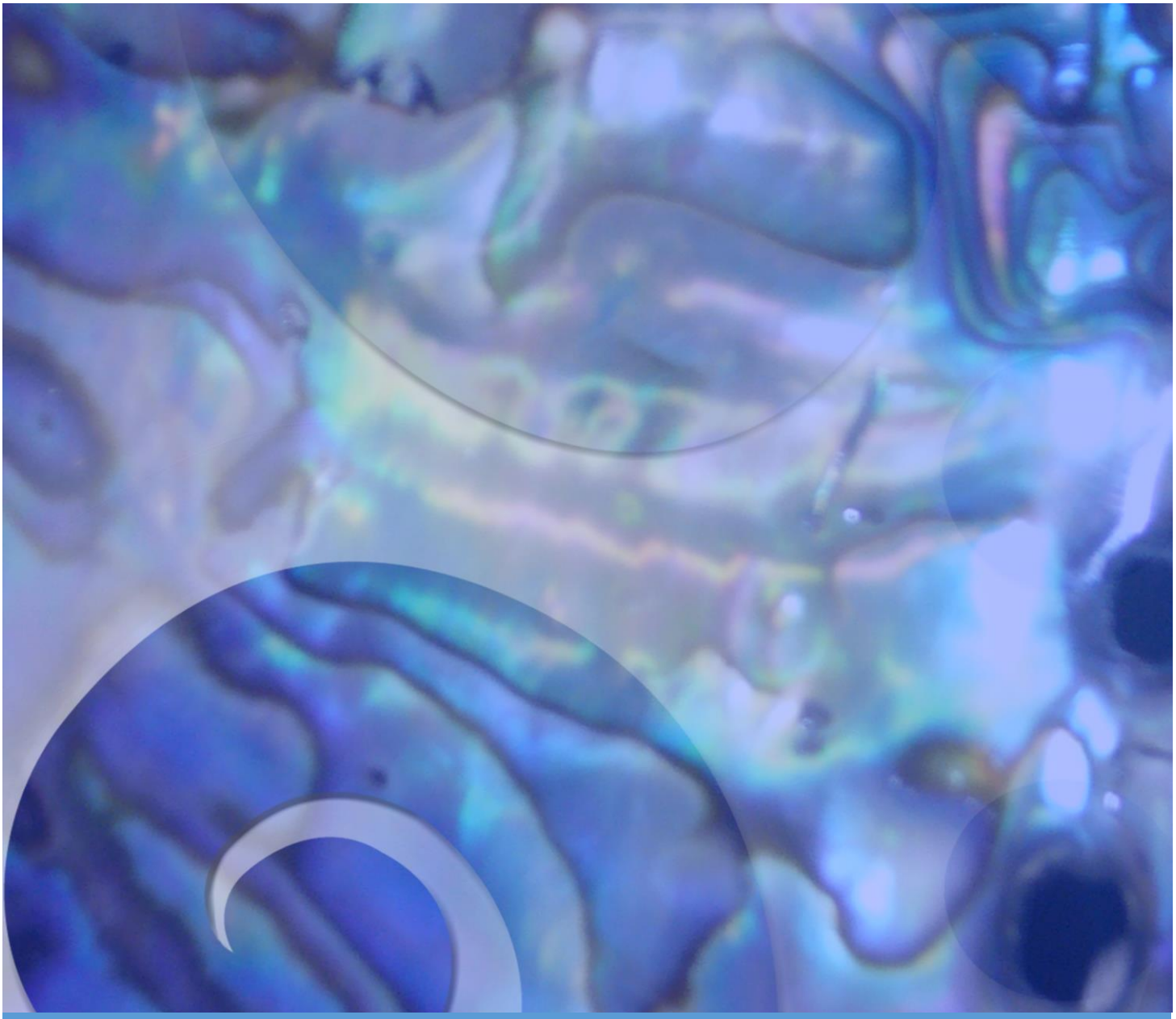

Mahitahi – a synopsis of social sector stakeholder views on Social Investment, Results Based Accountability™ and ideas that could benefit Investing for Social Wellbeing

A report for the Social Investment Agency by Shea Pita & Associates Ltd

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Shea Pita & Associates Ltd

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Author: Sharon Shea, Principal Consultant, Shea Pita & Associates.

Acronyms

Acronym	Description
AH+	Alliance Health Plus PHO
DOC	Department of Corrections
DST	Decision Support Tool
GAA	Government Agency Agreements
ISA	Integrated Services Agreement
IFSW	Investing for Social Wellbeing
MBIE	Ministry of Business, Innovation and Employment
MOE	Ministry of Education
MOH	Ministry of Health
MOJ	Ministry of Justice
MSD	Ministry of Social Development
NGO	Non-Government Organisation
NHC	National Hauora Coalition
OA	Outcomes agreement
OAMP	Outcomes agreement management plan
OMT	Operational Management Team
PHO	Primary Healthcare Organisation
RBA™	Results Based Accountability™
SABC	Skills and knowledge Attitude and opinion Behaviour change Circumstance change
SCU	Streamlined Contracting Unit
SIA	Social Investment Agency
SIAL	Social Investment Analytical Layer
SIDF	Social Investment Data Foundation
SIMM	Social Investment Measurement Map
SIU	Social Investment Unit
SMT	Senior Management Team
TPK	Te Puni Kōkiri
YNEET	Youth not in education, employment or training

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1. Executive Summary

Introduction

In early 2017, we were contracted to interview social sector stakeholders to explore the historical and future relationship between Results Based Accountability™ (RBA)[1] and Social Investment. We interviewed 42 people from 23 entities (government agencies, non-government organisations providers and iwi).

We have produced two documents for the Social Investment Agency (SIA). First, this report uses pertinent stakeholder insights (that were initially gathered about the concept of social investment in mid-2017) to inform how RBA can support the government's emerging Investing for Social Wellbeing[2] (IFSW) approach.

Second, we have also produced a companion report. It summarises stakeholder opinion about multiple concepts like equity, risk vs. strengths, whānau ora and targeted investment techniques (i.e. proportionate universalism)[3]. We then analysed those opinions and how they might inform a future IFSW approach. The companion report was provided to the SIA as an input into their current national engagement project which aims to define what Investing for Social Wellbeing might look like.

The Māori name of this paper is Mahitahi. Mahitahi means to work together and to collaborate. We have chosen the title Mahitahi, as it reflects the continued need for stakeholder collaboration to improve equity and increase social wellbeing for all. It also reflects sector stakeholder views that RBA supports willing partners to generate a common language, common purpose and common ground.

What is RBA and how has it been used internationally and domestically

RBA is an outcomes and strategic management framework (Friedman, 2005; Friedman, 2015). It is an action-oriented methodology that supports measurable improvements for clients and communities. The Ministry of Social Development first introduced RBA to New Zealand in 2006. Since that time, RBA has gained traction as a preferred outcomes model and has been adopted by multiple non-government stakeholders, including providers, community groups and iwi. Of significance, is the scale of RBA use nationally through its endorsement in government contracts with non-government organisations. Based on available data, approximately 65% of government agency contracts with non-government organisations were transitioned into streamlined contracts between 2013-2016. If agencies adopted the standard streamlined contracting template, which RBA was a component of, they are likely to have used RBA as a core part of their contracting. The streamlined contracting

[1] RBA is an outcomes and strategic management framework. It is an action-oriented methodology that supports measurable improvements for clients and communities. For more details see the companion report to this paper (see footnote 3), and Friedman, M. (2005) Trying Hard Is Not Good Enough (Trafford Publishing: Canada); Friedman, M (2015) Turning Curves (Trafford Publishing: Canada). For more detail see: http://resultsaccountability.com/. Accessed August 2017; Ryan, D. and Shea, S. (2012) Results Based Accountability: Guidelines and Resources (Ministry of Social Development: Wellington). Accessed online in December 2017.

[2] Cabinet paper Investing for Social Wellbeing, April 2018. Sourced: https://sia.govt.nz/assets/Documents/Cabinet-Paper-Towards-investing-for-social-wellbeing-April-2018.pdf, May 2018.

[3] Shea, S. (2018) Ka mua, ka muri – a report on social sector stakeholder views about social investment and RBA, and how these views can inform the Investing for Social Wellbeing implementation approach, (Social Investment Agency: Wellington).

approach has not formally been evaluated. However, stakeholder feedback in this report highlights some of the perceived enablers and barriers of that approach specific to RBA.

This report contains data and examples of how multiple stakeholders use RBA in New Zealand. These stakeholders ranged from non-government organisations and district health boards to primary healthcare organisations, a whanau ora commissioning agency and iwi. Based on data and commentary provided, organisations are working hard to understand what works and measure whether or not they are funding or delivering better outcomes for whanau/clients.

Benefits of using RBA

Stakeholder feedback of the perceived or actual benefits of using RBA, as part of a contracting approach was varied. It was stated that contracts which used RBA had the potential to be more outcomes or wellbeing focused; more inclusive of the provider and whānau 'voice'; more focused on the potential to use data to drive contract management feedback loops; better able to support improved performance conversations; better able to articulate the theoretical contribution relationships between client and population outcomes; and more able to recognise the value of Māori and community concepts of wellbeing.

Stakeholder views of the perceived or actual advantages of using RBA (in contracts or within their organisations) outweighed perceived disadvantages. Notable advantages were aligned with the benefits described above. They also ranged from clarifying accountability between population and client outcomes; building capability in outcomes thinking and practice; promoting overarching consistency of approach; enabling flexibility; supporting better relationships through clarity of expectations; creating a common language and respecting stakeholder expertise in the outcomes thinking process.

Disadvantages of using RBA

Disadvantages discussed by stakeholders were mainly associated with barriers to good quality implementation. Some of these barriers ranged from lack of buy-in and internal capability to implement RBA through to continued inconsistencies of approach across the sector; difficulties with data collection and reporting challenges; lack of strong leadership to support implementation; the perceived complexity of the framework and too much focus on quantitative data.

The author observed an acute loss of institutional knowledge post the end of the streamlined contracting project, as agencies restructured and/or lost experienced personnel due to natural attrition. The author also observed the loss of a dedicated cross-agency project leadership group, which was used to embed high quality use of streamlined contracting and RBA, as business as usual. In our and some stakeholder's opinions, these two issues are potential future barriers to high-quality RBA implementation.

When asked to discuss the positive differences (if any) between the pre-Streamlined Contracting Framework ('standard') and post-Streamlined Contracting Framework (which was RBA informed), stakeholders iterated many of the benefits outlined earlier in this summary. Other notable positives included the opportunity to design new data that better reflected client-centred outcomes and more transparency about who are the clients of services.

The SIA wanted to know if RBA supported the use of multiple feedback loops in the commissioning/contracting process. Stakeholders confirmed that it did in principle and whilst they valued the opportunity, in practice there was a mixed response to how agencies used data to inform their commissioning cycle. In short, practice was varied.

The published literature confirms some of the enablers, barriers and lessons shared by stakeholders for this report.

Integrated datasets and RBA

When asked about use of integrated datasets from Statistics NZ, the government agency stakeholders that we interviewed confirmed that they had not yet accessed the datasets to inform the use of RBA. This was also the case with respect to NGO stakeholders. However, all stakeholders were interested in how best to use these datasets to inform better use of RBA.

Stakeholder views of social investment and the relationship to investing for social wellbeing

Stakeholders were asked to define Social Investment. Definitions comprised two elements: conceptual ideas (i.e. what social investment does, should or could address) and systems-focused issues (what an investment system should be comprised of). In our view, many of the definitional and implementation ideas shared when discussing the future of Social Investment, align with the current definition and thinking for Investment for Social Wellbeing. In a way, some stakeholders anticipated changes in the investment approach.

For example, the conceptual ideas raised by stakeholders align with the current definition of IFSW in that it should be people-centric. Stakeholders suggested that an investment approach should promote innovation; focus on wellbeing; mitigate social determinants of poor outcomes; promote equity; protect indigenous rights and build social and human capital. Stakeholder comments also supported a positive lifecourse approach.

The systems-focused issues raised by stakeholders also align with the current definition of IFSW, in that it should be evidence-based, build partnerships and trust and be underpinned by goals and measurement. For example, stakeholders suggested the investment system should engage with multiple stakeholders; potentially use intermediaries to broker solutions; focus on prevention and enable Māori specificity in systems implementation; use data to drive decision-making; target investment to those most in need; clarify accountabilities; use a strengths-based approach; adopt disruptive technology and shift mindsets for sustainable change.

Stakeholder views of SIA

An opportunity to engage more purposefully with stakeholders to communicate the role, scope and function of the SIA was identified in this project. Most stakeholders said they had either not heard of the SIA or if they had, they did not know what the SIA offered to the sector. All stakeholders expressed an interest in the possibility of receiving support from the SIA in the form of: sector leadership; insights; prioritisation of Māori wellbeing and reducing inequities; and capability building.

As the SIA is currently rolling out a national engagement process about investing for social wellbeing; stakeholder knowledge of the SIA, is likely to have improved considerably since mid-2017.

Suggestions about effective use of RBA to support investing for social wellbeing

We have summarised factors that support effective use of RBA based on stakeholder feedback and literature scans. We have also outlined the synergies between the intent and definition of IFSW and how RBA can support future implementation.

In our view, it makes sense to consider using RBA to effect IFSW change, as it:

- Is already being used; it has traction and scale

- Is a practical framework that aligns with IFSW principles
- Values work that has already been done
- Is scalable
- Is adaptable and flexible
- Supports cultural specificity
- Can be used to support equity, whānau ora, proportionate universalism and strengths-based approaches

Conclusion

This report provides a snapshot of why, what and how RBA has and is being used in New Zealand. It also provides an opportunity to explore how RBA, if used well, can support an investment approach for wellbeing. However, enhanced future use at a national level, will require dedicated sector leadership at multiple levels.

As the name of this report suggests, we need to mahitahi - work together and collaborate, to improve equity and increase social wellbeing for all. We need to find tools that support 'what works'. Stakeholders we interviewed suggested that RBA provided multiple benefits and there were advantages to using the framework in order to showcase success. In particular, RBA was viewed as a framework that generates a common language, common purpose and common ground.

Overall, there seems to be a real opportunity for shared learning and advancing the use of RBA as a tool that supports a successful investment for social wellbeing approach.

2. Introduction

This section summarises the report's purpose, objectives, approach and qualifications. It also defines Results Based Accountability™ (RBA)[4] and the concepts of Social Investment and Investing for Social Wellbeing.

2.1. Purpose

In April 2017, the Social Investment Unit (SIU), now known as the Social Investment Agency (SIA), engaged Shea Pita & Associates to explore the relationship between Social Investment and RBA. During the project term, the New Zealand government changed and Social Investment is no longer a government priority; the new priority is Investing for Social Wellbeing (IFSW). Accordingly, this report summarises the results of stakeholder interviews and provides SIA with insight into the potential relationship between RBA and Investing for Social Wellbeing.

The Māori name of this report is Mahitahi. Mahitahi means to work together and also represents collaboration. We have chosen the title Mahitahi as it reflects the continued need for stakeholder collaboration to improve equity and increase social wellbeing for all. It also reflects sector stakeholder sentiment about a core benefit of RBA, which is using the framework to generate a common language, common purpose and common ground.

This report was originally commissioned by Ed Montague, the former General Manager, Commissioning, SIA. The author's key day-to-day contact was Vicki Evans, Project Manager, SIA.

2.2. Objectives

The original project objectives were:

1. To provide advice on the **origins and context of RBA** (as it relates to the New Zealand Government).
2. To provide information about the **range of contracts/social sectors** incorporating RBA, including their duration; and the degree of 'penetration' within and across sectors.
3. To outline the **process of building service contracts incorporating RBA** – how it works in practice including a comparison of the development process for contracts incorporating RBA vs. those without.
4. To outline the relationship between **RBA and the NGO Streamlined Contracting** workstream.
5. To provide information about the **links (compatibility/alignment) between RBA and the development of specific government outcomes frameworks**.
6. To understand the potential relationship between **Administrative data (IDI) and RBA outcomes data** – crossover and completeness.
7. To provide an overview of **RBA reporting and evaluation**.
8. To provide an overview of '**how it works in practice/what it looks like'**.
9. To provide an overview of **how RBA is used by Agencies**.
10. To provide insight into how RBA is used as part of a **'feedback loop'** (i.e. the degree to which (if any) it influences future commissioning decisions).
11. To provide an overview of how RBA is a **source of information on programme effectiveness and population level outcomes**.

[4] In some parts of the world, Results Based Accountability is also known as Outcomes Based Accountability (OBA).

12. To provide suggestions about **opportunities for better implementation** in alignment with social investment.

The authors have adapted objective 12 to read 'To provide suggestions about **better implementation of RBA in alignment with investing for social wellbeing**'.

During stakeholder engagement, the author and some stakeholders discussed the relationship between RBA, Social Investment and other concepts such as Equity, Whānau Ora, Targeted Investment and Strengths vs. Risk-based data. We have written a companion report called Ka Muri, Ka Mua[5], which summarises stakeholder opinion and how it relates to the current Minister of Social Development's preference for investing in the long-term wellbeing of New Zealanders, proportionate universalism[6] and strengths vs. deficit framed approaches[7]. Ka Mua, Ka Muri was submitted to the SIA for use in their national engagement process (May-August 2018) designed to inform what IFSW might look like.

2.3. Approach

The following approach was used to write this report:

- Agree project scope with the SIA
- A brief literature scan
- A desktop review of documentation
- Interviews with 42 people from 23 government agencies, non-government organisation (NGO) providers and iwi in May-June 2017 (see Appendix 1)
- Multiple draft reports provided for SIA feedback and peer review
- A final report provided to SIA
- A summary report prepared to share with stakeholders.

All interviewed stakeholders were provided with a participant brief and offered a face-to-face or virtual meeting. Participation was voluntary and stakeholders could exit at any stage. Some meetings were recorded and permission from stakeholders was sought beforehand.

2.4. Qualifications/Points to note

It is noted that:

- The author is a practitioner and trainer of RBA in New Zealand and internationally.
- RBA data presented in this report is sourced from third parties. The data was accepted as true and correct.
- All stakeholders were asked to be frank and honest with their feedback, irrespective of their historic and/or current use of RBA.
- The author has worked with most but not all of the agencies and NGOs. However, the author had not worked with all of the individuals that were interviewed from each agency.

[5] Supra, at footnote 3.
[6] https://pro.newsroom.co.nz/articles/2265-carmel-sepuloni-social-investment-here-to-stay. Accessed April 2018; https://www.beehive.govt.nz/release/newly-launched-book-social-investment-timely-and-thought-provoking. Accessed April 2018.
[7] https://pro.newsroom.co.nz/articles/2468-carmel-sepuloni-rebuilding-the-social-safety-net. Accessed April 2018. https://www.beehive.govt.nz/speech/launch-%E2%80%98social-investment-new-zealand-policy-experiment%E2%80%99. Accessed April 2018.

- Feedback is based on stakeholders who were interviewed for this project. The individuals interviewed may not necessarily represent an agency-wide view and/or may not have been privy to other relevant work that was occurring within agencies.
- In the government agencies, most of the stakeholders interviewed were not the original streamlined contracting project managers, as many had moved on due to restructuring or new opportunities. This meant that there was a loss of institutional knowledge about that project and how it had been rolled-out between 2013-2016 within the agency.

2.5. An overview of RBA

RBA is an outcomes and strategic management framework. It was developed by Mark Friedman, who is based in the United States of America[8]. RBA is an action-oriented methodology that supports measurable improvements for clients and communities (also known as populations)[9]. RBA is currently used in over ten countries including America, United Kingdom, Canada, South Africa, Australia, China and New Zealand.

The main concepts in RBA are summarised in the figure below. The concepts are often referred to in New Zealand, as 2-3-7:

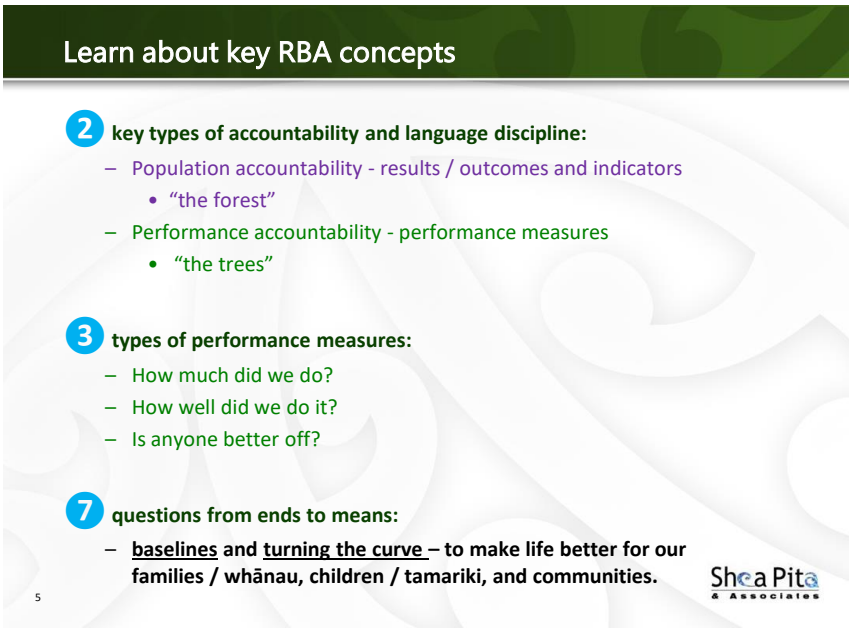

Figure 1: 2-3-7 RBA concepts

There are two types of accountability in RBA: population and performance. Population Accountability is about results or outcomes for defined populations of people. Example population groups are: Children in New Zealand, Adults in Tauranga or Rangatahi (Youth) in Otautahi

[8] Friedman, M. (2005) Trying Hard Is Not Good Enough (Trafford Publishing: Canada); Friedman, M (2015) Turning Curves (Trafford Publishing: Canada). For more detail see: http://resultsaccountability.com/. Accessed August 2017.

[9] Ryan, D. and Shea, S. (2012) Results Based Accountability: Guidelines and Resources (Ministry of Social Development: Wellington). Accessed online in December 2017.

(Christchurch). Example population outcomes are: New Zealanders are safe and free from alcohol and other drug harm[10] or Whānau are self-managing and empowered leaders[11].

Population outcomes are measured using indicator data. Example indicators are: immunisation rates, mortality rates, employment rates, % of YNEET in a geographic area, % homeless people in a geographic area. Most indicator data are sourced from the government due to its size and scale.

In RBA, accountability for population outcomes is always shared across multiple partners/stakeholders. This is because it takes multiple partners/stakeholders to work effectively together to improve population level wellbeing.

Performance Accountability is about results or outcomes for defined groups of Clients. Client outcomes are linked to effective services, programmes or systems (i.e. education system, health system, justice system). In RBA, there are four categories of client outcomes: skills/knowledge, attitude/opinion change, behaviour change and circumstance change. These categories are often referred to as SABC (an acronym which refers to the first letter of each client outcome category).

Client outcomes are measured using performance measures. Performance measures are a mix of inputs, outputs and outcomes data. In RBA, accountability for client outcomes is always held by a defined provider, organisation or stakeholder. The rationale is that providers, organisations or stakeholders should hold responsibility for improving their respective client wellbeing.

There are seven questions which support RBA practitioners to apply an 'ends to means' thinking process. If Ends equates to Outcomes, then the Means are the strategies and actions practitioners implement to achieve a defined end point. Some people refer to this type of thinking process as 'reverse engineering' (where you start with the outcome and then work your way back to understand what should be delivered to achieve the same).

An outline of the seven questions for population and performance accountability is provided below:

[10] Population outcome used by the Ministry of Health. Personal communication with Adrienne Percy on 17 September 2017.

[11] New Zealand Government Whānau Ora Outcomes Framework. Source: https://www.tpk.govt.nz/docs/tpk-wo-outcomesframework-aug2016.pdf. Accessed 17 September 2017.

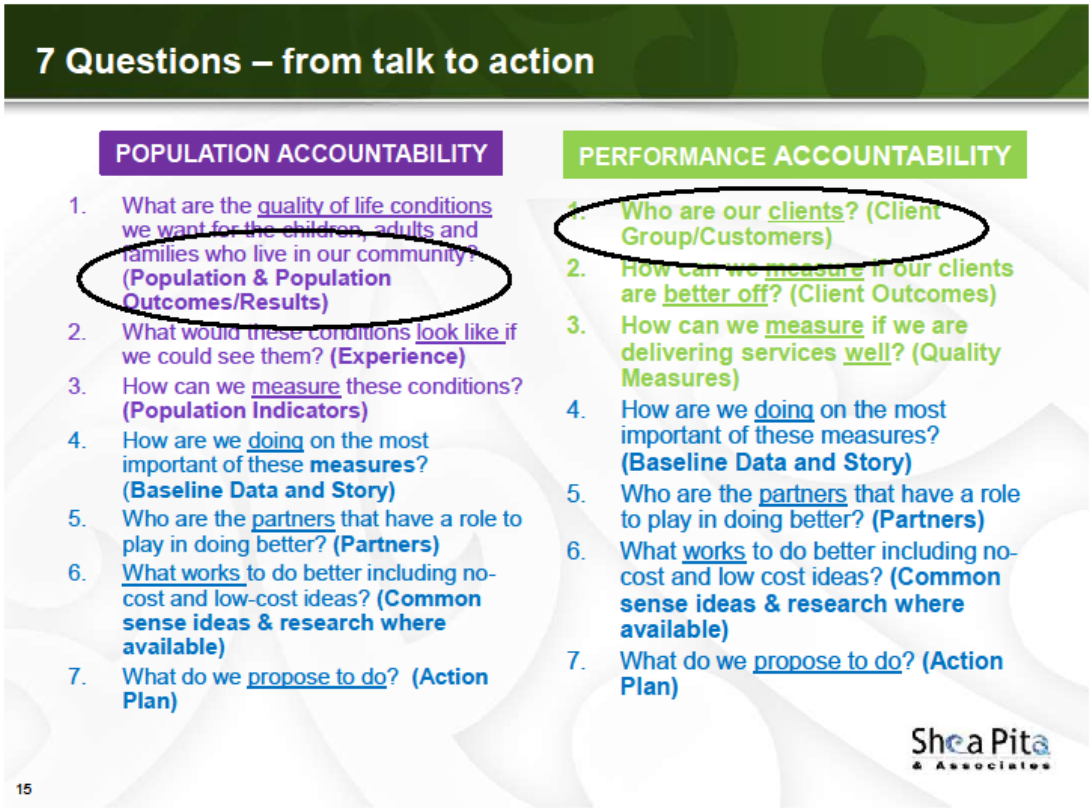

Figure 2: 7 Questions - from ends to means

In RBA, indicator and performance measure data that is actively used is graphed. This allows the user to visualise data trends and to unpack the trends to ascertain causal factors or drivers. In turn, this supports robust conversations about what it would take to turn the data curves in the right direction.

