community Connector role has been flexibly deployed and highly valued across diverse settings. The role was vital in enabling households required to isolate to do so safely and supporting households to reconnect with their community post-isolation. When demand for isolation support reduced, Community Connectors then pivoted to supporting other priorities as they emerged, such as young people's engagement in education, youth crime and migrant exploitation.

While the approach has clear value under emergency settings, stakeholders expressed that the approach would also be valuable to implement in BAU settings. Understanding the potential utility and versatility of a locally-led, regionally-enabled and nationally supported approach, central government stakeholders and RLG members strongly recommended that the model be embedded into standard practice within the public sector, urging:

> *"There should be a new norm after everything they have done in the last three years... What should we be doing? Well, it's incorporating the things that we've learned over the last three years and being different"* (stakeholder interview - survey workstream).

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

Providers were driven by a sense of responsibility to provide for their communities (RTE). Firmly rooted in the communities they serve, provider staff and Community Connectors were often already well-known and considered relatable and easy to approach. As households reflected: *"[We] have seen them out and about in the community"*, *"Already knew [cultural organisation] and trusted they would do the job"* (survey workstream).

Many providers were already supporting their communities through the pandemic, so it was efficient for MSD to contract these organisations to deliver the welfare response. More importantly, these providers' unique knowledge of their communities meant that they were best placed to provide for local needs.

> *"I would like to thank [cultural organisation] for their prompt service. It was both culturally responsive to my needs as well as making me feel safe and confident in their services... Each person I encountered over my last isolation were so professional, caring and supportive"* (household - survey workstream).

> *"They went above and beyond to make sure that our Pasifika community was well supported"* (household - survey workstream).

> *"I would recommend [iwi organisation] to anyone because they went above and beyond"* (household - survey workstream).

For both Māori and Pacific providers in particular, their deep cultural knowledge and understanding of context meant that their models of care aligned with households' preferences and needs. Their whānau-centred way of working made households feel like they were being supported by their own family members – *"They are part of my family. It's really close... they are on our side, beside my family"* (household - RTE). This relationality made seeking support easier and less stigmatising.

For Asian families, the ability to connect with a provider and/or Community Connector from within their culture and who spoke their language was significant. This enabled them to access support they would have otherwise been unaware of (RTE).

The CiC welfare response highlighted the effectiveness of procuring services from trusted local providers in emergency situations, but the extent of benefits to households has implications for BAU work with communities.

Future welfare responses should therefore consider the specific value of contracting providers that represent their communities. Doing so:

- ensures the availability of culturally-tailored support
- resources providers to whakamana (empower, validate) and support their own communities
- increases coverage of support for priority groups and reduces the risk of gaps in service.

Regional leadership structures should proactively recruit representation from priority groups to advocate for the needs of their communities

Some RLG members strongly believed their region's responsiveness to the needs of Māori and Pacific households during the CPF was primarily the result of iwi and Pacific representation on RLGs (case study workstream). These representatives had a clear line of sight to their communities and advocated for their needs.

However, the absence of representation of other priority groups (e.g., disabled people, older people, ethnic communities) meant that RLGs lacked insight into the specific needs of these cohorts. Members signalled that this impacted the extent to which their region was able to tailor the response to ensure accessibility for these groups. They also expressed concern about the extent to which these groups were able to access welfare support because of this.

To ensure the accessibility and adequacy of support for priority groups in future, regional leadership structures need to actively seek the membership of representatives of these cohorts.

High trust responses enable support to be quickly distributed to impacted households in crisis situations

Designing a welfare response that *"[satisfies] integrity risk but doesn't shackle operations in the timely way in which clients expect support"* was a significant task for MSD (MSD Service Delivery staff interview). As with the Wage Subsidy Scheme, the CiC welfare response was developed and implemented at pace to respond to surging demand for assistance. With households isolating, it was necessary for support (e.g., food packages, medicine) to be delivered without delay. As such, referrals for support needed to enable timely responses and not be overly bureaucratic for households to manage.