RBA recognises a 'line of sight' relationship between population and performance accountabilities. The rationale is that if client outcomes are improving (at service and systems levels), then associated population outcomes are more likely to improve.

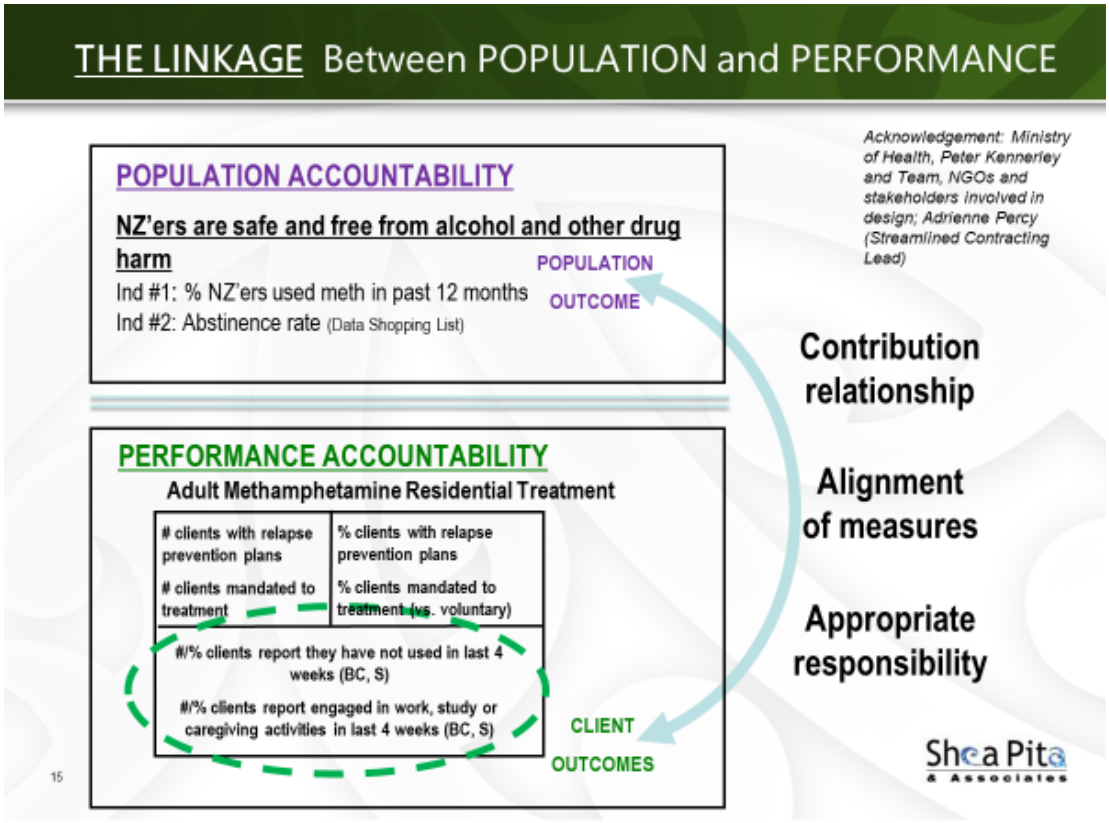

Figure 3: Line of sight link between population and performance

Note however, that the relationship between client outcomes and population outcomes is contributory only (compared to direct attribution). The difficulty of proving attribution is recognised between services, systems and populations in RBA, and caution is advocated when interpreting causation and correlation (as it should be, with all outcomes frameworks and data interpretation).

The line of sight argument is also supported by the fact that clients are sub-sets of populations. This suggests that at every cohort level, it is important to understand wellbeing to acknowledge the theoretical outcomes relationships between services, systems and populations:

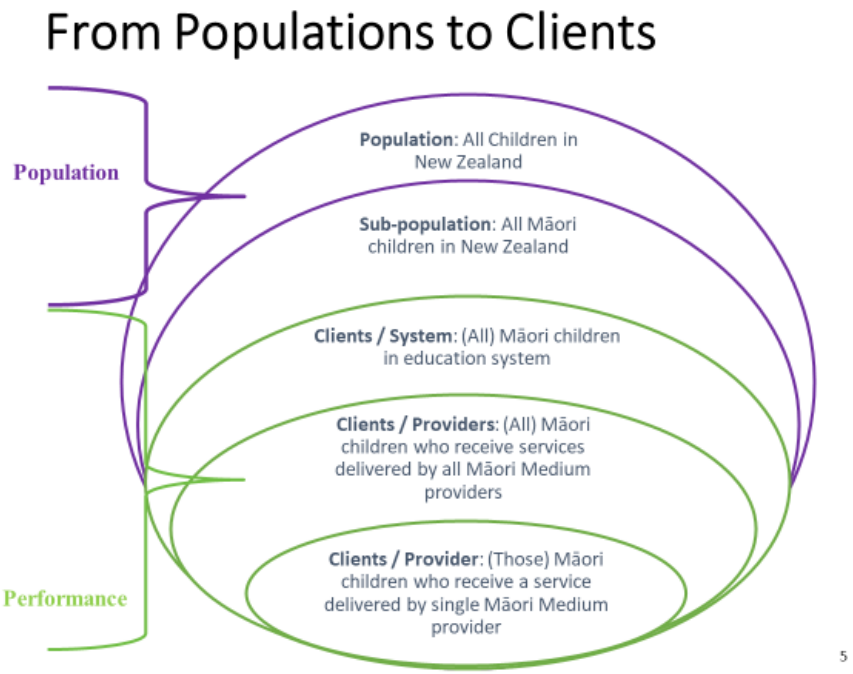

Figure 4: The relationship between services, systems and populations

Effective use of RBA should generate multiple opportunities for feedback loops, as frequent use of the seven questions generates conversations that move practitioners from 'talk to action'. The 'power' of RBA is not simply about identifying what and how to measure outcomes, if used well, it also involves:

- Developing a **common language** so people can talk to each other, not past each other about outcomes
- **Using data** to drive decision-making, continuous quality improvement and performance improvement
- **Change managing** outcomes-focused thinking and practice
- Understanding the **contribution relationship** between aspirational population outcomes and client outcomes achieved through services, programmes and systems.

RBA is an adaptable framework that can be used alongside other methodologies to support population and client wellbeing. For example, data generated from other outcomes tools, like the Outcomes Rating Scale[12], can simply be mapped into the performance measure framework and used as part of RBA.

RBA also aligns with Kania and Kramer's Collective Impact methodology[13]. Collective Impact is a methodology that supports large-scale social change. The complementary relationship between Collective Impact and RBA is outlined in the table below[14]:

[12] Source: http://scottdmiller.com/wp-content/uploads/documents/OutcomeRatingScale-JBTv2n2.pdf. Accessed 5 August 2017.
[13] Source: https://ssir.org/articles/entry/collective_impact. Accessed 5 August 2017.
[14] Sourced from Clear Impact consulting (www.clearimpact.com).

Five conditions of Collective Impact	Relationship to RBA
A Common Agenda	The use of population Results and Indicators provides a clear, practical and measurable way of articulating a common agenda for a community.
Shared Measurement System	Defining performance measures for each community partner that clearly align with the Common Agenda (Population Results and Indicators) provides the information needed to make decisions and revise strategies going forward.
Mutually Reinforcing Activities	Collecting data is only half the battle. Transparency in your planning can help you to use data to make decisions and guide your strategies to improve.
Continuous Communication	Communication, not just between partners but also with funders and the public, is a key component to any successful Collective Impact initiative.
Backbone Support Organisation	A backbone organization provides the supporting infrastructure for a Collective Impact effort and is a facilitator of a highly structured data-driven decision-making process.

2.6. Definitions: social investment and investing for social wellbeing

When we interviewed stakeholders, we discussed the concept of Social Investment. At that time, agencies had multiple definitions of the term 'Social Investment'. The Social Investment Agency (SIA) was charged with operationalising the former government's social investment strategy. The SIA defined Social Investment as:

> "….using data and evidence to improve the lives of New Zealanders by investing in what is known to create the best results"[15]

The SIA described four aspects of social investment:

- **Data** – using to understand current and future needs
- **Measure** – service effectiveness to meet peoples' needs
- **Long-term outcomes** – measuring over a person's lifetime and using this information to feed into decision-making
- **Fiscal implications** – understanding the implications of better outcomes and managing long-term costs to government.

The SIA was developing a Social Investment Commissioning Platform. The platform leveraged off the Productivity Commission's report entitled More Effective Social Services[16].

Presently, the Minister for Social Development has endorsed a new approach titled Investing for Social Wellbeing[17] (IFSW). In a recent Cabinet paper (April 2018) it was stated that:

[15] https://sia.govt.nz/about-us/what-is-social-investment/. Accessed April 2018.

[16] The New Zealand Productivity Commission (2015) More effective social services. Accessed online at http://www.productivity.govt.nz/sites/default/files/social-services-final-report-main.pdf, on 1 September 2017.

[17] https://sia.govt.nz/assets/Documents/Cabinet-Paper-Towards-investing-for-social-wellbeing-April-2018.pdf. Accessed May 2018.

> "Investing for social wellbeing means supporting and resourcing people to improve theirs and others' wellbeing which, in turn, will contribute to broader positive social outcomes. The approach is centred on an attempt to understand, and the need to appreciate, the complexities in people's lives as well as their ability to build resilience and fulfil their potential in different ways." (p.3)

The SIA defines IFSW as comprising four parts[18]:

- **People-centred**
- **Based on a wide range of evidence**
- **Built on partnerships and trust**
- **Underpinned by clear goals and robust measurement**

In addition, the term **Wellbeing** is defined as "the ability for individuals and families to live the lives they aspire as part of inclusive, fair and prosperous communities. It includes both material conditions and quality of life."[19]

2.7. What is different between social investment and investing for social wellbeing?

The Government has stated that Social Investment was a narrow concept that focused too much on fiscal restraint and future liability reduction[20]. The Government's view is that Social Investment generated a limited understanding of complex social challenges and solutions. Accordingly, the current government's new focus is a social wellbeing investment approach with an ecological and aspirational context[21].

The SIA states that the Investing for Social Wellbeing approach:

> "…takes into account all circumstances in a person's life. The new approach makes better use of all sources of information and evidence, including client and provider views and experiences." (p.2)

[18] https://sia.govt.nz/our-work/yoursay/faqs/#investing_for_social_wellbeing. Accessed May 2018.
[19] Ibid.
[20] Minister of Social Development's Cabinet Paper, April 2018. Supra at footnote 6.
[21] Ibid.

3. Research and analysis of stakeholder views about RBA

This section presents stakeholder views sourced from interviews completed in May-June 2017. The content of this section also contains findings from documentation analysis and research of RBA use internationally and domestically. Interviews with government agencies and NGO providers were undertaken in Auckland and Wellington. They were conducted either face-to-face, online and/or by phone.

3.1. Key findings

Literature on RBA use provides examples of successful use, enablers and barriers

- Readily available international and domestic literature confirms that RBA has been used successfully at population, systems and service delivery levels. RBA has also been used to support continuous quality improvement models.
- Research and evaluation reports have highlighted enablers, barriers and lessons learned to guide future use of RBA.
- Enablers are wide ranging from workforce development and sustained leadership through to coaching, engagement with multiple stakeholders, recognition of what it takes for teams to implement RBA and access to RBA subject matter experts.
- Barriers are also wide ranging. They range from lack of buy in and understanding of RBA through to less than optimal data collection, lack of champions, a more balanced use of quantitative and qualitative data and constant communications to support implementation.
- A range of success factors are listed in this report that are sourced from the author's experience, stakeholder feedback and the published literature. These are offered to readers as a guide to support continuous improvement of how best to apply RBA.

Origins and context of RBA use New Zealand

- RBA was first introduced into New Zealand by the Ministry of Social Development (MSD) in 2006.
- RBA gained traction as a preferred outcomes model between 2006-2012 as it was adopted by multiple non-government stakeholders, including providers and some iwi.
- Over time, it was also adopted by multiple government agencies (over and above MSD). For example, Te Puni Kōkiri used RBA in the early days of Whānau Ora. Use during this period, was driven by stakeholder views of the value-add of the framework.
- Between 2013-2016, RBA was adopted as an outcomes framework of choice in the whole-of-government Streamlined Contracting Framework (SCF) initiative. The Ministry of Business, Innovation and Employment (MBIE) was charged with implementing the initiative to improve government agency contracting with NGOs.
- As part of the streamlined contracting initiative, MBIE recognised the need to build sector capability in RBA. MBIE sponsored RBA introductory and advanced training for mainly government agency employees. Trainees valued the opportunity to learn about the methodology and reported improved skills, knowledge and learning outcomes.
- Between 2013-2016, approximately 65% of government agency contracts with NGOs were transitioned into the streamlined contracting framework. If agencies adopted the standard streamlined contracting templates, they would have used RBA as part of contract development.

- Based on several examples of how RBA has been used to inform the development of contracts (both streamlined and commissioning for Whānau Ora), these stakeholders have customised their contracting approach to be more:
    - outcomes or wellbeing focused
    - inclusive of the provider and whānau 'voice'
    - focused on the potential to use data to drive contract management feedback loops and performance conversations
    - able to understand the contribution relationships between client and population outcomes
    - focused on individual and family/whānau wellbeing
    - inclusive of a common language
    - able to recognise the value of Māori and community concepts of wellbeing
    - able to develop a consistent approach to outcomes-based contracting within agencies and the wider social sector.
- However, whole-of-agency adoption has not occurred and there are signs that some agencies are starting to adapt the streamlined contracting approach. This may detract from the original intent of the project supporting a consistent and high-quality approach to outcomes-focused contracting using a common language and tools.
- This situation has been somewhat enabled by recent sector restructuring (which has led to loss of institutional knowledge gained during the streamlined contracting project led by MBIE), and the loss of a cross-agency, streamlined contracting project leadership group.
- Nevertheless, Agency agreements to implement the streamlined contracting templates are still in place[22].

Current examples of RBA use in New Zealand by NGOs, government funders, commissioning agencies and iwi

- Multiple organisations shared examples of how they currently practice RBA and supplied data for this report.
- Examples of data supplied ranged from disability, mental health, well child and oral health services through to whānau ora, child public health promotion, youth justice, education, chronic disease management, Pacific health gain and youth sexual health.
- All stakeholders who shared their RBA examples (some of whom were 'beginners' and some more advanced), strived to use their data to inform decision-making about what works and how to fund and/or deliver more effective services for increased wellbeing.

Perceived advantages and disadvantages of using RBA

- Stakeholder views of the advantages of using RBA outweighed perceived disadvantages. Notable advantages included:
    - clarifying accountability between population and client outcomes
    - building capability in outcomes thinking and practice
    - promoting overarching consistency of approach whilst enabling flexibility
    - supporting better relationships through clarity of expectations and a common language
    - respecting all stakeholder expertise in the outcomes thinking process

[22] Personal communication with Justine Falconer, MBIE, 18 September 2017.

    - supporting cultural imperatives in outcomes design (including recognising individual and whānau wellbeing)
    - promoting the use of data to inform decision-making.
- Disadvantages discussed by stakeholders were mainly associated with barriers to good quality implementation.
- Barriers to good quality implementation ranged from lack of buy-in and internal capability to implement RBA through to continued inconsistencies of approach across the sector, difficulties with data collection; reporting challenges; and lack of strong leadership to support implementation.
- Suggested disadvantages linked to the RBA framework ranged from the complexity of the model through to too much focus on quantitative data.

RBA can support better contracting

- The positive differences between the pre-Streamlined Contracting Framework ('standard') and post-Streamlined Contracting Framework (which was RBA informed) included:
    - a more common outcomes approach
    - transparency of cross-government systems barriers (e.g. data management)
    - a move towards a common language
    - a more inclusive approach to designing contractual performance measures
    - a focus on outcomes
    - a focus on using data to drive performance
    - an opportunity to design new data that better reflects client-centred outcomes
    - more transparency about who are the clients of services.
- Stakeholders confirmed that RBA supports the use of multiple feedback loops in the commissioning process. Whilst stakeholders valued this in principle, in practice there was a mixed response to how agencies used data to inform their commissioning cycle. In short, practice was varied.

Room to improve use of integrated datasets and RBA

- With respect to integrated datasets from Statistics NZ, government agency stakeholders interviewed confirmed that they had not yet accessed the datasets to inform the use of RBA. This was also the case with respect to NGO stakeholders.
- However, all stakeholders were interested in how best to use these datasets to inform better use of RBA.

3.2. Literature about RBA use, enablers and barriers

3.2.1. International literature findings

In 2005, Penna and Phillips from Harvard University reviewed eight outcome models[23]. Four models were judged appropriate for programme planning and management: Logic Model, Outcome Funding Framework, Targeting Outcomes of Programs, and RBA. The authors suggested RBA was the best model for multiple uses such as programme/agency improvement plans and budgets; grant-making;

[23] Penna, R. and Phillips, W. (2005) Eight Outcome Models, Evaluation Exchange, Harvard Family Research Project, Volume XI, No. 2, Summer 2005 (accessed online at http://www.hfrp.org/evaluation/the-evaluation-exchange/issue-archive/evaluation-methodology/eight-outcome-models, on 15 August 2017).

project planning and start-up; development of community report cards and evaluation design. The authors also suggested that RBA had the following strengths:

- A thorough system for planning community-change efforts and improvement in programme, agency or system performance
- Use of lay language encourages ease of understanding
- Can provide a direct link to budgeting
- Useful for integrating different outcome systems.

These strengths have been demonstrated by some leading international examples of 'best practice' RBA use:

- **Leeds Child Friendly City**: http://www.leeds.gov.uk/childfriendlyleeds/Pages/How-are-we-doing.aspx. The former Director, Sir Nigel Richardson, adopted RBA as a strategic, change management and measurement framework. Leeds City achieved outstanding results including: reducing the number of children being looked after by the government, reducing the number of YNEET, reducing primary and secondary school absence.
- **Promise Neighborhoods:** http://www.promiseneighborhoodsinstitute.org/. The Director, Dr Michael McAfee, adopted RBA as a part of their approach to Collective Impact. Serving over 200,000 children, results include improved readiness to succeed in school, increased student proficiency in core academic subjects, successful transitions between school grades, improved high school graduation rates and may others. Dr McAfee often speaks internationally about the power of RBA and its ability to support addressing large-scale, complex social issues.
- **Salt Lake County Criminal Justice Services** – this initiative improved pretrial supervision efficiency by 81%[24].
- **Baltimore City Department of Social Services** – this initiative safely reduced the number of children in foster care by 70%.
- **Connecticut Department of Children and Families** – this initiative safely increased the number of children in family care by 57%.
- **Alan Richens Unit (Epilepsy Unit)** – this initiative increased the percentage of seizure patients seeing a specialist within two weeks by 26%.
- **United Way of Central Iowa** – this initiative helped increase the Des Moines high school graduation rate by 17%.

RBA has been applied at scale and at systems levels. Recently, Ahn et al (2017)[25] reviewed the effectiveness of a new quality assurance and continuous quality improvement (CQI) model for the state of Maryland, USA. The objective of the review was to understand the new CQI model and if it contributed to measuring the quality, including the impact, of child welfare practices.

By way of background, the US Department of Health and Human Services (DHHS) reviews state child and family programmes. The Departments, Children's Bureau, oversees child and family service

[24] See: https://app.resultsscorecard.com/SuccessStories/Network for more detail on the Salt Lake City and other examples up to United Way of Central Iowa.

[25] Ahn, H.; Carter, L.M.; Reiman, S.; and Hartzel, S. (2017) *Development of a Quality Assurance Continuous Quality Improvement (CQI) Model in Public Child Welfare Systems*, Journal of Public Child Welfare, 11:2, 166-189.

reviews which evaluate state-wide best practice and the delivery (or not) of family and child outcomes. States are legislatively mandated to adopt DHHS guidelines and subsequently, have developed their own revised CQI approaches to align with the same.

In Maryland, a new approach to the CQI management system was developed in 2012. The State adopted RBA as part of its approach. Its CQI model used quantitative data to measure and evaluate impact and qualitative data linked to RBA's 7 Questions. Data was gathered and used at both population and performance accountability levels. The implementation approach was very comprehensive. It included a regular mix of self-assessment, case reviews, on-site reviews, findings reports and continuous improvement plans. The state-wide implementation was also supported by multiple partnerships at state and local jurisdiction levels, with the education sector (the University of Maryland), providers, practitioners, families and children.

The authors concluded that positive outcomes occurred since the implementation of the CQI model. They stated that the model "contributed to a greater understanding and use of data across the state as a result of collaboration with local leadership" (p. 183). This was a core benefit associated with RBA.

In an opinion piece, Epps (2017)[26] summarised best practice use of RBA in the Early Childhood Education area. She outlined practical steps to implement RBA from population to performance accountability. Her key messages were 'keep it simple' by tracking the 'vital few' set of headline data and to use an inclusive approach that brings together relevant partners. With respect to using RBA at a systems level, she stated that:

> "Once strategies have been selected, they are implemented through programs and agencies. The early childhood service system includes the agencies and programs that serve children and families with the intent to improve the wellbeing of these individuals ….this work can be measured and tracked using the three questions of performance accountability ….some measures may be unique at the program and agency level. At the service system level, early childhood partner agencies can work together to determine the most important performance measures that they have in common." (p.7).

The value of RBA at a systems level, is that it encourages multiple partners to understand and combine their efforts for a common purpose. It also encourages partners to understand their ability to influence outcomes for a common set of clients. Ms Epps proved the effective use of RBA in an early childhood education system in the USA. She was the former director of the Baltimore School Readiness Initiative. This initiative comprised city-wide partners and contributed to improving kindergarten readiness from 27% to 58% over four years using RBA.

Hulsey et al (2015)[27] conducted in-depth case studies of five Promise Neighbourhoods to understand and document implementation successes and challenges. The report was designed to inform continuous improvement of the programme. Promise Neighbourhoods is a flagship initiative funded by the US Department of Education. It has provided nearly $100m of funding to non-profit organisations. Promise Neighbourhoods aim to mitigate poverty by building a 'cradle to career' continuum that support children to succeed. Promise Neighbourhoods adopted RBA as a core part of its infrastructure.

[26] Epps, D. (2017) Achieving measurable results for early childhood clients and communities, Australian Educational Leader, Vol 39. No.2, Ju 2017: 6-8.
[27] Hulsey, L.; Esposito, A.M.; Boler, K. and Osborn, S. (2015) Promise Neighborhoods Case Studies. Sourced online at

The study found that one of the success factors was a robust results framework with shared accountability. With respect to this issue, they stated that:

> "Rigorous use of data to assess progress toward targeted outcomes supports continuous improvement and shared accountability. The case study sites have found that training in Results-Based Accountability™, which [is] provided as part of the national system of supports, facilitates effective use of data." (p.11).

In Australia, Adult Learning Australia Ltd commissioned independent research about the merits of RBA and its use by Adult and Community Education (ACE) providers[28]. This research was a national project, funded by the Federal Department of Education and Training. The authors conducted three case studies of ACE providers who used RBA to in relation to non-formal learning programmes.

The authors found that RBA appeared to have merit as a framework to produce robust evidence about client outcomes, that it was used as a continuous improvement programme, and it was also used to inform funders about programme effectiveness (p.5). They commented that RBA was best implemented using an action learning approach as 'it is through the doing of RBA that the process starts to gel for staff' (p.5). Finally, they stated that successful RBA implementation was aided by a support programme that involved training, assistance, troubleshooting support, knowledge that it 'takes time' and a champion.

In Wales, Thomas (2011)[29], the use of RBA was evaluated linked to three demonstrator projects on chronic conditions management. The purpose of the evaluation was to obtain feedback on the RBA method and its effective deployment (or not). Using survey and focused-group methods of over 100 stakeholders who used RBA as part of the demonstrator projects (excluding clients with chronic conditions), the evaluators stated:

> "Overall, interviewees are very positive about the impact that RBA can have on the delivery of services and outcomes for communities, and feel the approach:
>
> - Is ground-breaking - most stakeholders feel they did not have an approach to measuring outcomes prior to RBA
> - Is inclusive – it encourages everybody to get involved and avoids the 'top down' approach
> - Adopts common methods and language – it uses plain language and adopts common sense methods that everyone can understand
> - Provides impact outcomes – RBA focuses on how service users or communities are better off when the service/s works the way it should
> - Results in an end product – it provides step-by-step processes to enable partners to get from talk to action quickly
> - Is motivating - the approach can be very motivating for practitioners who have access to data that indicates the impact of what they are doing." (pp.4-5)

The evaluators noted barriers to implementation including the complex nature of RBA, lack of experience using RBA, the time required to implement the framework in addition to the day-to-day

[28] Adult Learning Australia Ltd (2016) The ACE Sector & Results Based Accountability (Adult Learning Australia Ltd: Australia). Accessed online at https://ala.asn.au/wp-content/uploads/2011/02/RBA-ACE-Report-Final-Digital.pdf. February 2018.

[29] Thomas, C. (2011) Chronic Condition Management Demonstrators Evaluation Report, Evaluation of Results Based Accountability, May 2011. Accessed at http://resultsaccountability.com/wp-content/uploads/2014/03/Evaluation-of-RBA-May-2011.pdf. December 2017.

work, that implementation seems to be more difficult in larger organisations, that booster training is required, standardisation of data collection was an issue, and that it is easier to measure and track client outcomes compared to population outcomes. The evaluators commented that experienced facilitation is required when implementing population accountability and that inclusivity is an enabler of good RBA use (e.g. enabling patient/service users and managers/practitioners to be involved at multiple levels).

To facilitate sharing of best practice, an international Community of Practice, with strong New Zealand leadership, has emerged. Since 2013, there has been New Zealand speakers at successive international RBA conferences:

- **Johannesburg, South Africa** - RBA Africa Summit (2014):http://rba-africa.com/. From MSD: Sheridan Waitai. From Shea Pita & Associates: Sharon Shea.
- **Sydney, Australia** - RBA Australia Summit (2015): http://rba-australia.com/. From Te Kaha o Te Rangatahi Trust: Natasha Kemp and Te Ao Tanaki; from MOE: Shelley Hancock; Formerly from MBIE: Malcolm Morrison; from MOH: Adrienne Percy. From Shea Pita & Associates: Sharon Shea and Stacey McGregor.
- **Belfast, Northern Ireland** - Outcomes and Impact Summit (2016): http://outcomesandimpact.com/. From Te Pūtahitanga o Te Waipounamu: Maania Farrar; from Puawaitanga ki Otautahi: Alison Bourn.
- **San Antonio, Texas, USA** – November 2018. From MASH Trust: Rodger McLeod.

At all conferences, the New Zealand presentations have been acknowledged as of high quality and informative for international best practice[30].

3.2.2. New Zealand literature findings

Several New Zealand authors have commented on RBA implementation. Weir and Watts (2013)[31] evaluated the impact of RBA on Presbyterian Support Northern's (PSN) culture and performance. Impact Research NZ (Dr Weir) used a participatory action research, mixed methods approach to investigate changes that occurred to the organisational culture as a result of RBA, and whether service performance had improved.

Using a mix of focus groups, surveys, documentation and communications channel analyses, the authors found that RBA was a "change agent for service improvement and for demonstrating desired client outcomes" (p.18). The evaluators found increased staff engagement with RBA processes, staff using data and information sourced from RBA to actively improve client outcomes and a transition from staff seeing use as compliance, to use as a way to improve client wellbeing. The authors also stated that:

> "One of the most significant changes for the organisation since implementing RBA has been in how it reports to funders on client outcomes. RBA outcomes have been used to enhance the credibility of and reputation of PSN with their donor community, to attract more funding, and in the wider social services sector." (p.18).

Lessons learnt for successful RBA implementation included: dedicated communications about the purpose, role and use of RBA , staff training/coaching, a continued focus and leadership at multiple levels, recognition of staff workloads, realising the impact of staff turnover and building this into

[30] Personal communication with Adam Leucking, CEO, Clear Impact, USA on 19 September 2017.
[31] Weir, A. and Watts, R. (2013) Results-Based Accountability – Evaluating program outcomes in a social services organisation in New Zealand, Evaluation of Journal of Australia. Vol. 13. No.2. 2013. Pp13-19.

ongoing implementation planning and recognition that investment is required to support implementation.

Bridgman and Dyer (2016)[32] used RBA to evaluate an initiative called Toddler Day Out between 2014-2015. This initiative was delivered by Violence Free Communities, a community development organisation that has been implementing violence-prevention, resilience and community capacity building initiatives in West Auckland for 18 years. The evaluators used RBA and suggested that:

> "….using performance and population measures, justifies a large-scale research project investigating the promising, initial indicators of the [events] effectiveness in creating non-violent communities." (p.20)

The evaluators stated that attendees at the Toddler Day Out achieved improved knowledge outcomes, by obtaining useful information about multiple subjects. These subjects included, for example, how to play with children, how to manage difficult behaviour, how to access community activities.

The evaluators noted that whilst the knowledge gain outcomes may be 'transitory', there was also evidence to suggest that of those people who returned to the event within one year, 77% stated that they had made positive changes to their caregiving or parenting because of knowledge gained the year before. Examples of behavioural changes included enabling their children to engage in sport, dance or swimming; positive parenting; enrolling in ECE services; addressing home safety issues and a greater sense of family, cultural and community connectedness. The evaluator's extrapolated behavioural change outcomes data to estimate the number of people affected and stated that:

> "…for some issues, [this represented] thousands of people making positive changes in their lives." (p.27) [33]

In a recent article, Appleton-Dyer and Field (2017)[34] outlined how they used developmental evaluation, supported by Results-Based Accountability, to build provider capability and evaluate a range of community projects in New Zealand. The evaluators were contracted by MSD to work with a range of short-term community projects. These projects focused on anti-bullying and the exclusion of disabled people.

The evaluators stated that:

> "RBA provided a simple framework to guide community projects in identifying key indicators to understand the implementation and achievements of their work [….]developmental evaluation enabled an expansion of the RBA framework that supported the projects to recognise and acknowledge the complexity and contexts that they were working in." (p.123)

Section 3 outlines some practical examples of how RBA has been used in New Zealand by a variety of stakeholders to measure population and/or client outcomes. Some of which have been independently evaluated.

[32] Bridgman, G. and Dyer, E. (2016) using Results Based Accountability to Show Progress in a Long-Term Community Project. Whanake: The Pacific Journal of Community Development, 2(1), 19-38.
[33] Note that this statement was qualified.
[34] Appleton-Dyer, S. and Field, A (2017) Accountability and development? Supporting provider led evaluation of short-term community social change projects. Evaluation Matters – He Take To Aromatawai, 3:2017. Accessed online: http://www.nzcer.org.nz/system/files/journals/evaluation-maters/downloads/EM2017_3_100.pdf. March 2018.

3.3. The origins and context of RBA in the New Zealand government sector

3.3.1. History of RBA use by the Government

The origins of RBA in New Zealand began with a chance meeting in London between Mark Friedman (the author of RBA) and Richard Wood (the former Deputy Chief Executive, Family and Community Services, Ministry of Social Development):

> "The beginning of RBA in New Zealand actually occurred at the Women's Union Building on Great Smith Street in London. Richard Wood was visiting senior officials in the national government and was invited by a colleague to attend the RBA 101 session I was presenting that day. He came up to talk with me afterwards and we exchanged contact information." Mark Friedman, 2017[35]

In April 2006, Mark Friedman was invited to deliver training to the Ministry of Social Development. Friedman's work began with MSD but quickly spread to working with other Ministries (e.g. the Ministry of Health, the Ministry of Education), local councils and not-for-profit organizations, including, many Whānau Ora collectives.

Between 2006-2012, the RBA framework was adopted by multiple NGOs, some iwi and other organisations regardless of whether it was used by government agencies. The framework seemed to resonate with stakeholders due to its simplicity, its ease of use and its ability to support self-defined measures of individual and family client wellbeing.

In 2009, the then Minister of Social Development (Hon. Paula Bennett) supported MSD to lead a new approach to outcomes-based contracting called High Trust contracting (sometimes referred to as Integrated Contracting)[36]. This contracting approach adopted the principles of RBA and was designed to simplify the contracting process and to make it more outcomes-focused. The new approach was also designed to honour the fact that providers knew their communities better than funders. Overall, the contracts sought to:

> "recognise the trust built up over time between organisations, and the quality of that relationship; use simple but effective contracting processes to support and capitalise on the strengths and benefits of high trust relationships; have less detailed funding agreements; provide upfront funding and require reporting only once a year[37]."

Between 2010-2013, Te Puni Kōkiri (TPK) adopted RBA as part of its initial roll-out of Whānau Ora. This involved developing a national client outcomes framework and supporting Whānau Ora Collectives to report using RBA designed data.

In 2012, Cabinet directed MBIE to lead a project called Streamlined Contracting (also known as SCF – Streamlined Contracting Framework). The term of the project was from 2013-2016. RBA was adopted as the preferred outcomes methodology in the contracting framework.

[35] Personal communication with Sharon Shea, 14 September 2017.
[36] Source: https://www.beehive.govt.nz/release/contracting-overhaul-social-services-sector. Accessed 10 September 2017.
[37] Source: https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/annual-report/2009-10/communities-are-better-able-to-support-themselves.html. Accessed 10 September 2017.

At present, the use of RBA continues in New Zealand. The approach continues to resonate with former and new users.

3.3.2. RBA and Streamlined Contracting

The SCF was introduced between 2013-2016. The overarching objective of SCF was to implement a consistent outcomes-focused contracting approach across government agencies and to streamline the contract management process. A new suite of contract and contract management tools and templates were designed. Agencies were supported to adopt the same. Support included training and high-level advice.

The main genesis for adopting RBA came from a pilot phase in 2012, when pilot NGOs recommended RBA to MBIE as a user-friendly and understandable framework[38]. Apart from MSD, for many agencies, RBA was completely new.

The framework comprised the following:

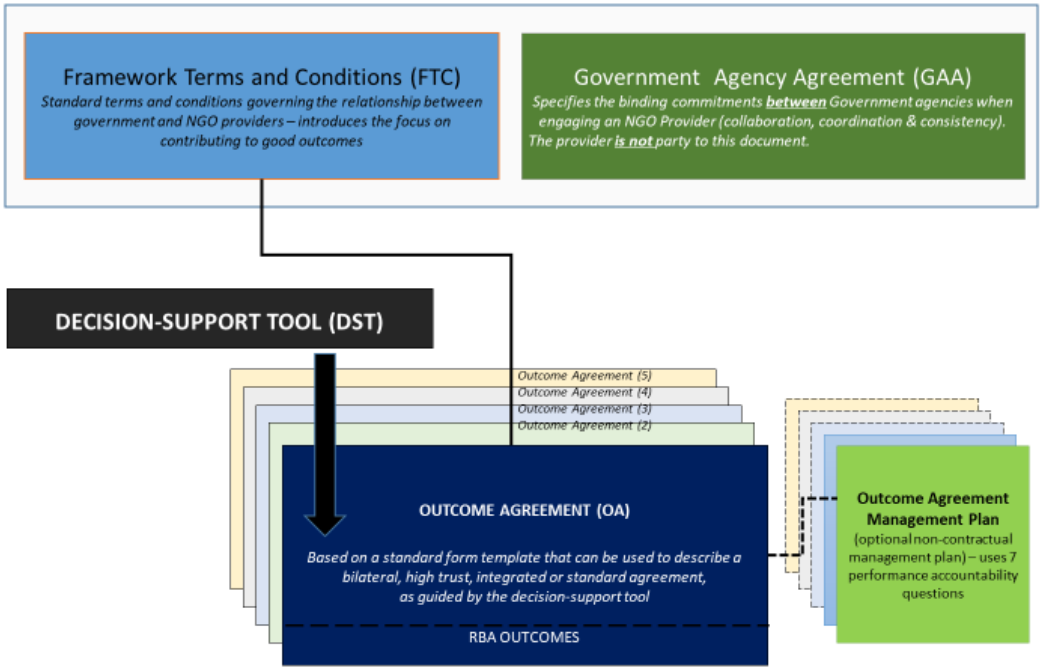

Figure 5: Streamlined contracting framework

The core documents were:

- **Standard terms and conditions** – for use by all government agencies
- **GAA** – cross-government agency agreement that commits agencies to work together to improve the contracting process
- **DST** – a decision support tool which supports a common framework to assess risk and make contracting decisions
- **OA** – a common outcomes agreement, which incorporates RBA

[38] Personal communication with Malcolm Morrison in 2013 and reconfirmed August 2017.

- **OAMP** – an outcomes agreement management plan, which incorporates RBA and guidance about how to use the 7 questions to inform outcomes-based conversations.

Customised RBA and SCF training was provided to agencies. Agencies were then expected to consistently apply the SCF documentation.

As part of the transition process, agencies were asked to submit 'transition plans'. They were also asked to establish a dedicated in-house Streamlined Contract Project Manager role or equivalent. This role was designed to support in-house implementation and the best use of RBA in the streamlined contracting process.

The explicit use of RBA in original SCF outcomes agreements was mandatory but was optional in the Outcomes Agreement Management Plan, as per the figure below:

RBA concept	Outcome Agreement	Outcome Agreement Management Plan
Population Outcome	✓ Appendix 1	
Indicator	Optional (and recommended)	Optional (and recommended)
Performance measures (baselines) – client outcomes	✓ Appendix 1 Appendix 3 (Reporting)	Optional (and recommended)
Story behind the baselines	Part of 7 questions to turn the curve	Optional (and recommended)
Partners		Optional (and recommended)
What works		Optional (and recommended)
Strategy & Action Plan		Optional (and recommended)

Figure 6: RBA in SCF documents

In theory, this meant that all streamline contracts should have included:

- A population outcome statement
- Performance measures for client outputs and outcomes
- Use of four of the seven questions including: the story (causal factors), partners, what works and action planning.

MBIE also supported agencies who were contracting with common providers, to join up and trial an integrated or multi-lateral streamlined contract. This included joint contract negotiation and a common OAMP. There is no readily available data about how many integrated streamlined contracts were developed and/or remain in place.

MBIE did not provide intensive 'hands-on' support within agencies to practically transition existing contracts into the new framework. In practice, how agencies designed the outcomes frameworks, its content and final data sets were up to each agency. The main caveat was that agencies needed to use the SCF templates.

During its three-year term, the MBIE SCF project had four project managers. The initial project manager and SCF architect was Malcolm Morrison. He departed MBIE in November 2014. The last project manager was Justine Falconer.

RBA training sponsored by MBIE

A core part of the SCF roll-out was the provision of RBA training. The majority of RBA training was conducted during mid-2014 to mid-2016. In total, approximately 1,000 people were trained, including people from government agencies and providers. The bulk of trainees were from government agencies.

The main training course was RBA101 (a 1-day course that offered introductory level understanding of the framework). A small number of people (circa 50) completed advanced training (Train the Trainer and Train the Facilitator). Some of the training events were based on half-day introduction sessions to RBA, which were 2-3 hours in duration only. Training was delivered by Shea Pita & Associates Ltd.

A snapshot of learning outcomes data sourced from trainee evaluations is outlined below. Trainees were asked to confirm if they agreed or disagreed with a range of skills, knowledge and attitudinal questions[39]:

Learning outcome	MBIE Provider RBA Training Courses (2015-2016)	MBIE RBA101 Training Courses	Total
	% (agreed or totally agreed)	% (agreed or totally agreed)	Average % (based on actual numerators & denominators)
"I know the difference between population and performance accountability"	99.15 (235/237)	99.29 (423/426)	99.2
"I know the difference between an indicator and a performance measure"	93.62 (220/235)	94.82 (403/425)	94.3
"I understand the difference between the two sets of 7 questions for whole populations and client groups"	90.68 (214/236)	89.16(378/424)	89.6
"I feel confident that I can explain the 2-3-7 basics to a colleague"	75.21 (176/234)	76.53 (326/426)	76.0

Table 1: RBA trainee learning outcomes

The majority of narrative feedback was very positive about the training and the framework. Example positive feedback included (outlined in verbatim below):

> *"The facilitator was fantastic; clear, listened carefully to questions and answered them simply and precisely. Really helpful when we were doing the exercises, polite and respectful. She really knows what she is talking about and not too technical, warm and funny."*
>
> MBIE Provider RBA Training, 16 May 2016.
>
> *"Ka nui nga mihi ki te kaiarahi o tinea kaupapa! Totally impressive!"*
>
> MBIE Provider RBA Training, 16 May 2016.

[39] A five-point Likert scale was used from totally disagreed to totally agreed.

"Great introduction to RBA and the need to work together with funders to co-design any performance measures."

MBIE Provider RBA Training, 18 June 2016.

"RBA trainer made RBA very simple to understand. Thoroughly enjoyable especially being someone unfamiliar accountability reporting."

MBIE Provider RBA Training, 1 November 2015

"Great workshop facilitation. pace was good. Useful to have key points repeated. Practical example were helpful."

RBA101 Training, 11 May 2016

"Great facilitation, appreciate the one on one time too!"

RBA101 Training, 2 April 2016

"I think I could talk through the steps with colleagues - with your book in hand. Very clear. By the end of the day, great learning curve"

RBA101 Training, 11 December 2015

"Good timing, giving that many of us have an understanding of RBA prior to course. Facilitator read situation well and shifted to meet audience needs. I have learned a couple of new things"

RBA101 Training, 31 August 2015

"Tutor was very knowledgeable. It was great, all CIA's should of attended rather than think they had been to RBA before as this tutor has been the best I have attended in 8 years and about 6 presentations."

RBA101 Training, 31 July 2015

"This was by far one the best workshop that I have attended. Love the fact that what I do contributes to the overall contractual outcomes."

RBA101 Training, 13 August 2014

"Wow, outstanding information. I really enjoyed the presentation. I understood fully, step by step process. I love easy, can do easy.... Thank you, Nga Mihi Korua"

RBA101 Training, 13 August 2014

Not all trainees, felt the training was of a high standard or that RBA was a tool they could use:

"The room was too cold. RBA needs to be a lot simpler if people are going to use it well. At the moment it is complicated and time consuming to use."

MBIE Provider RBA Training, 16 May 2016.

"Measures versus $, what is the intent now? The training would have been more relevant if funders presented and transferred their expectations in light of one-year contract. Which end soon / implementation/ duplication?"

MBIE Provider Training, 8 December 2015

"Group session ran on a bit"

MBIE RBA101 Training, 29 April 2015

"It was a shame there was a little opportunity to talk about the theory in context. There are unique challenges in applying these theory"

MBIE RBA101 Training, 29 October 2014

"Works best as collaborators between providers and funders together in a group."

MBIE RBA101 Training, 13 June 2014

When trainees were asked what follow-on services or supports they might require, the majority stated they would prefer:

- implementation facilitation
- structured peer support networks/communities of practice
- peer review by an advanced RBA practitioner.

The SCF project ended 30 June 2016. Streamlined contracting is now considered business as usual. The streamlined contracting templates, as well as online RBA training, can be accessed on the MBIE website (http://www.procurement.govt.nz/procurement/for-agencies/buying-social-services/results-based-accountabilitytm-rba).

The estimated scale of RBA use in streamlined contracting

The Productivity Commission interviewed MBIE about the SCF project in 2015[40]. MBIE confirmed that by 30 June 2016, around 2250 contracts transitioned to the new framework. This would equate to approximately 60% of government agency contracts with NGOs. Based on information shared for this project, as at 1 July 2016[41], agencies transitioned ~65% of their NGO contracts on to the streamlined contract framework:

Government Agency	Total number of NGO contracts held by the Agency	Total number of NGO Contracts transitioned onto the Streamlined Contracting Framework (includes estimates to 1 July 16)	%
ACC	53	0	0%
Ministry of Social Development (pre Oranga Tamariki)	1985	1957	98.5%
Ministry of Health	~2000	850	42.5%
Ministry of Justice	176	173	98.2%
Ministry of Education	1008	469	46.5%
Department of Corrections	147	43	29%
Ministry for Pacific Peoples	2	1	50%
Total	**5371**	**3493**	**65%**

Table 2: Summary of Agency use of the Streamlined Contracting Framework

According to MBIE, whilst the data in Table 2, shows an estimated conversion rate of non-SCF contracts to SCF contracts, it does not necessarily mean that all contracts incorporated the RBA

[40] Source: http://www.productivity.govt.nz/sites/default/files/social-services-final-report-chapter-12.pdf. Accessed on 1 August 2017.

[41] Data supplied by Justine McFarlane, June 2017. Note that Ministry of Health data was supplied to the Author in August 2017.

methodology[42]. However, if agencies were using the SCF in its purest sense, we can assume that the agency was also using RBA. The SCF data has not been audited.

Shea Pita & Associates knows, through professional engagement and interviews completed for this report, that the following agencies did use RBA as part of its streamlined contracting approaches: Ministry of Health (MOH), Ministry of Social Development (MSD), Ministry of Education (MOE), Ministry of Justice (MOJ), Ministry of Pacific Peoples (MPP) and Department of Corrections (DOC).

There was no readily available information about contract duration. Further validation information could be sourced from agencies.

3.3.3. Developing service contracts using RBA

Stakeholders were asked how they used RBA to develop service contracts. They were also asked how this differed from former approaches. As noted above, most agency stakeholders stated they incorporated RBA by way of the standard SCF transition process.

Six stakeholders provided detailed examples of their contracting processes. We outline below four examples: MOH, ACC, MSD and Te Pūtahitanga o Te Waipounamu.

Between 1 July 2016 to date, most agencies had undergone restructures or their previous in-house SCF project managers had moved on. Some stakeholders stated that restructures and loss of key staff created challenges regarding continued whole-of-agency, high quality adoption of RBA. They also said there was also a gap in terms of supporting, advising and monitoring cross-agency embedding of RBA. This gap was exacerbated by persistent systems barriers (e.g. information systems gaps and the need to build more capability).

Ministry of Health

Between July 2015-June 2016, the Ministry of Health led a dedicated project to transition around $1b worth of contracts into the SCF using RBA. The project lead was Adrienne Percy. Adrienne adopted a proactive approach, that used change management principles, to achieve a large amount of work in a short period of time. The priorities for the Ministry were disability support services (DSS) and public health contracts.

Adrienne established a Streamlined Contracting Unit (SCU), which procured external support for 12 months[43], and incorporated a wide range of internal experts to support the transition process. The internal leadership and management staff were capable and enthusiastic first-movers; who effectively became change champions.

The process flowchart below outlines MOH implementation processes:

[42] Personal communication from Justine McFarlane to Sharon Shea, June 2017.
[43] Expert Procurement Services was the main contractor. EPS sub-contracted Shea Pita & Associates to lead the RBA component, and Malcolm Morrison (EmpowerAS) to support the day-to-day transition from standardised contracting to SCF.

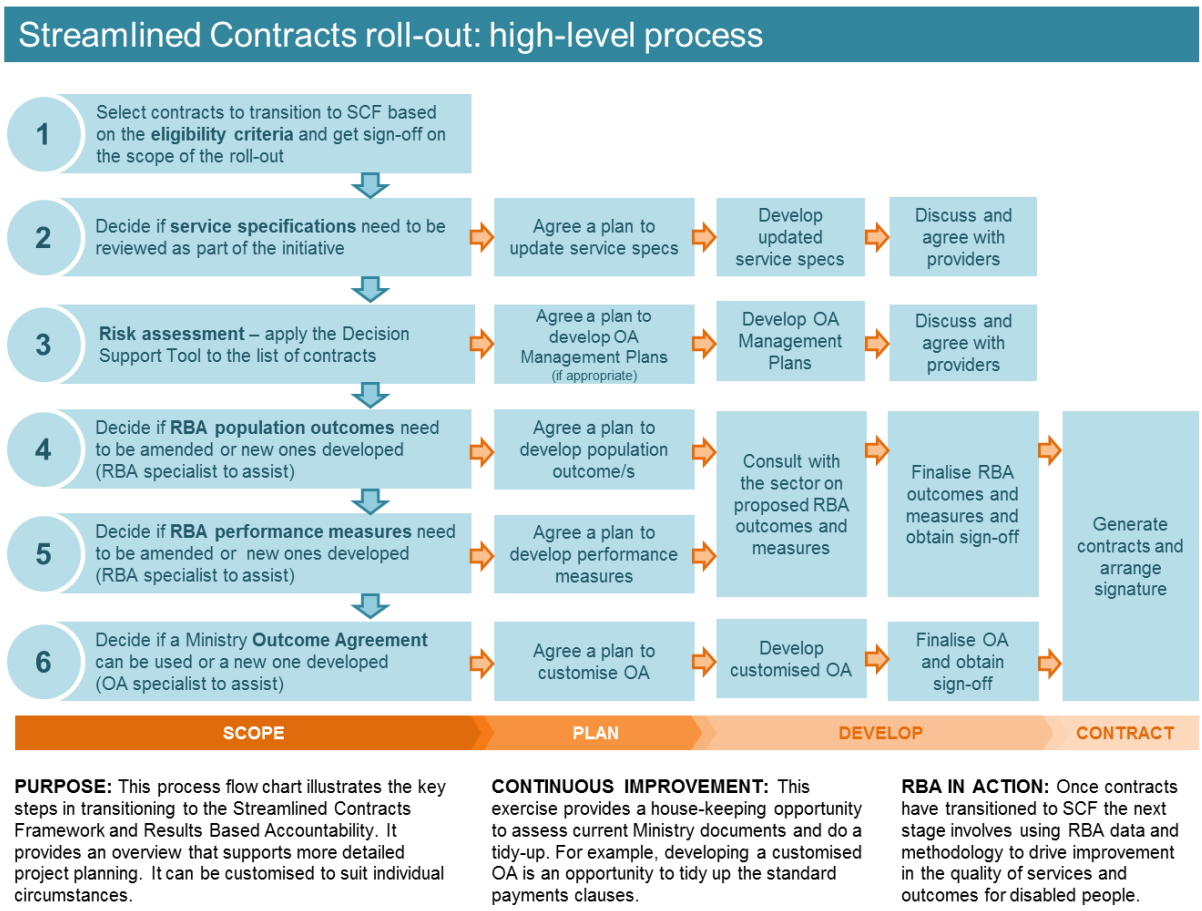

Figure 7: Streamlined contract roll-out: high level process

The Ministry developed other tools and guidelines. Selected examples are outlined below.