> *"[You] have to thinking about scalability, from an operational delivery lens. If you start introducing more complexity into the process, it takes people significantly longer to manage an interaction. If it's taking us longer, it's going to introduce backlogs and what comes with that is pressure from clients we have to serve ultimately in the first place"* (MSD operational staff interview).

The approach, which did not involve means-testing or strict eligibility criteria for households, was broad-based and relied on high levels of trust. A few Community Connectors, MSD Service Delivery staff, and central government stakeholders flagged that this high trust delivery approach could give way to a small number of households seeking more support than they needed.[17] Ultimately however, the approach enabled households to stay safe while positive with COVID-19. Most crucially, households agreed that the support they received was timely, and that it made it possible to stay isolated during their isolation period (survey workstream).

There is some debate about the feasibility and appropriateness of a high trust model under BAU settings, in part due to the costs involved. However, central government stakeholders and MSD Service Delivery staff unanimously considered it to be the right fit under the crisis settings of the pandemic – *"It was the right thing at the time, we got help to those people that needed it most"* (MSD Service Delivery staff interview).

If a similar model were to be adopted under BAU settings, improvements to provider reporting would enable greater transparency and accountability about how funding is used, and support providers in continuing to advance their own capability and learning (survey workstream).

[17] The reasons for any manipulation were unclear and may need further investigation (e.g., whether it reflected unmet need within households).

There is the desire for continued investment in cross-agency collaboration infrastructure

Towards the end of the welfare response, many central government stakeholders and RLG members were observing a return to agency siloes. The crisis of the pandemic galvanised collective action to support communities as partners from all levels of the response realised *"that if we all work together, we all collaborate – we have more power"* (RLG member - case study workstream). However, with the removal of the CPF, the momentum established during the response has waned, *"as the rubber band of government slips back from crisis to BAU"* (stakeholder interview - survey workstream).

Many evaluation participants expressed the desire to maintain the practices of collaboration and partnership innovated during COVID-19 them and embed in BAU settings. For this to happen, there needs to be clear direction from central government about expectations for a more joined-up public sector.

> *"Agencies come together for a crisis and then they go, 'OK, the crises are done and we're just gonna go back to business as usual'... and they all go back to the territorial and organisational siloes... The collaboration needs to continue, but it needs to be incentivized in a manner of 'it is simply expected now from your communities that you will behave in this manner rather than going back to your siloes'"* (stakeholder interview - survey workstream).

Flexible contracting models make it possible for community providers to tailor support to meet community needs

The CiC welfare response embedded a flexible funding and contracting model to adequately resource providers to tailor support to household need. The principles of Social Sector Commissioning were effectively enacted through the response and demonstrated progress towards relational partnership with the social sector, as opposed to transactional commissioning practices.

> *"We were able to serve our whānau to a great breadth and depth... this was empowered by the funding and support of MSD, and the fact that a government department let us take a leading role, by allowing flexibility in the way we utilised the funds that were allocated"* (provider - survey workstream).

A number of RLG members (particularly iwi and Pacific representatives) expressed concern that agencies were *"regressing fairly quickly"* back to low trust/high compliance commissioning practices and *"widget contracting"* models (RLG members - case study workstream). They saw the opportunity for substantial, long-term gains to be made in community outcomes through central government maintaining the good faith relationships with providers that were developed through the welfare response. This would require relational commissioning practices to be embedded across all levels through system settings (e.g., financial and procurement policies).

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

The CiC model shifted onus onto local and regional mechanisms to implement and oversee the welfare response, while also continuing to manage BAU activities. However, providers, RLGs and RPSCs reported experiencing strain from their workload, raising some concern about how resourcing (including workforce and budget) was allocated for implementation and delivery.

Just over a quarter (28%) of providers felt that funding allowed them to recruit skilled personnel for their staff, and most providers (71%) used volunteers to supplement their workforce. This points to the inadequacy of funding to meet the demand placed upon the provider workforce and the need for additional FTE budget, especially during the peaks of the pandemic (survey workstream). Pressures to support households' urgent needs also had repercussions for some providers' ability to deliver on other BAU work – *"we are concerned that we haven't met some of our targets for some of our other contracts due to COVID"* (provider - RTE).

Some central government representatives (especially from agencies representing priority group) were RLG members for several regions, which they reported to be *"quite taxing"* (stakeholder interview - survey workstream). They suggested that this constrained their ability to engage meaningfully in RLG matters. For members attending hui for regions where they were not resident, this was particularly difficult, especially when discussions required understanding of local context.

A few RLG members flagged concern that RPSCs were under-resourced for their roles, and that their capacity was *"spread very thin"* (RLG member – survey workstream). Central government stakeholders also raised concern about the resourcing of RLGs, with one noting that RPSCs were not *"funded to the capacity that they should be"* (stakeholder interview - survey workstream).

For decision-makers designing future models that utilise locally-led and regionally-enabled approaches, there is a need to examine the adequacy of resourcing and funding for providers and regional leaders doing the heavy lifting of implementation. In particular, consideration should be given to whether the workforce has the capacity to respond to the demands required of the job, and whether appropriate budget is allocated to support their work. This is particularly important for emergency responses during which providers and regional leaders are also expected to maintain BAU work. Where appropriate and feasible, sufficient funding should be ringfenced to increase the workforce to meet demand.

Appendix 1.
Key Evaluation Questions

Key Evaluation Question	Data source
Implementation	
How well was the welfare response implemented?	• Survey workstream • Stakeholder interviews – survey workstream • Case study workstream • RTE (cycle two) • RTE (cycle three)
What were the conditions and levers that enabled implementation of the response? What were the barriers to implementation and how were these addressed?	• Survey workstream • Stakeholder interviews – survey workstream • MSD Service Delivery staff interviews • RTE (all cycles)
How accessible was welfare support? What was the reach of the response?	• Survey workstream • MSD monitoring data
How did the implementation of the welfare response enable and embody MSD's organisational strategies: Te Pae Tawhiti, Te Pae Tata, and Pacific Prosperity?	• Survey workstream • Stakeholder interviews – survey workstream • Case study workstream • RTE (cycle two) • RTE (cycle three)
How and in what ways did the welfare response complement support from the Ministry for Pacific Peoples (MPP) and Te Puni Kōkiri (TPK), including how services were provided and allocated on the ground? How was duplication addressed?	• Survey workstream • Stakeholder interviews – survey workstream • Case study workstream • RTE (cycle three)
How could the response have been better? What could have been done differently?	• Survey workstream • Stakeholder interviews – survey workstream • Case study workstream • MSD Service Delivery staff interviews • RTE (cycle three) • RTE (lessons learned)

Outcomes	
To what extent did the welfare response achieve its intended immediate results and short-term outcomes?	• Survey workstream • Stakeholder interviews – survey workstream • Case study workstream • RTE (cycle three) • RTE (lessons learned)
What progress is being made to achieve medium to longer-term outcomes of the welfare response?	• Survey workstream • Stakeholder interviews – survey workstream
What were the unintended outcomes of the welfare response?	• Survey workstream • Stakeholder interviews – survey workstream
To what extent did the welfare response help to create, maintain, and/or improve relationships between national, regional, and community partners in the response?	• Survey workstream • Stakeholder interviews (survey workstream) • Case study workstream • MSD Service Delivery staff interviews • RTE (all cycles)
Synthesis	
What are the lessons for the policy design and delivery of future responses involving cross-agency coordination and regionally-enabled local delivery of public services?	• All data sources
What factors are critical to the success of locally-led, regionally-enabled, and nationally-supported approaches to increase community wellbeing and resilience?	• All data sources
What lessons can MSD learn from implementing the CiC welfare response, and what aspects of this approach could inform future ways of working with the community sector?	• All data sources