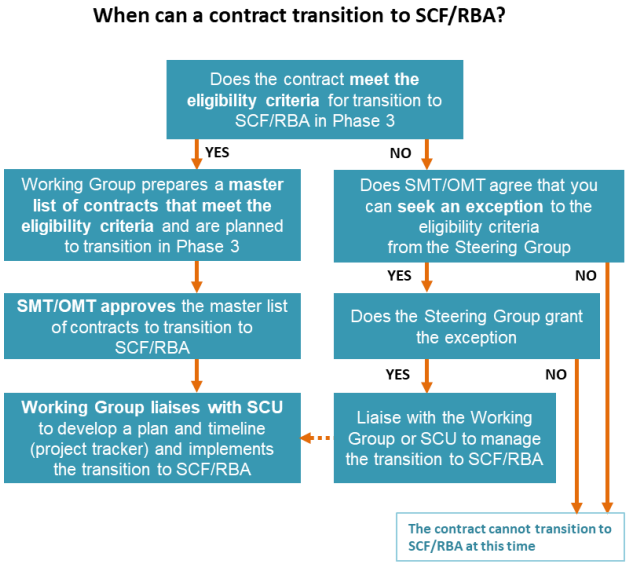

Figure 8: Eligibility criteria to transition contracts to SCF

The above guide supported staff to assess eligibility to transition contracts. The following guide supported staff to assess when to adopt co-design vs. in-house design of performance measurement data:

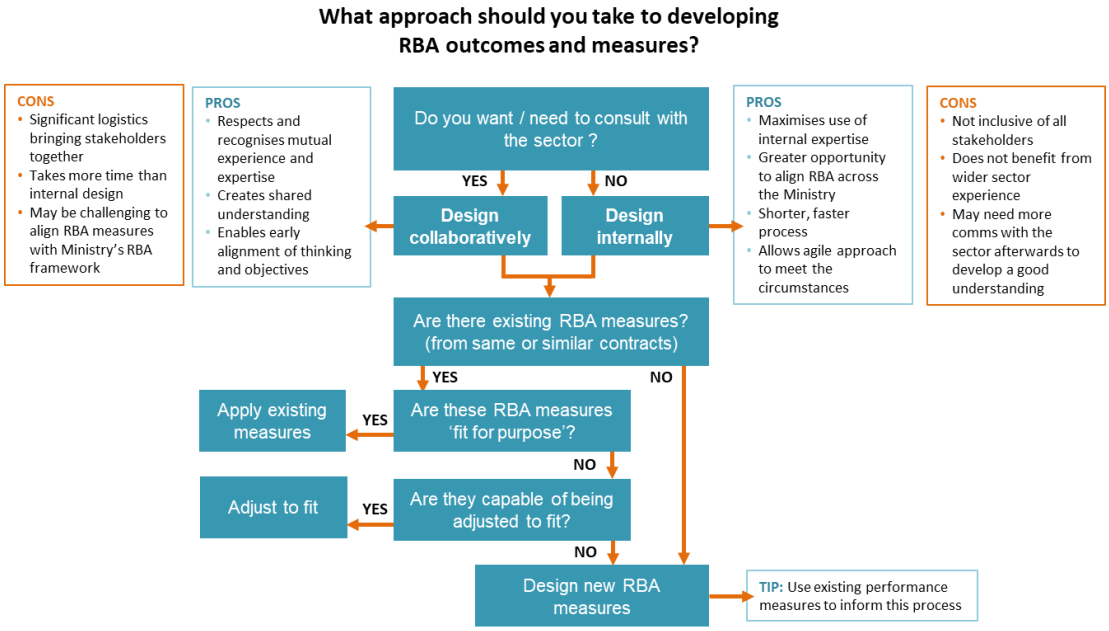

Figure 9: Decision-making tool to understand what approach to use to design RBA measures

The Ministry's approach to implementing RBA was very inclusive. Where possible, the Ministry utilised co-design processes with providers and consumers to develop contractual data sets. The main value of the co-design sessions was: they supported clarifying joint expectations about service intent, delivery and they respected the provider and consumer 'voice'. For example, the Ministry invited 70 providers (and consumers) to a two-day, disability support services co-design workshop in Wellington. This workshop focused on developing both population and client outcomes frameworks. The workshops generated a common population outcomes framework and a standardised set of draft performance measures. The Ministry then consulted with the sector on the SCF and the RBA frameworks. The final contracts went live in 2016.

The following figure provides an overview of how the Ministry saw 'RBA in action'. This stepped diagram supported Ministry staff to understand how RBA could potentially be incorporated and used in practice:

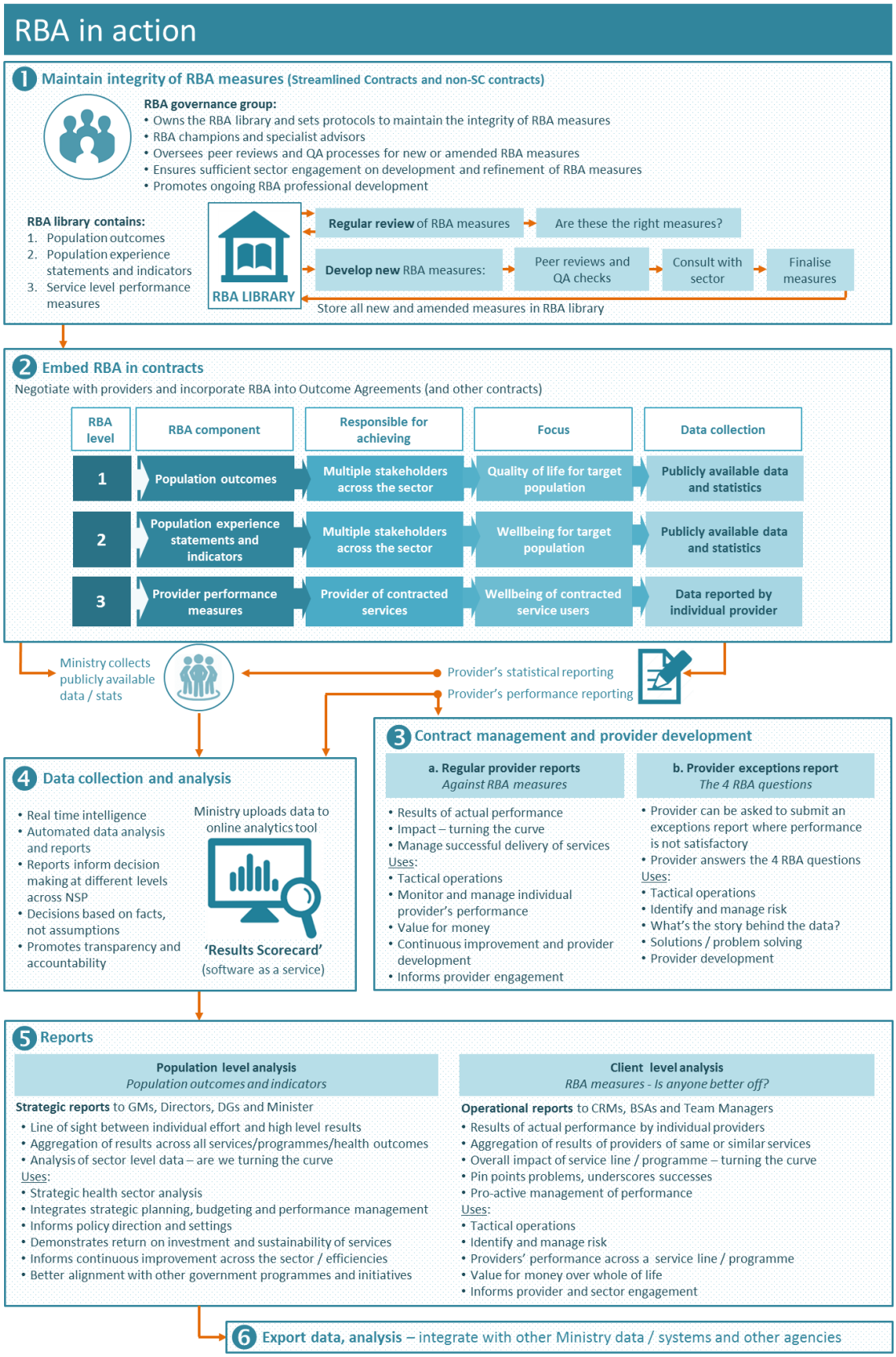

Figure 10: RBA in Action

The notable aspects of this approach are:

- Creating an RBA library of data for consistency across the organisation
- Using Ministry generated, and provider generated data sets to understand the performance story
- Using data and narrative generated by the four RBA questions (these questions are sourced from the 7 questions) to support performance conversations
- Creating scorecards to support best use of data
- Using feedback loops to support decision-making
- Integration of data across the Ministry and with other agencies to support analytics

The Ministry led an internal evaluation of the SCF project[44]. 77% of respondents agreed or strongly agreed that the new outcome agreement/s were of a good quality and fit for purpose. 58% of respondents agreed or strongly agreed that the RBA measures developed were good quality and fit for purpose (19% responded that they did not know/not applicable and 15% disagreed). The evaluation report found that to improve the process moving forward, the Ministry needed to:

- **Build provider readiness and sector engagement –** more needed to be done to support provider readiness for the change including improved knowledge about the frameworks, reporting processes.
- **Improve staff readiness and engagement –** more needed to be done to support and embed the transition so that it was viewed as 'business as usual' and not a short-term or one-off project
- **Strengthen project governance and management –**more emphasis on ensuring the membership had key influencers, lines of accountability were clear, project was sufficiently resourced and project structures were communicated.
- **Improve communications** –both internal and external. Ensuring appropriate communications with stakeholders and staff, in a timely manner, was viewed as critical.

As at 30 June 2016, the Ministry had successfully transitioned around 50% of its contracts using RBA.

Since 2016, the Ministry has been restructured and has adopted a new organisational structure. Adrienne continues to lead streamlined contracting and is supporting the Ministry to use RBA as part of a wider review of the service commissioning approach.

Recent examples of Ministry documentation support continued use of RBA in emerging commissioning platforms:

[44] Report shared with Author by Adrienne Percy.

Figure 11: Commissioning Framework for Mental Health, 2016

Source: Ministry of Health. 2016.

ACC

ACC designed a new approach to purchasing its Disability Support Services called *Living My Life* (LML). The lead ACC Managers were Brian Nevin and Cath Williams.

Between 18-25 October 2016, ACC held four design workshops to gather ideas and intelligence from providers/suppliers/stakeholders/clients/ACC staff about outcomes for LML. Attendees at these workshops received introductory RBA training, and participated in design sessions facilitated by Shea Pita & Associates and ACC.

A distinguishing factor of these co-design workshops was the use of a new RBA co-design approach based on: service principles and first-person narrative. First, the five foundation principles of LML were used to drive outcomes thinking at the workshop:

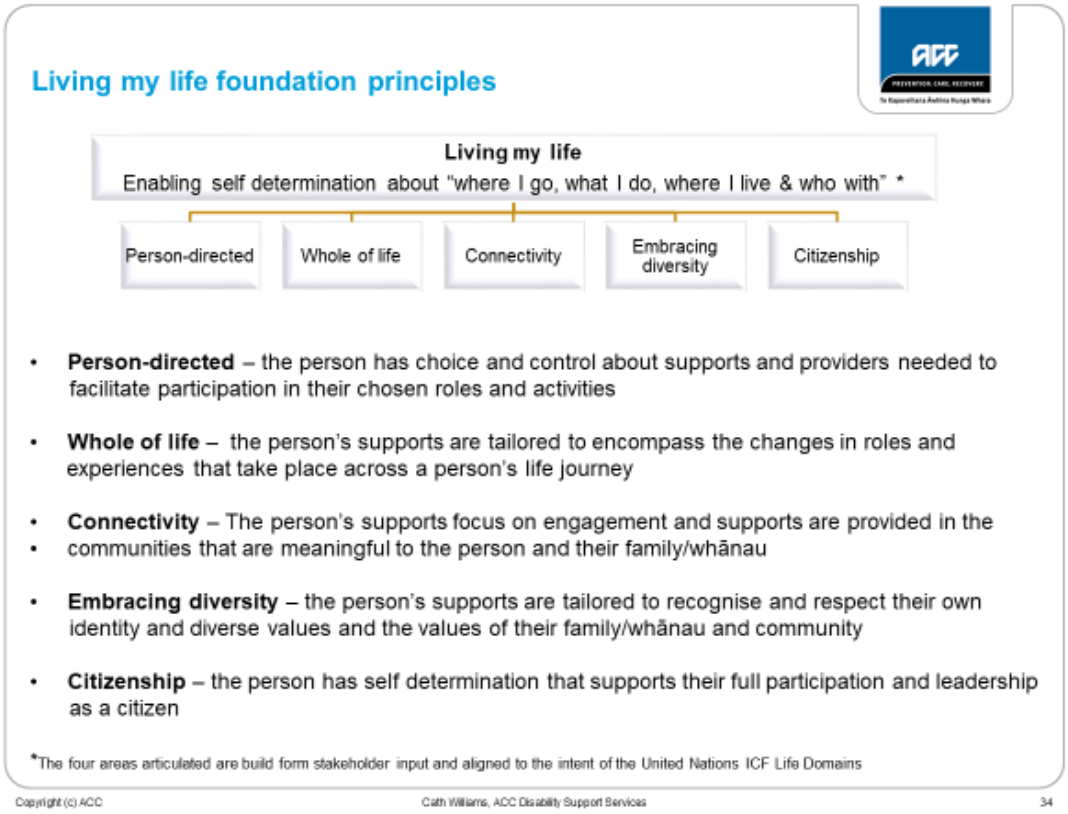

Figure 12: ACC's Living My Life Service Principles

Using the principles as a starting point, workshop participants were then asked to use first-person narrative to define client-centred outcomes. The first-person narrative approach meant that designers were asked to put themselves in the 'shoes' of the client (unless they were already a client) and to brainstorm what client outcomes 'looked like'.

A series of mind maps were designed to reflect the participants thinking. An example mind map for the principle of Connectivity is outlined below:

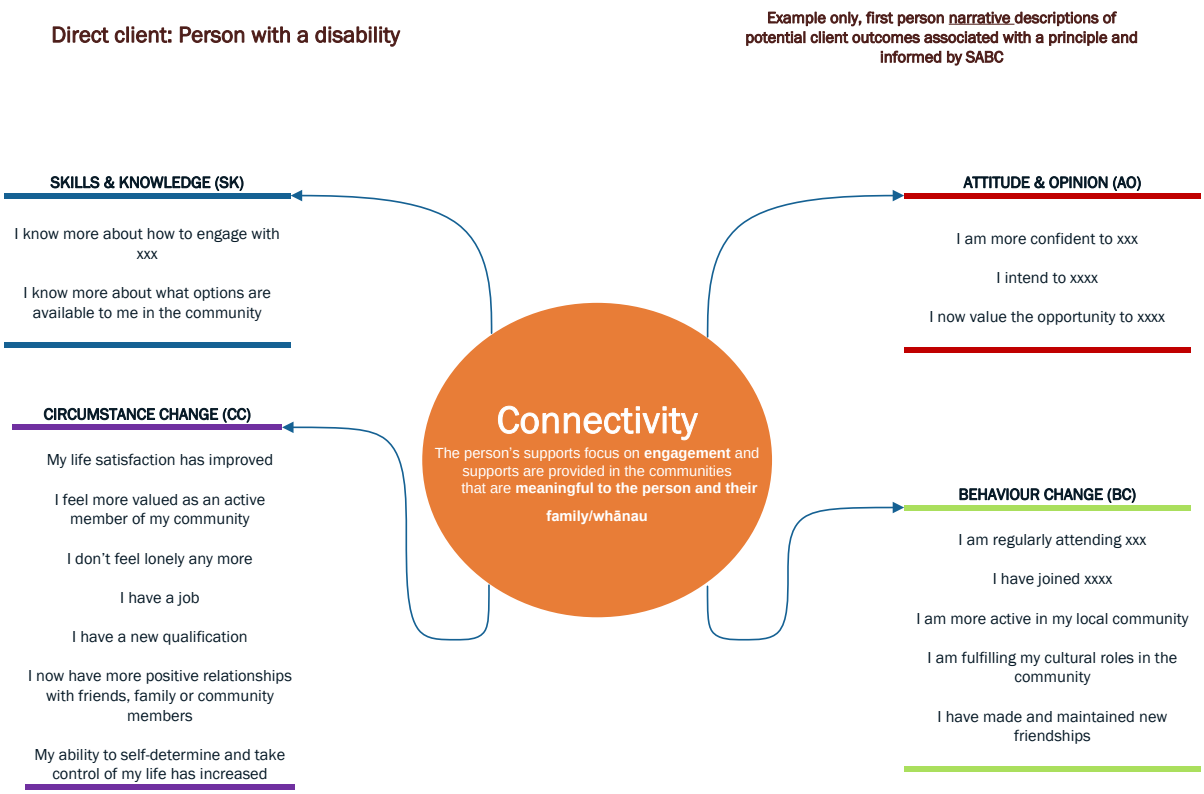

Figure 13: ACC's outcomes mind map to design client outcomes

Once the co-design workshops were completed, ACC finalised the design of the performance measures and the contract. At the time of writing this report, ACC was tendering for these services using RBA as part of the new framework.

Ministry of Social Development

MSD is refreshing its approach to streamlined and outcomes-focused contracting. In 2016-2017, it piloted a new approach called results-based agreements. The figure below outlines the draft commissioning framework. The framework is described as a 'learning system', that includes three phases: preparation; agreement development and delivery and learning:

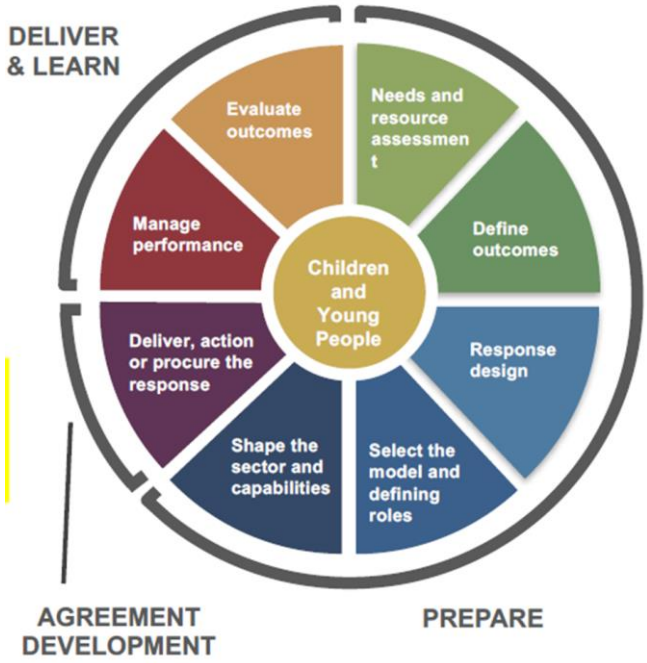

Figure 14: Results based contracting approach piloted by MSD, 2016-2017

To develop the results-based agreements, MSD proposes using the following steps:

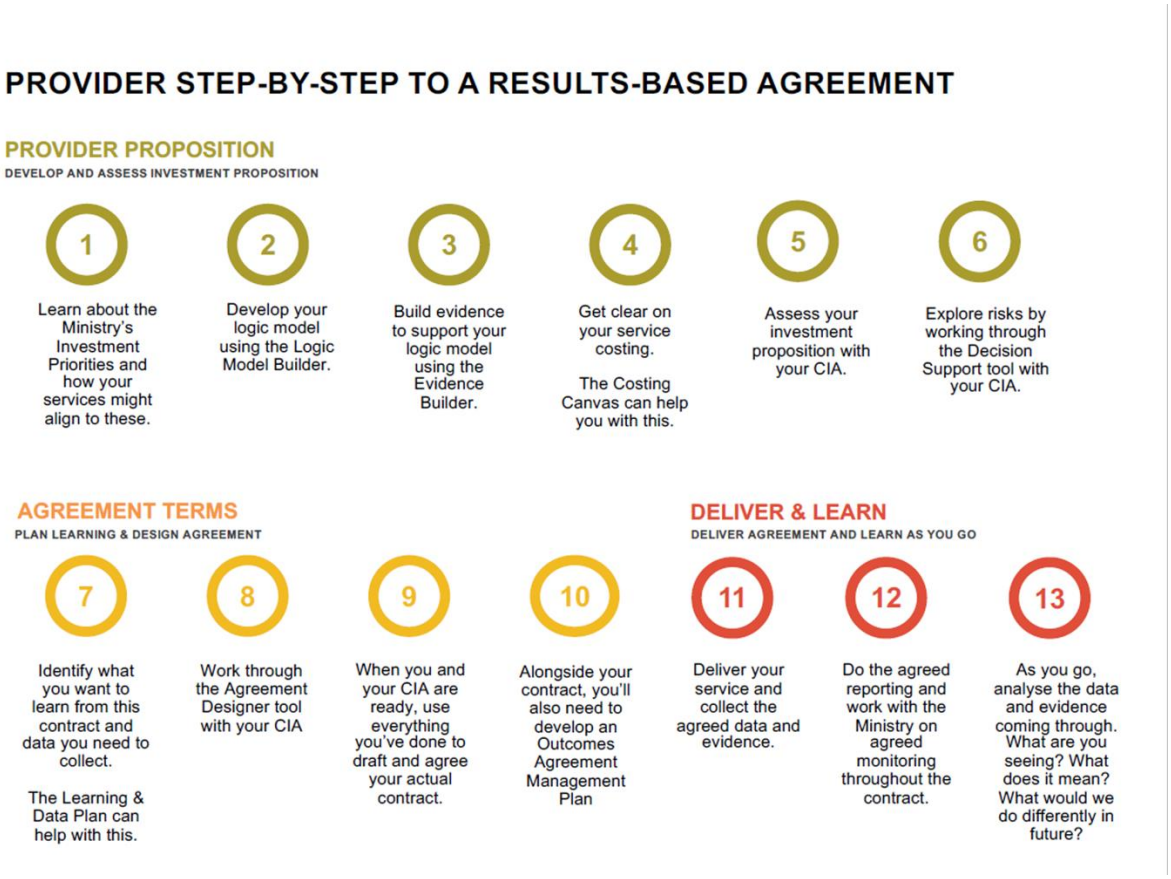

Figure 15: Step by step approach to a results-based agreement

This approach incorporates a hybrid of streamlined contracting, logic model and RBA. Practical application, at this stage, is highly inclusive and based on co-design between the funder and the provider.

According to Gordon McKenzie, (Manager, Manager / Family and Community Services, Safe Strong Families and Communities / Community Partnerships and Programmes), the new approach is progressing within parts of the Ministry[45].

Te Pūtahitanga o Te Waipounamu Commissioning Agency

Te Pūtahitanga o Te Waipounamu (TPOTW) is the Whānau Ora Commissioning Agency for the South Island. It was established in April 2014. TPOTW is unique in that whilst it funds Navigation services, it also funds "local solutions developed by local people with local leadership"[46].

This means that in funding rounds (which are called Waves), TPOTW supports idea-generation from the community to respect community knowledge and innovation. What is fixed however, are the population outcomes and indicators that commissioned initiatives must contribute to:

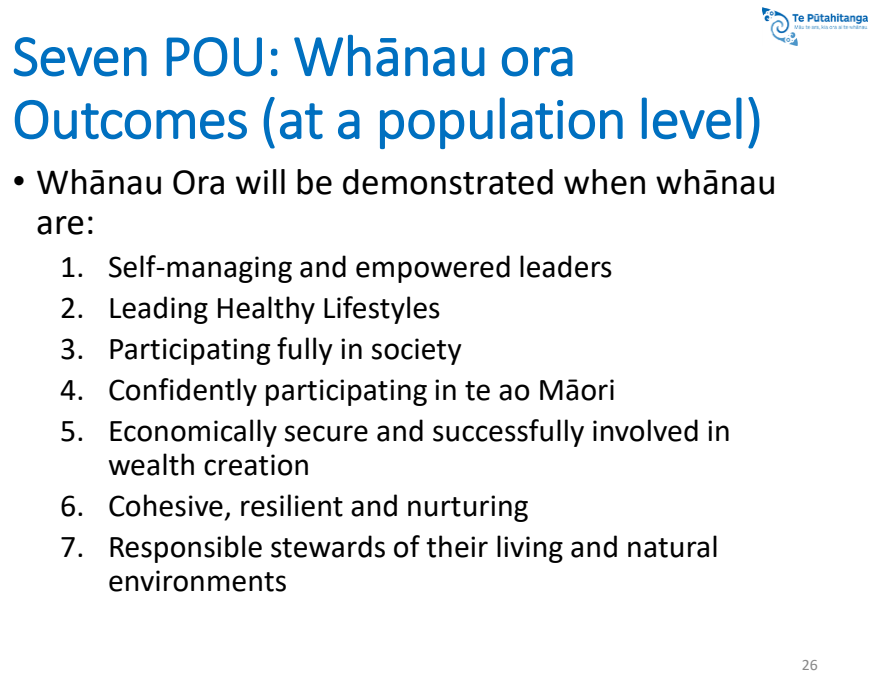

Figure 16: Te Pūtahitanga o Te Waipounamu Population Outcomes Framework

Te Pūtahitanga o Te Waipounamu's population outcomes framework is directly aligned with the governments Whānau Ora Framework entitled "Empowering whānau into the future"[47].

[45] Personal communication with Gordon McKenzie, 18 September 2017.
[46] Source: http://www.teputahitanga.org/what-we-fund. Accessed 18 September 2017.
[47] Source: https://static1.squarespace.com/static/548669c2e4b0e9c86a08b3ca/t/599233d4f14aa1b166579ec5/1502753750641/Wha%CC%84nau-Ora-Outcomes-Framework-approved-by-Whānau-Ora-Partn....pdf. Accessed 18 September 2017.

Since 2015, Te Pūtahitanga o Te Waipounamu have used RBA in their contracts with a wide variety of entities (individuals, new entities, established providers). Te Pūtahitanga o Te Waipounamu chose to adopt a prudent mix of in-house and co-design processes with its Navigators and other contracted entities to design and agree contractual performance measures. In 2015, this included a series of engagements with external parties which included training and discussion about the measures and reporting processes. Successive training has been provided by Te Pūtahitanga o Te Waipounamu up to early 2017.

Te Pūtahitanga o Te Waipounamu have processes to inform how contracts advisors incorporate RBA measures into agreements. This includes using its in-house 'library' or index of performance measures to assess how to measure initiatives. The existing measures are aligned with one or more of the seven population outcomes (and their associated indicator data). New data is only designed where existing measures do not reflect the initiative.

As Te Pūtahitanga o Te Waipounamu is committed to continuous quality improvement, it is refreshing its outcomes approach to incorporate more 'shift' based measures (i.e. before and after) and revising its data collection strategies and analytical capacity to produce even stronger proof of impact. It has built its in-house capacity and has a new RBA specialist as part of its core team.

3.4. Examples of RBA use by NGOs

The examples below are of organisations that have and/or using RBA to support analysis of programme or service implementation. The data and the analysis represent the organisation's views and/or an independent evaluator view. There will be many more examples in New Zealand. This is simply a selection based on information supplied by some of the stakeholders that were interviewed for this report.

MASH Trust, Palmerston North

The MASH Trust is an NGO based in Palmerston North[48]. The Trust provides support services to people who have a disability, mental health issue, or alcohol and addiction issue. The Trust also provides youth respite care. Services are delivered through residential homes, in the community, and to people in their own homes.

The Trust has been actively using RBA since 2016, as a result of transitioning its DHB contracts into the streamlined contracting format. The transition process involved co-designing population and client outcomes framework with the Mid-Central District Health Board and agreeing a series of 'vital few' performance measures to understand if clients are better off.

The better off or outcomes data outlined below is based on two services: Alcohol and other Drug and Mental Health Residential. Two tools were used to collect outputs and outcomes data from clients: The Alcohol and Drug Outcome Measure Tool (ADOM)[49], and the Person-centred Planning Recovery Wheel, which was developed in-house by the Trust.

The figures below demonstrate improved before and after scores for a client with AOD (Figure 23) and a client with mental health issues (Figure 24). For the provider, a lower 'after' score implies that client outcomes have improved:

[48] For more details see: http://www.mashtrust.org.nz/.
[49] For more detail see here: https://www.tepou.co.nz/outcomes-and-information/adom-tools/136. Accessed 17 September 2017.

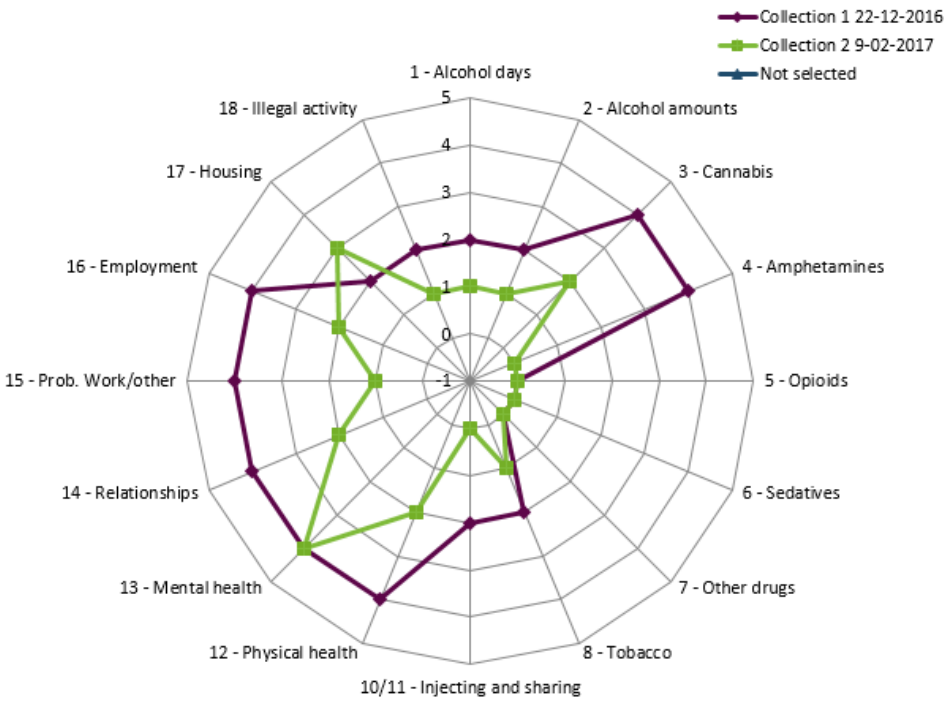

Figure 17: ADOM spidergram of improved client outcomes before and after service delivery

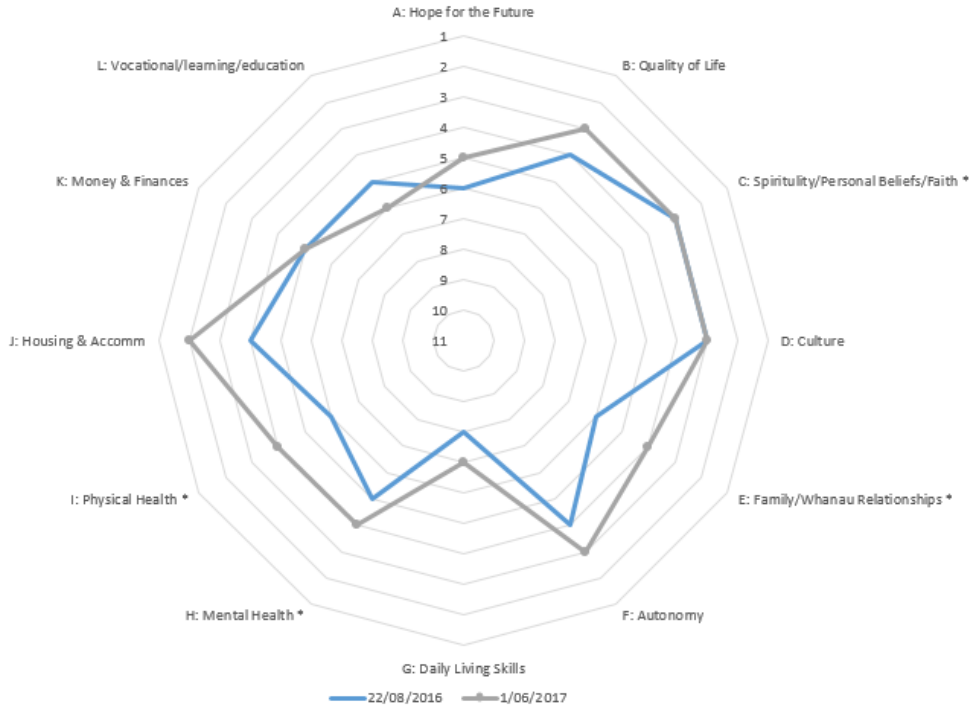

Figure 18: PCP Spidergram of improved client outcomes before and after service delivery

The figure below shows aggregated data based on before and after (entry and exit scores), for all of MASH Trust's Alcohol and Other Drug (AOD) clients. According to the provider, the data suggests

that client outcomes are improving as clients are exiting with a lower (i.e. improved) score, compared to entry.

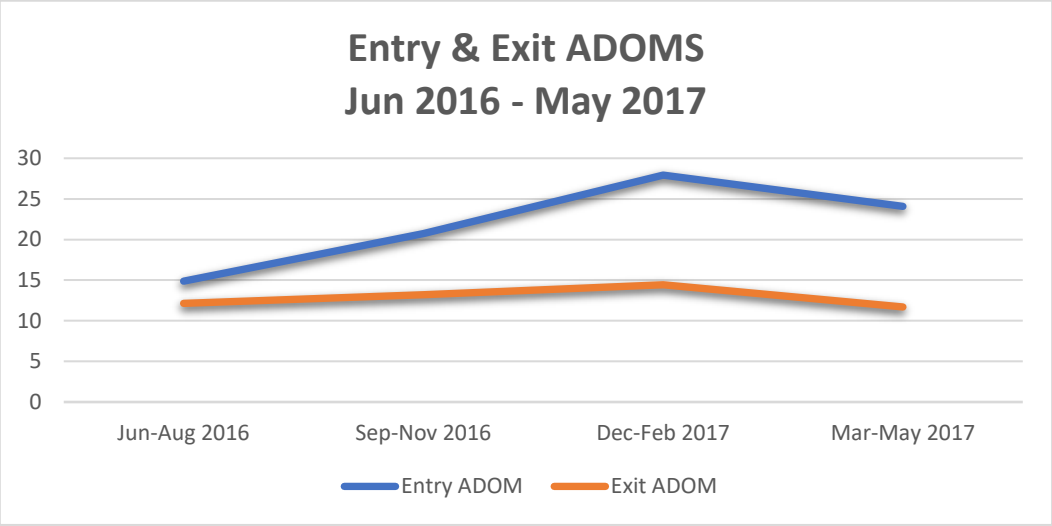

Figure 19: Entry and Exit scores for AOD clients using ADOM tool, July 2016 to May 2017

The lead for this work is Rodger McLeod, Manager - Mental Health and Addiction Services, Mental Health and Addiction. Mr McLeod recently spoke at the international RBA conference in San Antonio, Texas, 8-10 November 2017[50].

Te Puawaitanga ki Otautahi Trust

Te Puawaitanga ki Otautahi Trust (the Trust) is a kaupapa Māori NGO located in Christchurch[51]. It is also known as the Otautahi Māori Women's Welfare League. The Trust delivers a wide range of health, education and social services to individuals and families/whānau. They have a large team that delivers services on site and in the community to promote participation and access to health, education or support services. They are committed to improving whānau outcomes and wellbeing.

The Trust has been using RBA since 2015. They use the Clear Impact Scorecard software, which is an online reporting tool (software as a service). This software was developed to support best use of the RBA methodology.

The following data is associated with the provider's quality of effort or how well it delivered its services. The data is about the provider's Well Child / Tamariki Ora (WCTO) service, and the completion and timeliness of Core 1 contacts. Core 1 contacts relate to the first engagement between the WCTO practitioner and women/whānau with babies/pēpi who are 4-6 weeks old[52].

[50] For more details see: https://clearimpact.com/our-events/measurable-impact/.
[51] For more details see: www.whanauoraservices.co.nz. Accessed 10 September 2017.
[52] There is a total of 7 core contacts provided through the well child service, from the time of accepted referral until the child is around 4 years of age.

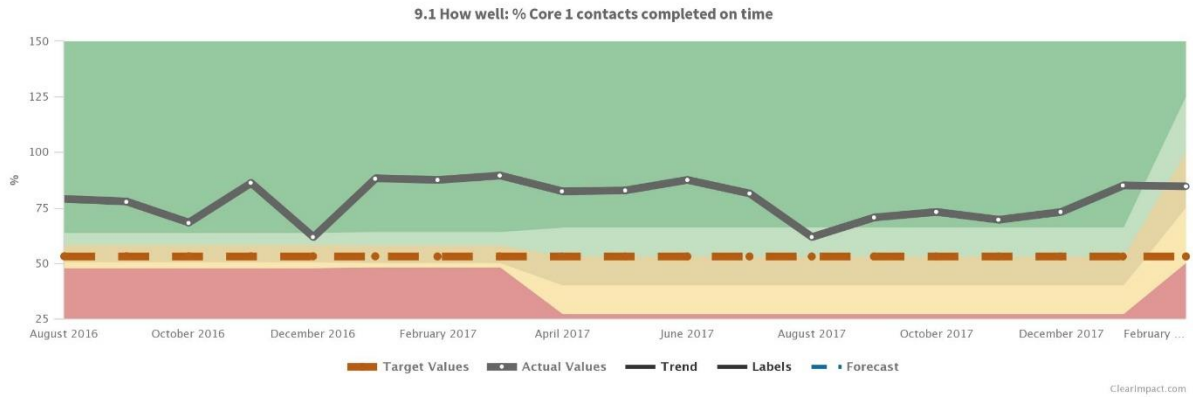

Figure 20: How Well: % Core 1 contacts completed on time, August 2016-February 2018

The current delivery trend exceeds the benchmarked target of 53% (which is based on equivalent quality of effort data for high deprivation clients across the Canterbury DHB district). This suggests that the Trust is performing comparatively well, with respect to delivering timely services to clients; the majority of whom are regarded as 'high needs'.

Trust management uses this data to inform performance improvement conversations in team meetings. They use the 7 questions; most notably, questions 4 to 7, to guide discussions.

The lead for this work is Mrs Alison Bourn, CEO. The Tamariki Ora Service Manager is Mrs Di Oakley. Mrs Bourn spoke at the international RBA conference in Dublin, in 2016.

Te Kupenga Hauora O Ahuriri

Te Kupenga Hauora O Ahuriri (Te Kupenga) is a charitable trust based in Napier. It provides a wide range of health and social services to whānau/families in the Hawkes Bay region. The range of services provided are targeted at tamariki (children), rangatahi (youth) in decile 1 and 2 schools, whānau (families) who reside in lower socio-economic communities, pakeke (adults) and kaumatua (older people). Te Kupenga is also a whānau ora provider and works alongside whānau so they become empowered and inspired about creating positive futures for themselves[53].

Te Kupenga have been using RBA since 2013 (originally as part of TPK led Whānau Ora). According to Te Kupenga, RBA has been "instrumental in building an outcomes focused approach to service delivery and reporting on outcomes"[54]. They are using the Clear Impact Scorecard to monitor and report on data.

Te Kupenga's population outcomes framework is:

> **All whānau/families in Ahuriri are: Safe/*Kia haumaru te noho!;* Connected/*Puritia tō mana ake!; Self-determining/Tū Rangatira and Aspirational/*Whāia te iti kahurangi!**

One of the indicators Te Kupenga uses to measure *Safe Whānau* is Ambulatory Sensitive Hospitalisations (ASH) rates. One of the largest contributors to ASH rates in the district, for children 0-4 years, is poor oral health (McElnay, 2014)[55]. Dental conditions account for many ASH admissions

[53] For more details see: http://www.tkh.org.nz/.
[54] Personal communication with Jen Robins, Manager, Te Kupenga on 4 August 2017.
[55] McElnay, C. (2014) Health Equity Report 2014 – Hawkes Bay District Health Board. Sourced: www.hawkesbay.health.nz. Accessed in September 2017.

and rates for Māori are 4.3 times higher than non-Māori. Evidence suggests that acute admissions can be reduced through early interventions delivered in primary care or community settings (McElnay, 2014).

To contribute to turning the population indicator curve downwards, Te Kupenga delivers a Dental Health Education Service. The purpose of this service is to upskill and support parents and caregivers to access district-wide oral health services. The dental educator also works with other providers to upskill and support them to work better with Māori families (e.g. General Practitioners, Tamariki Ora/Wellchild Nurses, and Family Start). Te Kupenga's service is open to all whānau but the majority of Te Kupenga's clients are Māori.

Literature suggests that simply improving access to oral health care is not enough to reduce inequalities in oral health. Services need to build client knowledge and support positive attitudes towards preventative behaviours for oral health[56].

The following quantity of effort or how much performance measure data, represents the number of clients (under 12 months) who are enrolled in Te Kupenga's service:

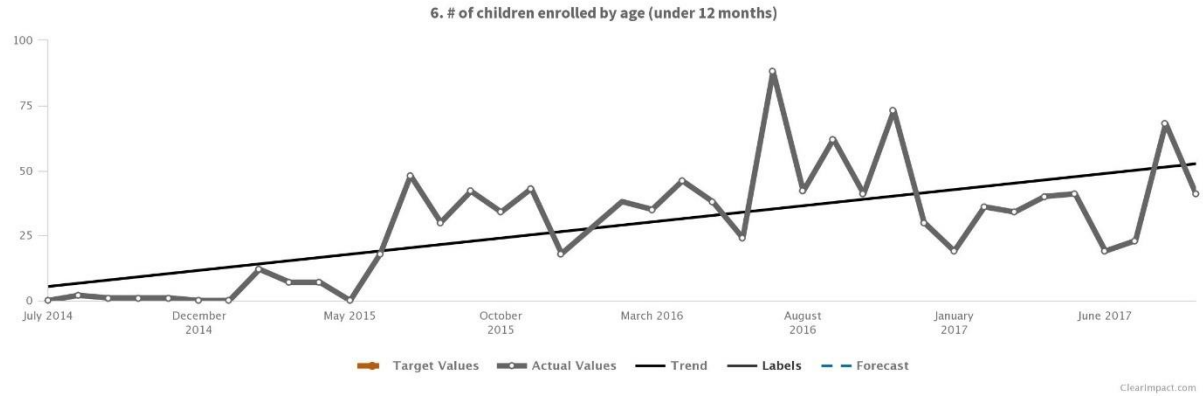

Figure 21: How much: # of children enrolled in Dental Health Education Service, July 2014-September 2017

The upward trend over time, suggests that Te Kupenga is successful at improving access to its preventative service, as it is supporting more and more children. Conversely however, this may also speak to a growing need for services and supports of this type.

The following Better Off data measures positive behavioural change of parents or caregivers who support their children to attend enrolled oral health care services. A key role of Te Kupenga's service is to educate and support parents to prevent their children's teeth from decaying. It is noted however, that whilst the service focuses on improving parent/caregiver behavioural change, in some cases, the causal factors for non-attendance are directly linked to systemic barriers (e.g. lack of culturally competent services), rather than the willingness of parents to support their children's wellbeing.

[56]Rohleder., M & Apata, A. (2009). *Health Impact Assessment: Implementation of Oral Health Strategy.* Hawkes Bay District Health Board. New Zealand. Source: https://www.health.govt.nz/system/files/documents/pages/community-clinic-flaxmere.pdf. Accessed 18 September 2017.

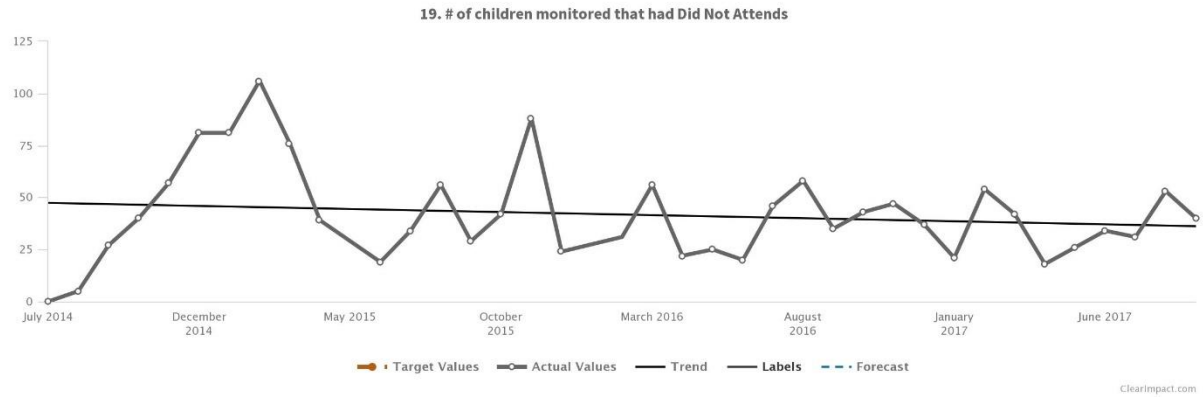

Figure 22: Better off: # of children enrolled in an oral health service who did not attend, July 2014-September 2017

This data shows, that whilst there are peaks and troughs, overall, the trend is a reduction in the number of children who *did not* attend their appointment. Several recent issues have been identified that impact on non-attendance including more transient whānau, a rise in homelessness, and whānau experiencing significant stress due to financial issues. However, Te Kupenga is committed to turning the data curve, even more faster, in the downwards direction.

The lead for this work is Mrs Audrey Robin, CEO. The CEO is supported by Mrs Jen Robin-Middleton, Operations Manager and Mrs Sue Curtis, Dental Educator.

Te Kaha O Te Rangatahi Trust

Te Kaha O Te Rangatahi Trust (Te Kaha) is a Māori community-based youth provider delivering a range of services to children, adults and youth[57]. Te Kaha provides health, education and whānau ora services specialising in youth sexual health, mama and pēpi services, pre-school wellbeing services, physical fitness, and specialist youth whānau ora services. Te Kaha's services are delivered in house and in the community.

Te Kaha has been using RBA since 2013. They use the Clear Impact Scorecard software to support their data reporting and use. It is worth noting that Te Kaha have completed 18,000 RBA informed client surveys.

In 2014, Te Kaha received funding from the *Te Ao Auahatanga Hauora Māori: Māori Health Innovation Fund* for three years from March 2014-June 2017. This fund was administered by the Ministry of Health. The Innovation Fund aimed to:

> *"…improve Māori health outcomes and achieve Whānau Ora through innovative service design, delivery/implementation and evaluation."*[58]

The Fund prioritised Tikanga a Tamariki Mokopuna and a focus on using Te Ao Māori approaches to build whānau health through improved child health outcomes. Te Kaha used the innovation funding to implement a flagship new programme called The WOW Bus: Waka Ora on Wheels. The WOW programme involved mobile education for tamariki/children, teachers and whānau linked to four modules:

[57] For more details see: https://www.tekaha.co.nz/.

[58] Source: http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/te-ao-auahatanga-hauora-maori-maori-health-innovation-fund-2013-2017. Accessed on 15 September 2017.

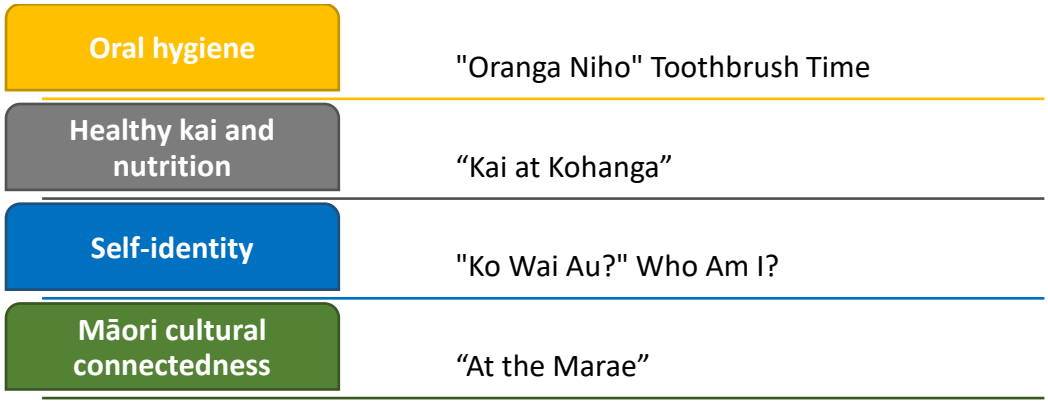

Figure 23: Four learning modules of the WOW Bus

The population outcome for the WOW Bus is: **All Tamariki in South Auckland are healthy, nurtured and engaged**. The indicators for population wellbeing is: ECE enrolment rate, Oral health provider enrolment rate and PHO enrolment rate (0-5 year olds).

A formative, process and impact evaluation of the WOW Programme was independently completed by Communio in 2017[59]. The evaluators stated that:

> “The WOW RBA™ framework and reporting scorecards proved useful to demonstrate the potential for the WOW programme to assist whānau to work towards health and wellbeing by, for example, supporting them to enrol their tamariki into related services, such as dental services, early childhood education and general practice.
>
> The programme built on Te Kaha’s relationships and reputation as an innovative and high quality organisation that has the health and wellbeing of the community firmly at heart. The WOW programme reached hundreds of children, their whānau and teachers/kaiako across South Auckland and resulted in improvements in the levels of knowledge and skills among participants.” (p. 71).

Self-reported new knowledge gain (via customised client surveys administered after learning modules) included:

- The type of food children should eat to keep healthy
- How much of different types of food should children eat
- The correct size of toothpaste that children should use
- How long should children brush their teeth for
- How children should brush their teeth
- How much healthy food children should eat every day (i.e. 5 or more portions of fruit and veggies; like a rainbow of food on their plate)
- What the best drinks for children are (i.e. water and plain milk)
- Why it’s important to eat healthy food (i.e. it makes children strong and helps children to learn)
- How to greet people in a cultural setting (i.e., hongi and shaking hands)

[59] McFarlane, M. (2017) Waka Ora on Wheels: A Māori Health Innovation funded by Te Ao Auahatanga Hauora Māori Evaluation Report. Provided by Te Kaha o Te Rangatahi Trust to Shea Pita, December 2017. An evaluation was required by the Ministry of Health as part of the funding contract.

- Whaikorero (male speeches following the karanga)
- The karanga (female calling on to the marae)
- The importance of making people feel welcome or the powhiri process
- Why it's important to know where you come from (i.e. respect for ourselves because we are unique)
- Cultural identity (i.e. pepeha, from your mountain through to your tupuna)

Attitudinal/opinion shifts were also measured using before and after questions in client surveys. Positive shifts were noted for issues such as:

- Parental or caregiver intent to provide their children more portions of fruit and veggies compared to the frequency of portions currently served
- Parental or caregiver intent to reduce fizzy drink and replace fizzy drink for water
- Parental or caregiver intent to brush their children's teeth more regularly.

Unintended outcomes noted included parents/caregivers brushing their teeth more frequently and intending to eat more healthily in their own right.

Te Kaha is using this report to seek ongoing funding. It wishes to expand the scale and scope of the programme across Auckland.

Te Kaha also delivers Sexual Health Services to rangatahi. The following Better Off data represents the average percentage change in student knowledge about puberty:

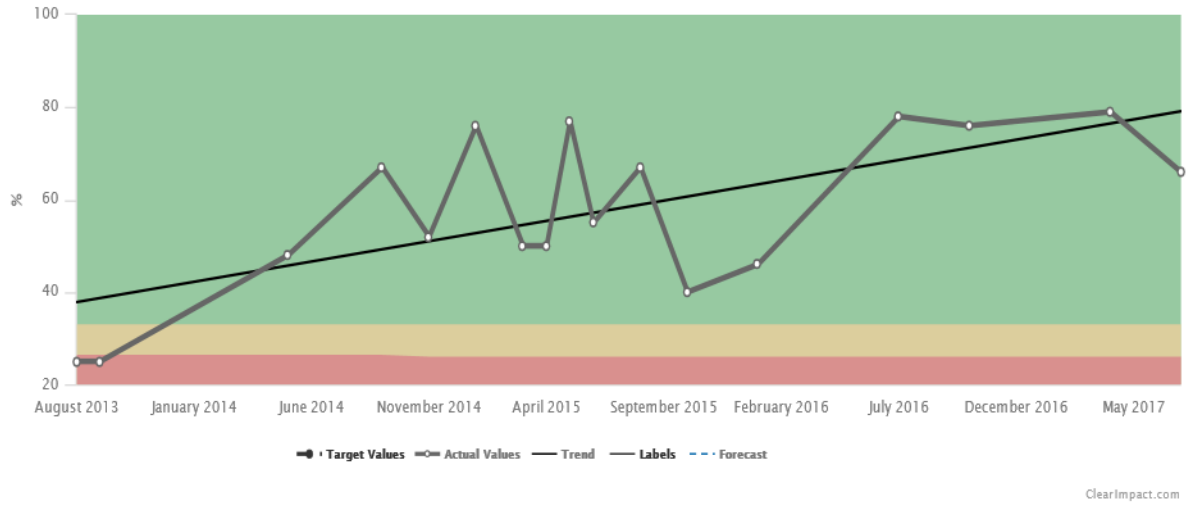

Figure 24: Better Off: % students who report improved knowledge about their body changes during puberty (Average & change), 2013-2017.

Despite the peaks and troughs, the overall data is trending upwards. This suggests that Te Kaha's health education services are improving youth knowledge.

The lead for this work is Ms Natasha Kemp, CEO. The CEO is supported by Mrs Debi Kapa, Operations Manager and Ms Te Ao Kapa, Outcomes Champion.

Start Taranaki

START Taranaki is a community-based charitable trust, based in Taranaki. The Trust specialises in working with youth and provides a Supervision with Activity (SwA) programme. The intervention programme is for recidivist youth offenders and comprises three phases: Isolation, Ora Toa and Transition. The Trust focuses on building meaningful relationships between young people and positive role models[60].

Impact Research NZ (Dr Annie Weir) was commissioned by START Taranaki to conduct research into a new way of evaluating and reporting programme outcomes. A review of current evaluation and reporting practices was undertaken. Having looked at various outcome focused evaluation methods it was agreed a Results Based Accountability framework would be developed that linked to their strategic and operational plans and to a newly developed organisational evaluation plan.

The following data is based on the Youth Survey Factor Scores for their intervention programme. The aim of the programme is to help youth understand and manage their behaviours and equip youth with the skills and strategies to enable them to function in society.

The two Figures below present the percentage scores for each of the 11 factors that are measured by questions in the survey. The RBA factor scores represent the six youth that responded to the survey.

How Well: Youth Satisfaction with the service and factors	
Service engages well with youth	96%
Service is strengths based	89%
Service is tailored to meet youth needs	71%
Service is culturally responsive	58%

Figure 25:Youth Satisfaction with the service and factors (N=6)

Is Anyone Better Off: % Youth who report:	
Improved living skills	83%
Relationships improved	100%
Confidence and self-esteem improved	72%
Safety improved	83%
Increased empathy with family/whānau	82%
Feel better able to make informed decisions about future life choices	92%
Well-being improved	83%

Figure 26: Youth Outcomes by factor, (N=6)

The results were triangulated with document review, staff surveys and stakeholder surveys. The evaluator concluded that Start Taranaki delivered improved outcomes to youth that accessed its programme. This report was shared with the former Minister of Social Development, who accepted the report and wrote a letter congratulating Start Taranaki for their performance.

Brainwave Trust Aotearoa

Brainwave Trust Aotearoa is a charitable trust that aims to raise public awareness around healthy brain development in babies, young children and adolescents. The Trust delivers seminars and

[60] For more detail see: http://www.starttaranaki.co.nz/.

programmes based on robust scientific research to a variety of organisations and individuals who have an interest in ensuring the safety and wellbeing of young New Zealanders[61].

Impact Research NZ (Dr Annie Weir) was commissioned by Brainwave Trust Aotearoa to review existing organisational evaluation policies and practices. Work was undertaken over a year to implement a Results Based Accountability (RBA) framework which involved designing and implementing a range of stakeholder surveys to gain baseline data on how effective their programmes and seminars are in meeting the desired outcomes as well as identifying areas for improvement.

The following data is based on the Brainwave Schools Programme Students' Survey RBA Factor Scores. The aim of the Brainwave School's programme is to raise students' awareness, understanding and knowledge of the brain, its functions and the impact of social, environmental, physical and cognitive factors on healthy brain development in babies and young children.

The Figures below present the scores for each of the six factors that are measured in the survey. The RBA factor scores represent the 25 students that responded to the survey.

How Well: Needs of Students are met: Total % combined for questions below;	
• The information presented in the programme was easy to understand • I can relate to the material • The Educator listened to me • The Educator was respectful to students	75%

Figure 27: Student Survey Satisfaction factors (N=25).

Is Anyone Better Off: % Student scores by Outcome Factor	
Improved knowledge	86%
Better able to make informed decisions about future life choices	89%
Change in behaviour	73%
Change in attitude and beliefs	82%
Students are empathetic	86%

Figure 28: Student Outcomes Survey factors (N=25)

The outcome factors measure the extent to which students' knowledge and understanding of brain development in babies and young children had increased as a result of their involvement with the Brainwave Schools Programme. The evaluator concluded that the programme had delivered improved outcomes to its clients.

3.5. Examples of RBA use by DHBs, PHOs, a Commissioning Agency and Iwi

Northland District Health Board

The Northland District Health Board (DHB) is responsible for providing or funding the provision of health and disability services for people in Northland. The DHB has four hospitals and a range of community-based health services[62].

[61] For more details see: https://www.brainwave.org.nz/.
[62] For more detail see: http://www.northlanddhb.org.nz/.

The DHB has been using RBA for several years, for certain services. It was first used purposefully in Mental Health. The Ministry of Health showcased the DHB's use of RBA in its new Mental Health Commissioning Framework (MOH, 2016)[63], as follows:

Northland DHB adopted a different approach to reviewing its contracts for service by going on a journey of discovery with its community. It considered the government expectations and focus areas and what these mean for the people of Northland. As a new planner and funder, Trish Palmer sought to understand the current DHB services, what is funded, by how much, and how those services are distributed across Northland. This information led her to discover that some parts of Northland had no services in their area, prices for the same service varied, access to specific services depended on where you live, the availability of some services was seasonal, and some services were seeing as many as 40 times more people for the same level of funding. Once she had a good understanding of the issues, finding some options to address them was the next step.

The process

Key questions guiding the process were: 'Would I use this service?' and 'Would I want my grandmother to use this service?' The changed approach put people at the centre and engaged/involved whānau. With a focus on outcomes, it aimed to leave people better off as a result of contacting the DHB's services, and to prioritise resources and value for money.

Values and guiding principles were agreed at the outset. These provided a 'go-to place' if the group started to get lost. It was always a matter of checking back with the values: what matters to clients? From the beginning the board agreed that any funding that was freed up through the process would be re-invested in mental health.

The RBA approach was chosen because it was thought to ask the right questions. All current providers were trained in RBA, and performance data across all providers was shared. This sharing of data allowed providers to compare their performance, and non-performers could identify their non-performance for themselves. Providers were expected to fully participate in the process and be part of decision-making and were not there just as representatives.

A number of forums seeking feedback from consumers and their families and whānau were held throughout the rohe (area). In addition, open stakeholder group discussions were held on what works, what does not and what could be done to leave us better off. Listening to people and understanding what they want highlighted that people were not asking for a lot; for example, they wanted to 'be asked what we want or need' and to 'feel in control'.

The open planning discussions took place without competition or secrecy, and reached agreement on what was needed to meet the needs of the Northland population. Disinvestment decisions were made collectively, and how this money would be re-invested and prioritised was discussed.

Providers voluntarily agreed to report more, so that results agreed through the RBA process could be measured.

What difference has it made?

It has been an iterative process of working together to build trust and relationships. The visions of people and organisations have changed, and there is an increased focus on the kaupapa Māori approach. It has been a shared journey, and the process has been as important as the

[63] Ministry of Health (2016), *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*, (Ministry of Health: Wellington).

outcomes. Trish Palmer says there have been some early adopters and some watchers, but it is the engagement in development that leads to ownership.

Figure 29: Case study of Northland DHB use of RBA in Mental Health

Recently, the DHB CEO (Mr Nick Chamberlain) has decided to formally adopt RBA to inform its next strategic plan, its outcomes-focused NGO contracting, and it will also be used to inform its own provider arms approach to outcomes-focused service delivery. A dedicated outcomes team has been established and has adopted a staged approach to roll-out RBA across the DHB and the wider health sector over several years.

The following data is associated with the DHB's Oral Health Service Outcomes Framework. This Framework focuses on preventative care. Evidence suggests that fluoride varnish is an effective way to prevent caries and reduce the proportion of children who have decayed, missing or filled teeth. Accordingly, the DHB purchases fluoride varnishing from multiple oral health providers, including its own provider arm, to deliver this service across Northland.

The performance measure below includes aggregated data for all providers contracted to deliver fluoride varnish to children. This service is prioritized for those who are most at risk of poor oral health.

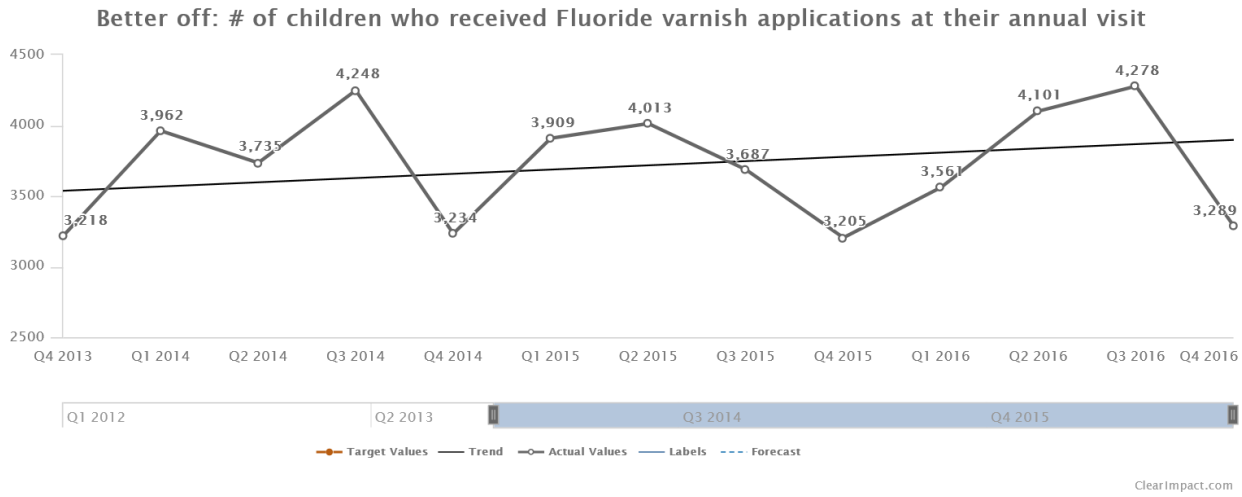

Figure 30: Better Off: # of children who received fluoride varnish at their annual visit, Q4 2013-Q4 2016

The overall trend is upwards (with acceptable seasonal reductions in the fourth quarters). The overall consistent upward trend over time, suggests that more clients are better off as their teeth are protected early, from future decay.

At a population level, a relevant population outcome is *Healthy Mouths, Healthy Lives for all Northlanders*. The following indicator data is one way to track whether the population outcome is being achieved:

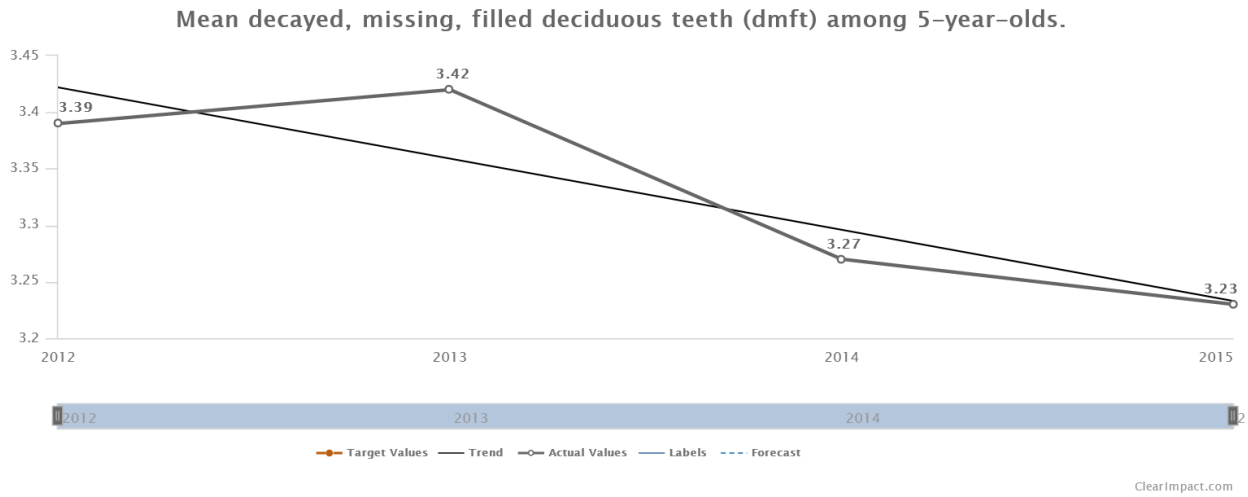

Figure 31: Mean decayed, missing and filled teeth among 5-year olds in Northland, 2012-2015

The overall downward trend of the indicator data suggests that the oral health of young Northland children has improved over time, as there are less decayed, missing or filled teeth. In the RBA context, the DHB suggests that the fluoride varnishing programme *contributes to* turning the indicator data curve in the right direction but is not solely responsible for the same.

The overall sponsor for this work is Mr Nick Chamberlain, CEO. The RBA Champions are: Mr John Wansbone, GM, General Manager, Planning, Integration, People & Performance; Ms Sunitha Gowda, Public Health Strategist/Acting Team Leader Healthy Lifestyles Team; Mr Stephen Jackson, Planning Manager and Ms Susanne Scanlen, Portfolio Manager, Health of Older People, Long Term Supports-Chronic Health Conditions, Palliative Care, NDHB.

Waitemata and Auckland District Health Boards

Waitemata and Auckland District Health Boards are two of the largest DHBs in New Zealand.[64] In 2015, as part of the Māori Health Gains project, Waitemata District Health Board and Auckland District Health Board introduced a client outcomes framework related to Māori Health Providers and a new integrated contracts approach. As a result of this project, WDHB have been purposefully using RBA with Māori Health providers since late 2015.

The following represents a recent quarterly snapshot of aggregated data for six Māori health providers under the new contracting framework.

[64] For more details see: http://www.waitematadhb.govt.nz/ and http://www.adhb.health.nz/.

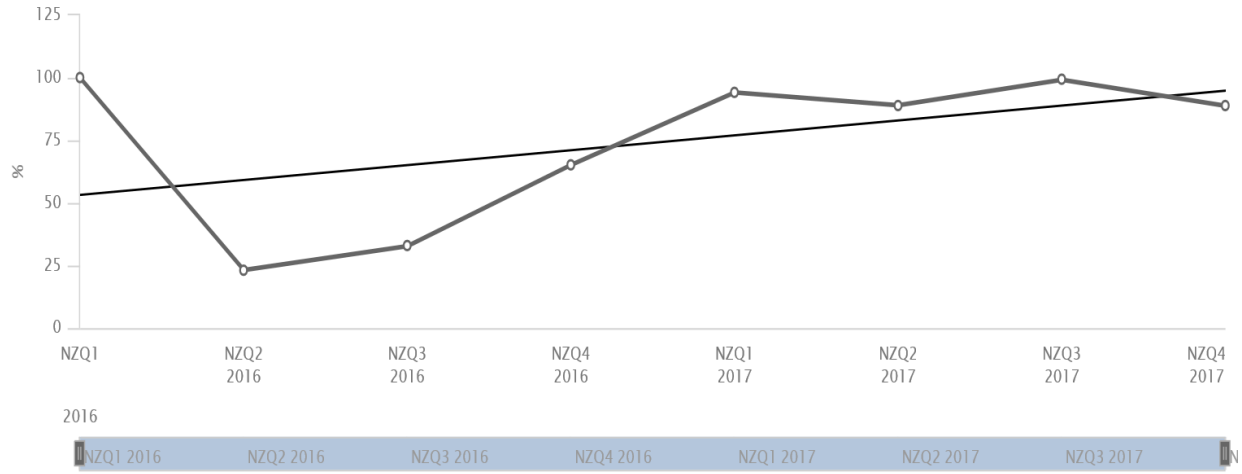

Figure 32: Better off: % health education participants (at Pākeke Ora) who report they learnt something new about managing their medication, 1 July 2015-30 June 2017

This subjective outcome measure was designed to ascertain if adult (pakeke) attendees at health education events gained knowledge associated with medication management. Most of these adults are managing long-term conditions. This data trend shows that overall, adults are learning more about how to better manage a long-term condition. Evidence suggests that medication management is a key success factor of keeping people well and out of hospital (Ministry of Health, 2016)[65]. The DHB is also using a variety of objective clinical measures that relate to anticipated client outcomes.

The lead for this project is Ms Aroha Haggie, GM, Māori Health Gain, Waitemata and Auckland DHBs.

Te Puni Kōkiri led Whānau Ora Commissioning

As noted earlier in this report, TPK originally commissioned Whānau Ora programmes. TPK used RBA to develop performance measures for commissioned programmes.

Several reports have been produced summarising results. In 2015, the report entitled *Understanding Whānau-centred Approaches: Analysis of Phase One Whānau Ora Research and Monitoring results*[66], used RBA sourced data as part of the review of Whānau Ora. The report stated that:

> "The immediate impacts of collective services were extensive, and multiple improvements were noted in several social, economic, cultural and collective areas associated with whānau wellbeing. Some gains were in 'intermediary outcomes' (for example, improved service access, motivation) and others were in 'higher-level' outcome areas (for example, increased income, improved employment and so on). The most common intermediary improvements were accessing services, happiness, relationships and leadership. The most common higher-level improvements were in safety and education/training.
>
> On average, whānau experienced more than seven intermediary gains and more than three higher-level gains in wellbeing. A moderately strong correlation was noted between whānau-centred approaches and intermediary whānau gains, and between intermediary

[65] Ministry of Health (2016) Self-management Support for People with Long-term Conditions (2nd edn). (Ministry of Health: Wellington).
[66] For more details see: https://www.tpk.govt.nz/en/a-matou-mohiotanga/whānau-ora/. Accessed 15 September 2017.

and higher-level whānau gains. The relationship between whānau-centred approaches and higher-level improvements was weak and appears to be mediated by shorter-term intermediary gains.

The correlation between intermediary gains and whānau-centred approaches remained moderately strong across different aspects of service delivery (that is, building rapport and meeting whānau goals and needs).” (p.31)

Te Pūtahitanga O Te Waipounamu Whānau Ora Commissioning Agency

Te Pūtahitanga O Te Waipounamu is the Whānau Ora Commissioning Agency for the South Island. It was formed in 2014 as a legal partnership of Nga Iwi O Te Waipounamu – the nine iwi of the South Island. Their role is to invest in building sustainable whānau capability by supporting initiatives that seek to enhance the wellbeing of whānau to achieve their goals and aspirations[67].

Te Pūtahitanga o Te Waipounamu have been using RBA since 2015. The following data is a snapshot of aggregated quarterly data of selected commissioned initiatives 2016-2017:

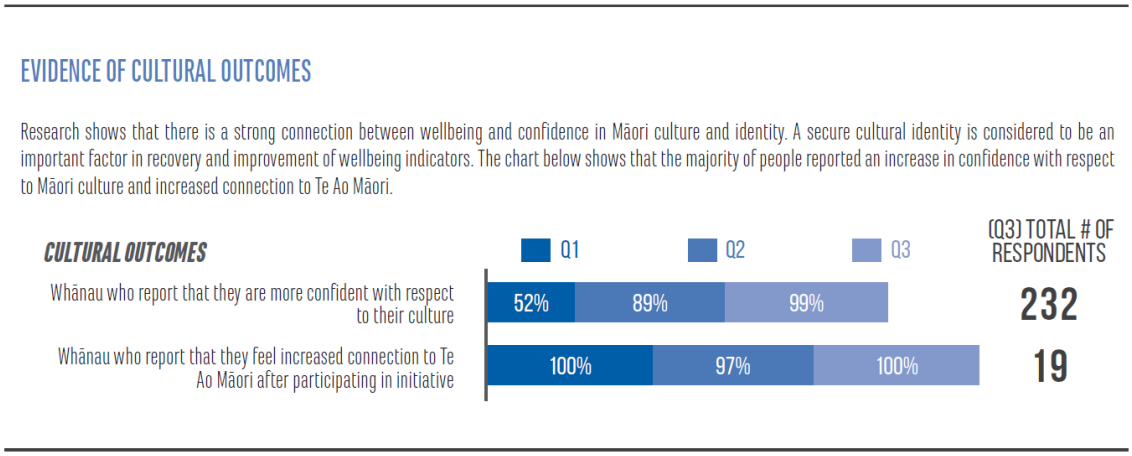

Figure 33: Summary of cultural outcomes, 1 July 2016-30 September 2017

[67] For more details see: http://www.teputahitanga.org/.

EVIDENCE OF WELLBEING OUTCOMES

Research indicates that subjective ratings of self-reported wellbeing parameters provide valid and consistent measures of real phenomena. The performance measures presented in the dashboard below aim to showcase the difference the initiatives are making by providing a benchmark of New Zealand averages for Māori population. The graphs show that whānau that receive support from Te Pūtahitanga's initiatives score higher across all of the population indicators.

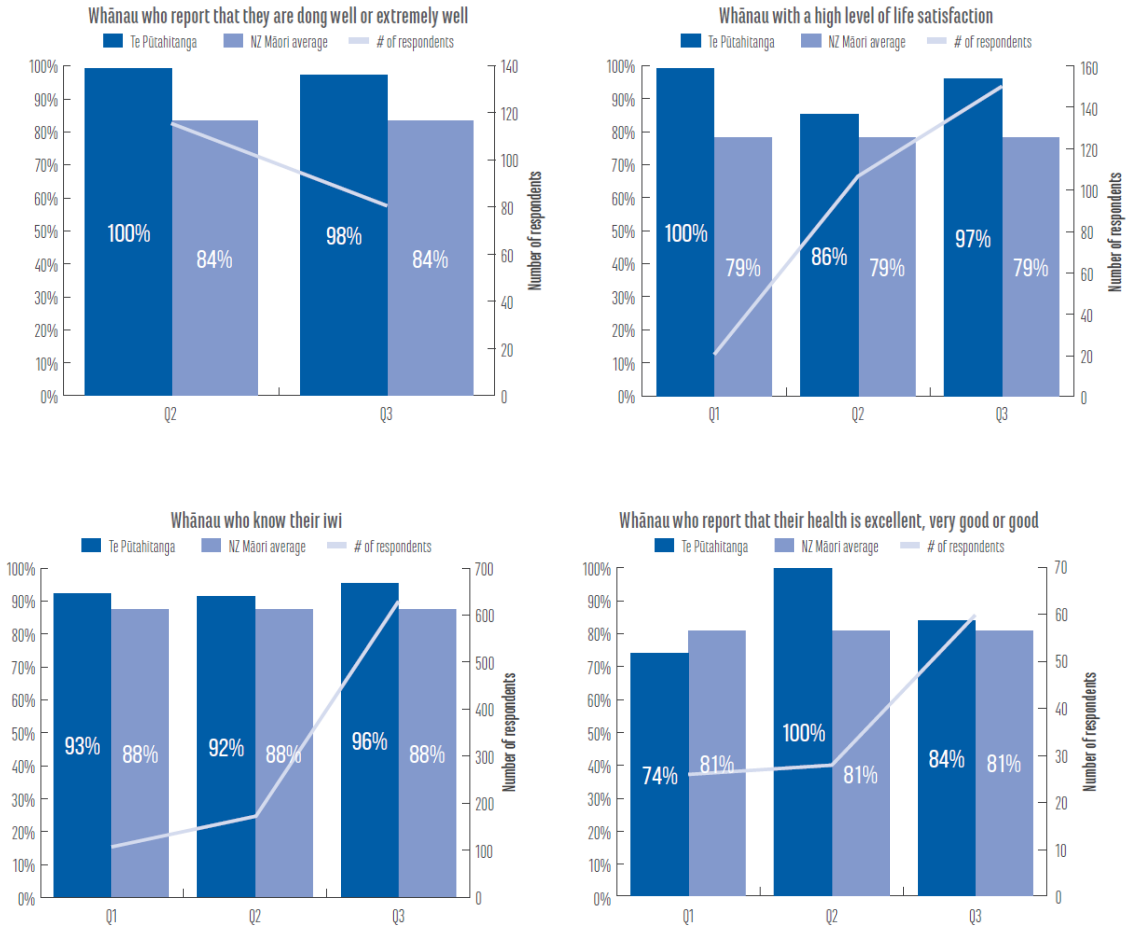

Figure 34: Summary of whānau ora wellbeing outcomes, 1 July 2016-30 September 2017

Tuwharetoa Māori Trust Board

The role of the Tuwharetoa Māori Trust Board is to administer the Trust's assets for the benefit of Ngati Tuwharetoa iwi, including maintaining and enhancing the wellbeing of Taupo Waters and supporting the progression of cultural, social, environmental, and economic outcomes for their people[68].

The Tuwharetoa Māori Trust Board developed their population and performance outcomes framework in 2015 for selected areas including administering grants and scholarships and supporting community and marae-based programmes that enhance the wellbeing of Ngati Tuwharetoa

[68] For more details see: www.tuwharetoa.co.nz.

whakapapa whānau and community. Their overarching framework is accessible here:

Tuwharetoa outcomes framework. The Trust board are monitoring population level outcomes.

The Board implements a Supporting Literacy Programmes in Schools initiative. Schools, who are partnering with the Trust on this initiative, have identified that they do not have the resources or the capacity to deliver targeted literacy programmes themselves, and they requested support from the Trust to engage whānau. The result is a wraparound approach that includes schools and whānau to reach and enhance literacy achievement across Tuwharetoa.

The following data represents how the Trust measures Better Off outcomes associated with the initiative.

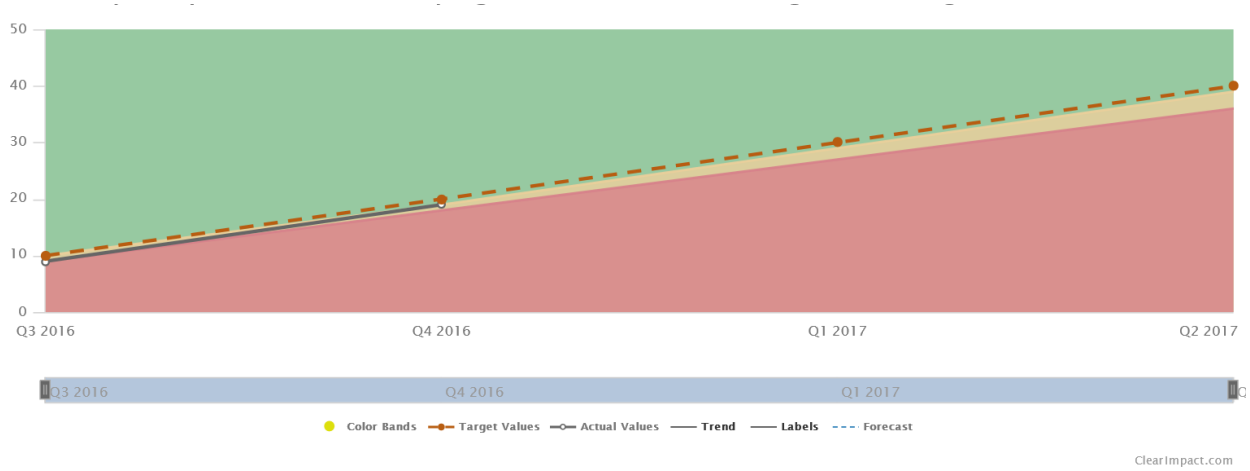

Figure 35: Better off: # of priority learners who have progressed from not achieving to achieving national standards in reading, Q3 2016-Q2 2017

The initiative is in its early days, but initial data suggests that the programme is contributing to more priority learners achieving national standards in reading. This is an important result for the programme as evidence confirms that educational success, and those who have more years of schooling, tend to have better health and longer-term outcomes than others (Feinstein et al, 2006[69]; Ministry of Education, 2016[70]).

The Trust use the Clear Impact scorecard to report data and they supplement their quantitative data by using the 7 questions to inform service delivery actions.

The lead for this work is Mr Topia Rameka, CEO and Ms Marie Otimi, Wellbeing Manager, Tuwharetoa Trust Board.

[69] Feinstein, L.; Sabates, R.; Tashweka, M.; Anderson, A. S.; and Hammond, C. (2006) . WHAT ARE THE EFFECTS OF EDUCATION ON HEALTH, (OECD). Source: https://www1.oecd.org/edu/innovation-education/37425753.pdf. Accessed July 2017.

[70] Ministry of Education (2016) *Four Year Plan 2016-2020.* Source: http://www.education.govt.nz/assets/Uploads/4YP-Plan-on-a-Page-A4-2016.pdf. Accessed July 2017.

Te Awakairangi PHO

Te Awakairangi Health Network is a Primary Healthcare Organisation in the Hutt Valley, Wellington (Te Awakairangi). Te Awakairangi plans, funds and provides a wide range of primary healthcare services including working co-operatively with its 20 general practices, community providers, whānau ora collectives and DHB providers[71].

Te Awakairangi Health have recently adopted RBA and are in the process of developing outcomes frameworks. One of their goals is to re-shape long-term conditions management in general practice to improve client outcomes. This will include providing a suite of resources and support to enable general practice teams to provide targeted care to patients with or at risk of having a long-term condition.

A clinical measure of improved client outcomes is whether a client's HbA1C (or blood glucose) is under 64mmol. If the blood glucose level is over 64, this indicates the levels glucose levels are much too high and they are not managing their diabetes. This can lead to other longer term negative outcomes for example, limb amputation, blindness and dialysis.

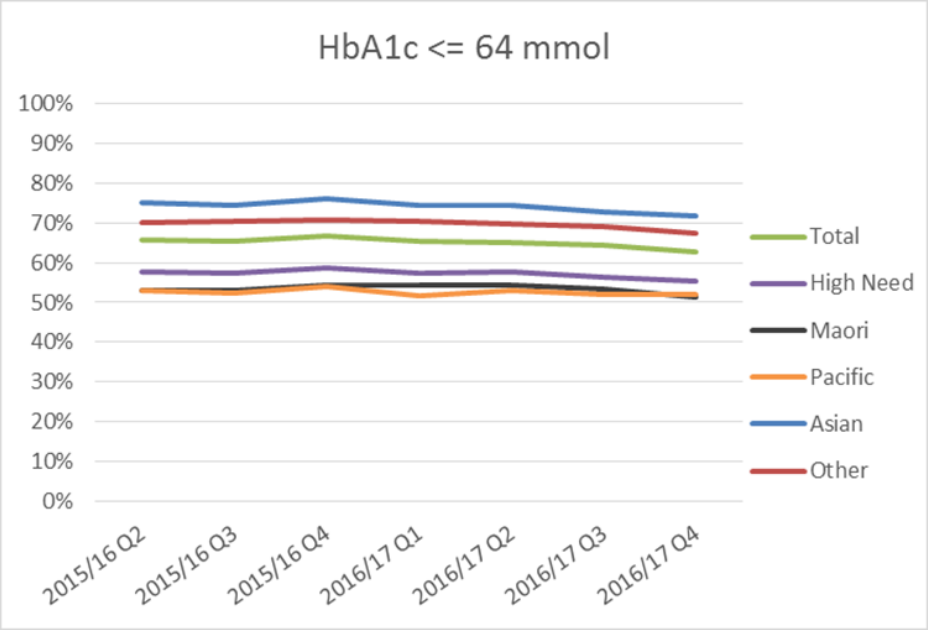

Figure 36: Better off: % of total population with diabetes who have an HbA1c <= 64 mmol, October 2015-30 June 2017

This data shows that a whilst a reasonable percentage of clients are managing their diabetes, others are not. Further, the data shows that success may have hit a plateau. There are also discrepancies by ethnicity, so this points to the need to customise diabetes management programmes to meet different client needs and causal barriers. The PHO is now using this better off data to inform 'turn the curve' conversations using questions 4-7: story, partners, what works and action planning.

The lead for this work is Mrs Bridget Allan, CEO and Mrs Sandy Bhawan, Programme Manager.

Alliance Health Plus PHO

Alliance Health+ PHO (AH+) was established in 2010. It is situated in South Auckland. It is a Pacific-Led organisation that focuses on improving health equity and the wellbeing of its enrolled patient population. It specialises in supporting Pacific patient and family wellbeing. The PHO is part of The

[71] For more detail see: http://www.teawakairangihealth.org.nz/.

Alliance Group, which comprises AH+ and a Community Initiatives Trust. The PHOs vision is: Strong Families, Strong Communities, Living Well Longer.

The PHO manages a Pacific Integrated Service Agreement (ISA). The integrated contracting process combined multiple funding agreements for three associated providers into one contract. The PHO manages and supports multi-provider contractual delivery. The benefits of the integrated approach are a shared outcomes framework, reduced administrative compliance across networked providers, committed effort to wider systemic changes in the health system e.g. shared reporting, shared case management system, shared clinical governance. In short, the integrated agreement supports the delivery of health services that are more clinically integrated, more convenient and people-centred.

Central to ISA is a common outcomes framework. AH+ has adopted RBA. In addition, AH+ has incorporated the Whānau Ora approach to engage with Pacific families and achieve people and family-centred outcomes.

Between 2015-2017:

- $3.25m has been invested in the ISA
- The ISA includes three large Pacific providers in South Auckland
- 150k has been invested in a new data management system

A snapshot of selected outputs and outcomes data is outlined below:

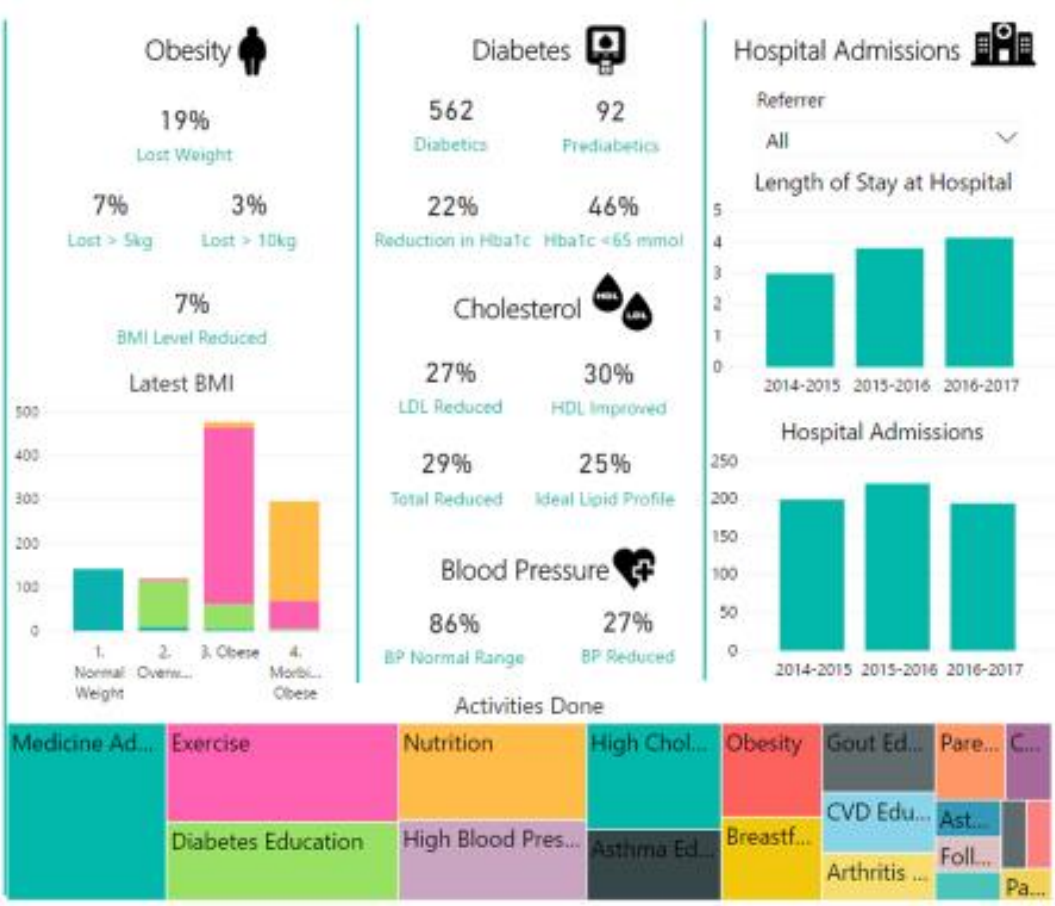

Figure 37: AH+ Outputs and Outcomes data for the ISA, 2015-2017

Better Off measures used by the PHO include: reduction in weight, reduction in BMI, increase in the proportion of clients who have clinically acceptable HbA1c levels, increase in the proportion of clients who have clinically acceptable Blood Pressure, reduction in hospital admissions.

From a family perspective, the following snapshot provides selected outputs and outcomes data collected by the PHO:

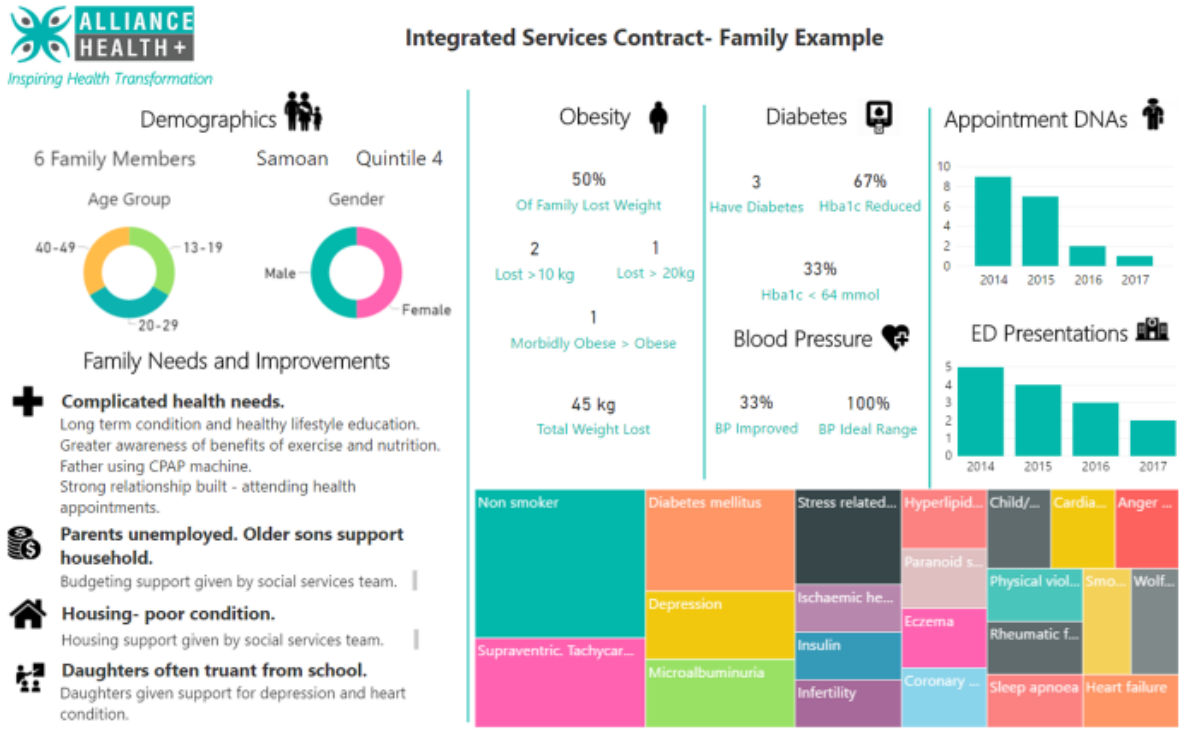

Figure 38: Family snapshot of outputs and outcomes data, AH+, 2015-2017

Additional measures shown here include: reduction in Emergency Department presentations (which speaks to improved access to primary care services and general wellbeing) and reduction in Did Not Attends (which speaks to positive behavioural change).

The CEO of AH+ is Mr Wayne Williams. The ISA Manager is Mr Ray Tuala and the Clinical Lead is Ms Pauline Sanders-Telfer.

National Hauora Coalition

The National Hauora Coalition (NHC) is a collective of 60 health and social service providers that deliver a wide range of services to families/whānau. NHC provides guidance and support to enable its members to work in transformative ways to improve whānau, hapū and iwi outcomes[72].

The NHC describe RBA as a 'foundation methodology' within the wider operating system of the National Hauora Coalition. NHC used RBA to measure its school-based health programme called Mana Kidz. According to NHC, RBA provided it with a "disciplined framework to clearly articulate both performance and population level indicators across the sore throat clinic activity in Mana Kidz."[73]

[72] For more details see: http://www.hauoracoalition.maori.nz/.
[73] Personal communication with Tereki Stewart, Chief Operating Officer, NHC on 20 September 2017.

Overall, Mana Kidz was designed to improve child wellbeing. One aspect of inequitable outcomes that is prevalent in New Zealand is the unacceptable proportion of Māori and Pacific Island children that experience Rheumatic Fever. Rheumatic Fever rates in New Zealand are akin to those in third world countries[74].

To help combat this situation, NHC hypothesised that if sore throats (that are associated with *Group A Streptococcus*) were treated early as part of a school-based health programme, this would contribute to a reduction in Rheumatic Fever rates in Counties Manukau. An overview of the hypothesis using data to tell the story, is outlined below:

Activity	**How much did we do**	**How well did we do it**	**Are children better off**	**Population indicator**	**Population Outcome**
Sore throat clinics	Number of children treated for Group A streptococcus	Percentage of children receiving treatment within 48 hours of lab result	*Percentage of children completing antibiotic treatment with good adherence*	*Rate of rheumatic fever in 5-12 year olds in Counties Manukau Health (% decrease)*	All children have the best start to life

Figure 39: Hypothesis to improve RF rates using RBA data

NHC designed and continues to deliver the programme through a distributed network of primary and community health providers across 88 schools in South Auckland. Using RBA, NHC created a series of performance measures to understand outputs and outcomes. It is worth noting that the programme has large scale outreach in that there are currently 34,000 children attending Mana Kidz schools. The programme has also completed more than 140,000 sore throat assessments, which is a key part of the diagnosis and treatment pathway to prevent rheumatic fever.

Example performance measures are outlined below:

How much did we do (quantity of effort)	• *Number of children with throat swabs taken* • *Number of children treated for Group A streptococcus*
How well did we do it (quality of effort)	• *Percentage of children swabbed within 72 hours of symptoms* • *Percentage of children receiving treatment within 48 hours of lab result* • *Percentage of children treated for Group A streptococcus*
Are clients better off (quantity and quality of effect)	• *Percentage of children completing antibiotic treatment with good adherence (i.e. they've taken all the antibiotics prescribed to them to treat the condition)* • *Percentage of children receiving Group A Streptococcus result*

Figure 40: Mana Kidz performance measures

[74] For more detail see: http://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/rheumatic-fever.

The table below highlights performance measurement data for the quarter leading up to June 2016:

How much did we do	How well did we do it	Are children better off
Number of children treated for Group A streptococcus	Percentage of children receiving treatment within 48 hours of lab result	Percentage of children completing antibiotic treatment with good adherence
4,251	**95%** (4,047)	**93%**

Figure 41: Mana Kidz performance measure data, Q4 2015-16

Based on data collected to date, NHC were able to demonstrate that for its clients, the programme improved medication adherence and a reduction in the Group A Strep load within school populations. At a population level, NHC tracked the Rheumatic Fever indicator. Data up to June 2016 showed a 66% reduction in the number of 5-12 year olds developing rheumatic fever in Counties Manukau Health.

As NHC states:

> "We have applied [our RBA] framework across the various aspects of the programme to build a comprehensive, disciplined approach to performance management and quality improvement. The data has proved invaluable in driving improvements and demonstrating performance across different parts of the programme. Our approach to data and reporting is a process of continual improvement and development."[75]

The lead for this work is Mr Tereki Stewart, Chief Operations Officer, NHC.

3.6. Stakeholder views on using RBA

3.6.1. Views on the advantages, disadvantages and barriers

Stakeholders were asked to share their perceptions about the advantages and disadvantages of RBA. We have analysed the feedback according to three components: advantages, disadvantages and barriers to implementation. We have separated the last two categories because many stakeholder comments were not about the methodology per se. They were more about gaps in practical implementation.

Advantages

- **Accountability** – clarifies accountability between partners and stakeholders at multiple levels (i.e. difference between population vs. performance accountability)
- **Capability building** – builds capability with respect to knowledge of outcomes and associated strategies to achieve improved wellbeing
- **Champions** – supports building a network of outcomes-champions in organisations, which supports building internal capability for sustainable use
- **Clear Impact Scorecard**[76] – related online software is easy to use once you know how to use it; use graphed data to inform conversations about how to achieve outputs and outcomes; use data to change mindsets and focus on what's most important

[75] Ibid.

[76] www.clearimpact.com.

- **Co-design** – offers the opportunity to co-design data with stakeholders/partners to build more relevant data sets and improve buy-in to the importance of data; buy-in early is key to sustainable relationships
- **Common language** – so important; often funders and providers or staff to staff or governance to staff talk past each other; creates unnecessary risks and poor relationships
- **Culturally respectful** – as RBA is a framework, practitioners can design and/or choose content that best reflects culturally respectful/culturally informed data design and implementation
- **Direction setting** – helps users to clarify their most important outcomes-focused direction
- **Encourages new ways of thinking and innovation** – the seven questions encourage people to think differently, to make the most of existing and to justify new resources
- **Feedback loops** – the seven questions encourage feedback loops; using data to drive decision-making
- **Flexible and respectful** – RBA is a framework; it's up the user or practitioner to determine the design of the final set of measures
- **Focus on client wellbeing** – real ability to focus on client outcomes and measure change; who is better off is central to the method; not by chance, on purpose
- **From ends to means** – re-focuses conversations from 'what we do', to 'what we want to achieve and then how we're going to get there'; standardises opportunities to hold purposeful conversations
- **Funder and provider relationships** – has improved relationships; clarified roles; clarified expectations; improved co-operation
- **Generates interest and buy-in to data** – organisations have realised the importance of good quality data collection and why it's important to get 'clean' data that is usable and of a high standard
- **Get real** – can understand the realities of whānau; can use this to help inform the design of data and what's achievable; can support discussions about equity, poverty and strengths-based approaches
- **Informs better contracts** – trust is built during the design process, can lead to longer-term contracts between funders/providers (i.e. NGOs have moved from 1 year to 3 years)
- **Line of sight** – providers know that what is delivered at client and systems level contributes to population outcomes; providers understand how they contribute to the bigger picture and are not solely accountable for population level change
- **Mindset shift** – creates new strengths-based and outcomes-focused conversations; not just about effort, it's also about effect
- **Other models or frameworks and data** – if you want to use data generated from another tool or framework, it's easy to 'map and gap' that data into the RBA framework; not an 'either/or'
- **Performance measures** – focus on measuring client outcomes and outputs; better off measures are most important
- **Population vs. Performance** – clarifies the difference between population and client outcomes; less confusion
- **Reduced but more meaningful reporting** – has reduced reporting; made it more focused on outcomes not just outputs; created new conversations; encouraged 'vital few' data conversations about the quantum of data to be collected, reported and used
- **Understand impact** – at population and client levels; four categories of client outcomes are easy to understand e.g. skills and knowledge, attitude, behaviour and circumstance (SABC)

- **SABC design** –can use the better off data categories as a guideline to designing outcomes linked to the client 's journey through services; an innovative way of showing how a provider makes a difference along an outcomes continuum based on the client's journey
- **Simple framework** – once you get the basic concepts, the framework is quite simple
- **Subjective and objective data** – the framework encourages use of both types of data; subjective data reflects the voice of the client
- **Use inform evaluations** – can use data to inform evaluations e.g. How Much data can inform formative and process improvement evaluations; Better Off data informs outcomes evaluations
- **Use data to inform insights into service model delivery** – the data and information that is generated can be used to inform service model improvements and design; especially when you use the seven questions
- **Value for money** – can be used to inform value for money and investment conversations/assessment tools
- **Voice of the client** – can be gained in many ways when using RBA e.g. co-design of measures, subjective data, turning the curve conversations (using the seven questions)
- **Who does what** – clarifies who is responsible for what; especially when you use the seven (7) questions well

Disadvantages

- **Does not provide an answer to contribution vs. attribution** – this will always be a matter of debate; 'long distance' between client outcomes and population results
- **Focuses too much on quantitative data compared to qualitative data –** not enough emphasis on the importance of using qualitative information like case studies and narrative.
- **Is complex –** it was not simple, and it was difficult to explain the relationship between population and performance accountability
- **Is not a value for money framework –** agreement that it can inform, but it is not a framework in its own right
- **Is not an evaluation framework –** agreement that it can inform, but it is not a comprehensive evaluation framework in its own right
- **Is only one part of the contracting / commissioning process**

Barriers to good quality implementation

- **Buy-in** – there is not always buy in to using a common framework (amongst agencies or providers), so this creates implementation barriers
- **Capability readiness and building** – needed more than what was anticipated in the SCF 2013-2016 project; focus was mainly on agencies but needed to offer more to providers as well. Need multiple partners on the journey at the same time
- **Champions –** need at every level; when champions or leadership move on, then implementation can become vulnerable; this includes changes in policy and governance
- **Change management** –underestimated the change management required; focused more on the documentation rather than mindset shifts
- **Clear Impact software** – is online scorecard software that is aligned with RBA. Licences are a cost to the provider. Not many Funders use this software; it would be good to get a better connect between funder and provider use
- **Early days** – in some cases, the use of RBA in SCF was towards the latter part of the three-year roll-out project led by MBIE. Therefore, it's still 'early days' in terms of use

- **Inconsistency of approach** – there are still inconsistencies in application which supports lack of buy in
- **Knowledge of RBA and power struggles**– sometimes providers know RBA better than agencies, but agencies hold the 'power'
- **Lack of quality data** – data collection is not of a consistent and high quality; there are ongoing challenges with good collection of data (at scale)
- **Leadership** – you need strong leadership at multiple organisational/government layers to ensure high quality implementation. This has not always been the case.
- **Misunderstanding about what RBA is and is not** – some people still do not understand what RBA is and is not. For example, it is not a comprehensive value for money or evaluation framework but data that is generated can inform those types of analyses, with careful planning and initial design
- **One part of the commissioning / funding cycle** – RBA is one part of the cycle only. Therefore, if it's not integrated or is seen in isolation, this can create a disconnected approach
- **Poor or fractured relationships –** between agencies and providers, providers and providers, within sectors: can mean that introducing a new framework is hindered
- **Systems barriers** – can provide additional and unnecessary barriers e.g. absence of client management systems; imbalance of power relationships between funders and providers; lack of trust in the sector; fear of change; poor contract management systems in agencies and the persistent inability to easily collect, extract and use reported provider data (this was a very common theme during the interviews)
- **Training** – more training is required at agency and provider levels
- **Unfair or poor use of the framework; especially data** – by providers, or between agencies and providers, can mean that people reflect negatively on the framework but fail to recognise that it's more about poor use than the framework per se
- **Variable quality of use** – there is still a lot of variable use, within agencies and providers. Time is required to consolidate great practice.

Note that these barriers are likely to be common for the implementation of other outcomes frameworks.

3.6.2. Views on the differences between 'standard' contracting and contracting using RBA

For the purposes of this report, standard contracting is defined as pre-the streamlined contracting framework (SCF). Pre- SCF, most agencies were not using RBA (a notable exception being MSD).

The table below summarises a 'before and after' analysis, in terms of pre and post SCF. The analysis highlights what stakeholders discussed most often:

Before (pre-SCF)	After (post-SCF)	Caveat
No common outcomes approach	A [more] common outcomes approach	Work in progress.
Lack of a cross-government transparency of systems barriers	Transparency of cross-government transparency of systems barriers	The shared programme management team meetings for SCF, hosted by MBIE, enabled agency managers to share their systemic barriers including lack of quality contract management and

Before (pre-SCF)	After (post-SCF)	Caveat
		reporting systems and the difficulties of whole of government change management.
A complex and disconnected language	A move towards a common language	If used consistently, the RBA approach generated a common language.
Internal agency design of performance measures only	A mix of internal agency design and co-design with providers	Agencies adopted different approaches that best suited their scale and transition planning. Where there was a co-design approach, the overwhelming feedback was that it enhanced the relationship between funder and provider.
A focus on outputs	A move to focus on outcomes and outputs	The quality of RBA use is important to make this a reality
A focus on using inputs and outputs data to drive performance	A focus on using outcomes data to drive performance	As above
Using standard administrative data only	Value of designing new data to support data gaps	The opportunity to design new data, that supported the true intent of the initiative was perceived as invaluable by many stakeholders.
Focusing on generic groups of service users or populations	Being specific about who is or are the clients (people and settings[77])	Clarifying who clients are is a key part of RBA. Pre-SCF, the clients could be referred to as generic groups (adults who have a disability) or even whole populations (all children in Wellington). Except for national services with considerable reach, most services are not able to deliver to whole populations of people. Also, client specificity helped funders and providers to discuss the impact on direct vs. indirect clients. These matters were sometimes masked prior to adoption of RBA.

Figure 42: Summary of pre and post SCF differences focusing on RBA

[77] Examples of settings include a marae, an early childhood education organisation, a local council, a local business employing people.

3.6.3. Views on how RBA supports feedback loops in commissioning

The RBA methodology supports multiple feedback loops across the commissioning cycle. During the MBIE SCF project, an Embedding RBA course was offered. In this course, trainees were encouraged to use RBA and the data generated across the commissioning cycle. Trainees were asked to think about data with respect to three components: Design It, Collect It and Use It.

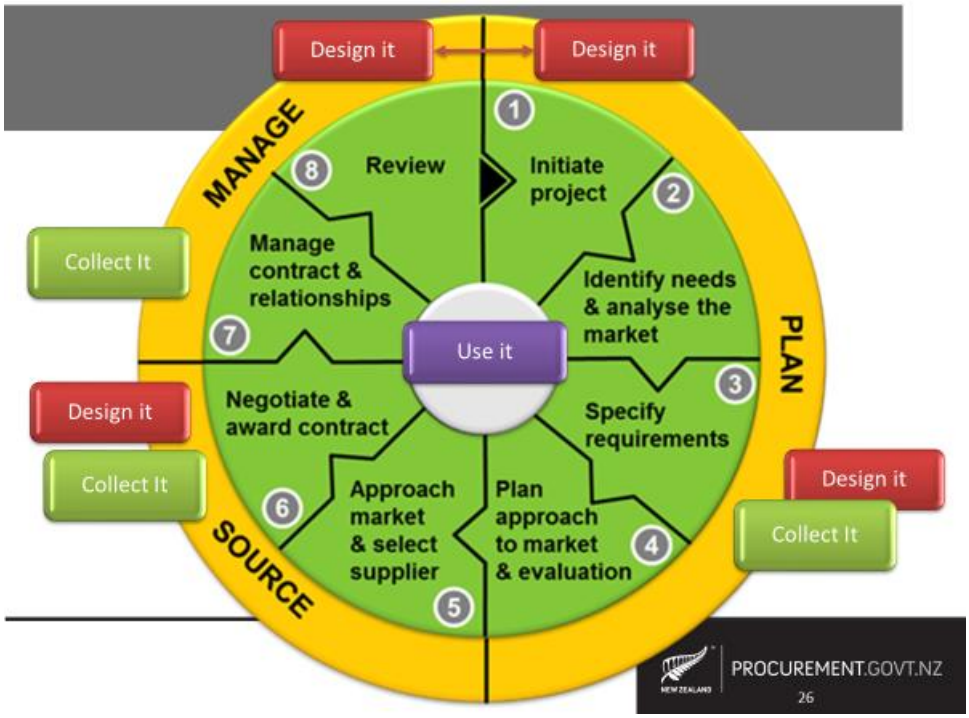

Figure 43: Embedding RBA designed and collected data by using it across the commissioning cycle

Trainees were encouraged to use data through multiple feedback loops across the cycle because at that time, data was not being consistently used *across* the cycle. Often, data was being isolated in Step 7: Manage contract and relationships.

Recent stakeholder interviews provided mixed responses as to whether data (RBA generated or not) was being used across the commissioning or funding cycle through feedback loops. In short, some agencies and NGOs stated that they did use multiple feedback loops and others said they did not, but they wanted to.

3.6.4. Views on RBA reporting, evaluation and use in programme effectiveness and population level outcomes

Stakeholders were asked about their views on how RBA informs reporting and/or evaluation. Most government agency stakeholders commented that their use of RBA-informed data, generated as a result of transitioning to streamlined contracting, was in its 'early days'. Due to these contextual issues, government agencies did not supply data for this report. However, all agency stakeholders interviewed were supportive of using RBA to inform reporting and use of data to drive effectiveness. Other non-government stakeholders provided data and examples of use for this report. Examples of 'turned curves' are outlined later in this section.

All stakeholders raised pre-and post SCF systemic barriers to using data. These included the ongoing challenges of collecting good quality data (especially subjective data at scale) and the ability to access affordable information systems that can easily record, report and trend data over time. Notably, these issues were constant, irrespective of whether the social sector was using RBA or not.

Stakeholders confirmed that descriptive statistical analysis is the most common way RBA data is reported. In all cases, descriptive statistics were supported by qualitative data. Stakeholders used qualitative information to provide contextual background information and insight into performance. In some cases, the qualitative reporting template referred to the RBA 7 Questions, especially questions 4-7, to guide provider reporting. Questions 4-7 focus on understanding causal factors or drivers, partners, what works, and actions plans. Some stakeholders also commented that in addition to the 7 questions narrative, other types of narrative reporting were used to reflect the 'voice' of the client (e.g. vignettes, case studies, short story videos or online posts).

The use of RBA in formal research and evaluation is emerging in New Zealand. Examples of this were outlined earlier in this report. More research and/or evaluation, using RBA as an input, would be helpful to learn lessons and continuously improve how best to use RBA in practice.

3.6.5. Views on the relationship between Integrated Data Infrastructure (IDI) and RBA

The Integrated Data Infrastructure (IDI) is a research database which contains people focused and household focused datasets. The data is sourced from a government agencies, Statistics NZ and non-government organisations.

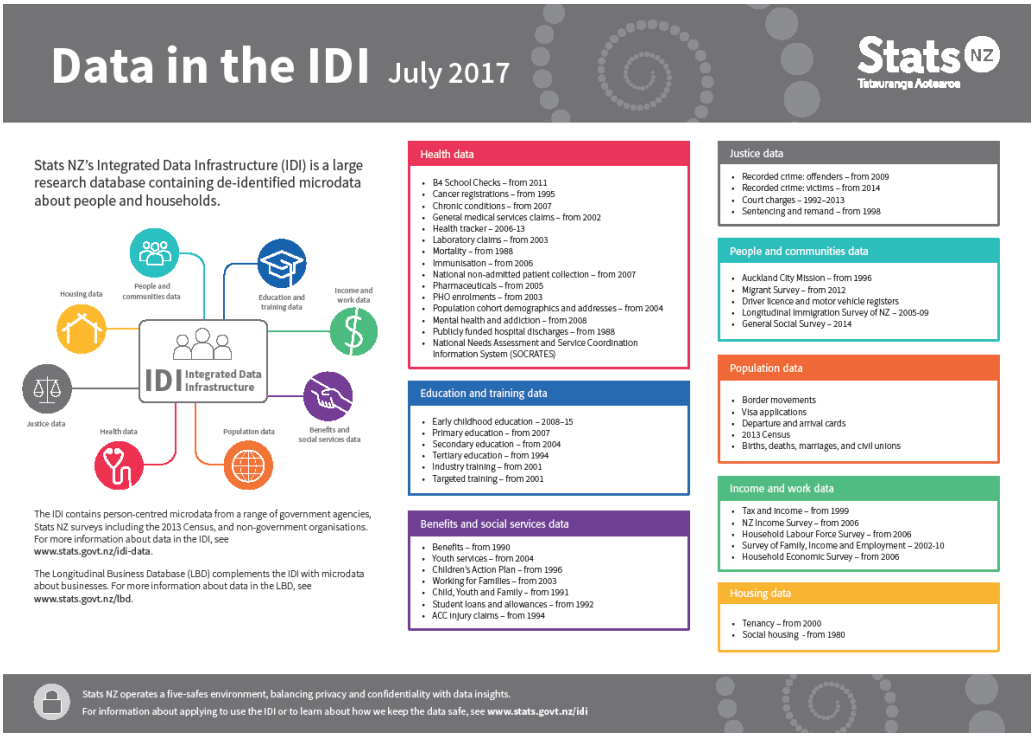

Figure 44: Overview of IDI. Source: www.stats.govt.nz

Access to the anonymised or de-identified dataset is managed by Stats NZ. Stats NZ state that the IDI can be used to:

> "Link data from multiple sources to gain system-wide insights

View longitudinal, life-course information

Identify risk factors and protective factors

Perform predictive risk modelling

Evaluate effectiveness of particular interventions

Identify characteristics of groups with positive and negative outcomes

Tailor interventions to people based on characteristics they share with groups studied"[78]

The IDI dataset cannot be used to:

"Follow individuals who are using services, i.e. case management

Identify specific individuals who are at risk or would benefit from a specific intervention

Identify specific individuals who are abusing systems and take enforcement action"[79]

The stakeholders interviewed were asked about the relationship between IDI and RBA. A small minority of stakeholders were familiar with IDI. Most had heard about it, but that was the extent of their knowledge. The majority of stakeholders confirmed they had not accessed IDI as part of their current use of RBA. This included the government agency stakeholders.

Several, mainly non-government stakeholders, confirmed that whilst they had not accessed IDI specifically, they had accessed secondary data sets readily available from Stats NZ to inform the design of performance measures and to choose relevant indicators specific to population level outcomes. This also included accessing data for comparative or benchmarking purposes.

As outlined on the Stats NZ website, the majority of organisations using IDI are Universities and large government agencies conducting large-scale research projects and/or evaluations[80].

The author suggests that as the IDI data set is based on groups of people and is a population level dataset, it is an informative dataset for choosing indicator data sets to measure population outcomes or aggregated data sets that measure systems-level outcomes. The indicator data may also inform RBA practitioner's choice of performance measurement data (as long as the difference between an indicator and performance measures is not confused) e.g. data for immunisation can be collected at population and client levels. The former piece of data is an indicator and the latter is a performance measure.

All NGOs interviewed were keen to know more about the relationship of RBA and IDI, including the mutual benefits. For NGOs, in-house or externally contracted capability to access and use the IDI data set was extremely limited.

In the author's view, there is no reason why the practical use of RBA cannot be better informed and enhanced through improved understanding, use of and access to IDI data. At present, the IDI data set is more aligned with population outcomes and systems-level accountability. However, some of this data may be able to be disaggregated to a client level for performance measurement purposes

[78] Source: http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/integrated-data-infrastructure/idi-data.aspx. Accessed 10 September 2017.
[79] Ibid.
[80] Source: http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/integrated-data-infrastructure/researchers-using-idi.aspx. Accessed 10 September 2017.

(subject to further investigation and relevance). Overall, whatever the future use of IDI and RBA, this will require increased leadership and access to specialist resources.

4. Research and analysis of stakeholder views about social investment and the relationship to investing for social wellbeing

4.1. Key findings

- Stakeholders were asked to define Social Investment. Definitions comprised two elements: conceptual ideas and what a social investment system might look like.
- It could be said that stakeholders anticipated the current government's wellbeing investment approach, as many of the definitional and implementation ideas shared for Social Investment are relevant to Investing for Social Wellbeing.
- Conceptual ideas underpinned stakeholder's views of what social investment does, should or could address. Ideas included concepts ranging from promoting innovation; a focus on wellbeing and the social determinants of poor outcomes through to promoting equity; protecting indigenous rights; building social capital and human capital.
- Systems-focused aspects ranged from the need to engage multiple stakeholders; use intermediaries to broker solutions; focus on prevention and enable Māori specificity through to using data to drive decision-making; targeting investment to those most in need; clarifying accountabilities; using a strengths-based approach; adopting disruptive technology and shifting mindsets for sustainable change.
- When discussing the role of the SIA, most stakeholders said they had either not heard of the SIA or if they had, they did not know what the SIA offered to the sector.
- Once the SIA's role was explained, all stakeholders expressed an interest in the possibility of receiving support from the SIA in the form of: sector leadership, insights., prioritisation of Māori wellbeing and reducing inequities, and capability building.
- Since mid-June 2017, the SIA has continued to engage with stakeholders and as a result of their latest national engagement process, it is highly likely that their sector profile has continued to increase.

4.2. The relationship between stakeholder views of social investment and investing for social wellbeing

When we interviewed stakeholders about Social Investment and RBA, stakeholders also shared views about how to define Social Investment and implement the approach. In some cases, this latter conversation was prompted by us and in other cases, it was initiated by stakeholders.

In our view, some of the definitional and implementation ideas shared by stakeholders are relevant to investing for social wellbeing as they were about how to use an investment approach to advance wellbeing in general. To a certain extent, it could be said that stakeholders anticipated some of the current sector discussion and change. In our opinion, their views inform potential enablers of a social wellbeing investment system and approach for those New Zealanders who need it the most.

In the following sections, we summarise stakeholder views about social investment and the relationship of those views to the emerging investing for social wellbeing approach.

4.2.1. Stakeholder definitions of Social Investment

Stakeholders shared their definitions of the term Social Investment. We have summarised their views into two categories: (1) Concepts and (2) System Components (see Appendix 2 for full detail).

Overall:

- When stakeholders shared their definitions of social investment, there was a common theme that an *investment approach should be based on wellbeing*. This is aligned with the people-centred definition of IFSW.
- Concepts shared by stakeholders, that align with the people-centred component of the current definition of IFSW, include an outcomes focused approach; that funding is an investment that prioritises wellbeing; that it should consider social ecology and tackle social determinants and that investment should be oriented towards protective vs. risk-factors. These concepts are also considerate of a positive lifecourse model.
- System components shared by stakeholders, that align with the current definition of IFSW such as a system that is evidence-based, builds partnerships and trust and is underpinned by goals and measurement include: the need to incorporate multiple stakeholders (from investors to family/whānau), an intermediary role that could broker solutions, investments aimed at prevention, investments targeted to those who need support the most and clarity of accountabilities (at population and client levels).

One stakeholder commented that the non-government organisation (NGO) sector was 'nervous' about the concept and potential practical application of Social Investment. This was due to the developing nature of the approach and consequent uncertainty about future use. It is unknown if this attitude prevails in the current environment.

Multiple stakeholders stated that they have been outcomes focused for many years, and their organisational philosophy and commitment has always been about improved wellbeing. The implication being that the government focus on outcomes and wellbeing was in 'catch-up' mode.

One large NGO stakeholder confirmed that the origins of their organisation was founded on the concept of social investment, in that early intervention in the lives of children and families was designed to create the best possible start in life.

In sum, many of these views, although expressed with respect to social investment, support the Government's current approach; therefore, potentially anticipating the desire for a shift in definition and implementation approach from social investment to investing for social wellbeing.

4.2.2. Views about and knowledge of the Social Investment Agency

Stakeholders were asked whether they knew about the SIA and what role they thought the SIA should have moving forward. The following points were made in mid-2017:

- **Limited knowledge and awareness** – the majority of stakeholders had heard of the SIA but did not know a lot about the agency. Some had not heard of the SIA or SIU at all. At the time of the interviews, the wider NGO market did not seem to be the target market for SIA engagement, but there was definitely a lot of interest from NGOs about wanting to understand more about the SIA. These views are likely to have changed particularly as the SIA is engaging in a series of national hui/meetings with multiple stakeholders in 2018
- **Leadership role** –stakeholders were keen to see the SIA take on a cross-government leadership role regarding the positive relationship between RBA and Social Investment.

- **Insights** – most stakeholders were keen for the SIA to provide data and insights into what works, provide more details about the 'how to' and what comprised effective initiatives.
- **Inequities and Māori wellbeing** – some stakeholders were keen to see SIA take a leadership role in this area but with high levels of engagement with Māori. This included conversations about the need for data that is both specific to individual and to families/whānau wellbeing.
- **Capability building** – some stakeholders raised the need for centralised co-ordination of access to RBA and Social Investment capability building opportunities. This applied to agencies, providers, and other groups i.e. iwi. The concept of 'readiness' was often raised, especially by those stakeholders who had embarked on purposeful change management within their own organisations and with other external organisations.

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5. Suggestions about effective use of RBA to support Investing for Social Wellbeing in Aotearoa/New Zealand

In this section, we provide suggestions for better implementation of RBA in alignment with investing for social wellbeing. We summarise factors that support successful RBA use and how RBA may be used well to support IFSW implementation moving forward.

5.1. Summary of factors that support how to use RBA successfully

Based on the author's RBA experience and international and domestic literature (outlined in Section 3), below are factors that support great use of RBA:

- **It is important to distinguish between the framework and how it is applied** - sometimes, lack of optimal use is confused with framework deficiencies.
- **An inclusive approach** - existing frameworks (i.e. logic model) or data sets can be mapped into RBA to honour previous work and/or to understand alignment and the value-add of the RBA approach. However, it is important to maintain the fidelity of each framework. In some cases, hybrids become confusing and the resulting product loses its integrity.
- **Expectations** - providers and funders should communicate early about expectations and parameters for design (if any). Best case scenario is that both parties co-design the content. We have seen funders not agreeing expectations and/or changing them mid-stream. This causes huge disruption for providers and unnecessary stress for all concerned.
- **A team approach** – the team responsible for RBA implementation should have a mix of skillsets. This includes the RBA exert or champion and other skillsets such as subject matter expertise, data analysts, researchers and evaluators.
- **Co-design works best** – co-design of the outcomes framework content with multiple stakeholders works best to build early buy-in and engagement. It is important however that designers take ownership of the final content.
- **Train, train, train** - training is critical for staff to use the framework well. Training is an investment in workforce and community capability.
- **Capability building and fidelity of use is not a one-off thing** - funders and providers need to be supported over time to embed great use of RBA. This can take a variety of approaches but a longer-term commitment to use, continuous quality improvement and developing a common language between these parties can support success; including greater strategic and operational alignment.
- **Recognising RBA as a minimum staff skillset is helpful to embed practice** - staff should be acknowledged for turning data curves and supporting evidence-based client outcomes. Acknowledgement can take many forms, for awards and certificates to financial bonuses or an extra day off.
- **Coaching** - is helpful during implementation. Frequency and duration is based on the skillset and progress made by the organisation.
- **Champions** - it is best if internal champions are professionally developed to support whole-of-organisational commitment. Practitioners and organisations need to be trained to use the

framework and supported throughout their journey. Champions need to be at all levels; from the Board and CEO, to Senior Management and Staff on the ground.

- **Using evidence and research** - RBA practitioners should always strive to use evidence and research to inform outcomes framework design. This should be balanced with the desire to be innovative and having the courage to design new metrics which measure desired outcomes that are not yet universally measured (e.g. outcomes that reflect cultural views of wellbeing).
- **An input into evaluation** - in our view, RBA is an input into evaluation. The data and thinking that is generated can inform and/or support an evaluation process. Careful thought needs to be put into other universal steps such as creating an evaluation plan, complementary qualitative analyses, clarity about the evaluation methodology, and other relevant issues. If the data generated via the RBA framework is to be used for research and/or evaluation. It is important to engage early with the researcher and/or evaluator.
- **Quality data is key** - post design of the outcomes framework, quality collection of data is key. This is especially so if organisations want to use the data for formal evaluation and/or advanced statistical analysis.
- **Using data to drive performance** - the framework comprises good advice regarding how to use data to drive performance improvement and/or contract management. These processes are supported by using the 7 Questions in RBA when assessing data.
- **Subjective vs. objective** - it is important to get a balance of subjective vs. objective data.
- **Change management is key** - effective implementation of RBA within an organisation, a sector or across whole of government, requires a change management approach.
- **Communicate, communicate, communicate** - regular communications during the use of RBA is very important, at all levels. This keeps practitioners and stakeholders full engaged, informed and more likely to buy-in to use.

These factors should be taken into account when planning to maximise the use of RBA moving forward.

5.2. The synergies between RBA and Investing for Social Wellbeing

We outline a table below which identifies the positive connect between stakeholder feedback and definitional elements of Investing for Social Wellbeing. Note that the term ‘practitioner’ below, refers to anyone who is optimally applying the RBA framework to improve outcomes.

Principle or concept	Social Investment Agency definition of IFSW	RBA
People-centred	People-centred People are supported and resourced to improve theirs and others' wellbeing	• RBA supports greater understanding of life courses, needs, frontline delivery and boundary-less services through optimal application of the framework, which should challenge current silos and boundaries • For example, when designing outcomes frameworks and strategies for implementation, practitioners not only use multiple inputs to inform the thinking process (e.g. epidemiology, landscape analysis, frontline delivery information), they can also seek to define life course impact through discussing the twin accountabilities and inter-relationships between Population and Performance. This provides opportunities to challenge the status quo, to define the relationships between services and population wellbeing and to create transparent 'lines of sight'. • In addition, clients or populations of interest must always be at the forefront of RBA design to focus on measuring 'what good looks like' from a people-centric approach. ACC's recent use of the framework demonstrated how practitioners can use a first-person and person-centred view to anchor outcomes framework design in the realities of client everyday living and future aspirations. • RBA has created a platform for innovative design of measures that focus on cultural perspectives of wellbeing. As a 'template', it enables practitioners to design or utilize pre-existing measures that focus on individual and collective (i.e. family/whānau) wellbeing, and those matters that are culturally relevant can be prioritized in the framework (e.g. language, customs, belonging, values and connectedness). • When applying the 7 questions, practitioners are encouraged to think about 'what works' and the most important actions that will overcome systemic barriers, such as, boundary-laden services. By supporting practitioners to constructively question why outcomes are not being achieved, the RBA structured way of thinking creates opportunities for dynamic idea-generation using data to drive decision-making.
Wellbeing	Wellbeing – the ability of individuals and families to live the lives they aspire as part of inclusive, fair and prosperous communities. Material and quality of life.	• RBA prioritises outcomes, not just outputs. RBA has traction with multiple stakeholders primarily because it is a framework that re-engineers thinking towards ends, not just means. • Optimal application means that outcomes thinking permeates policy, strategy, systems and service design and delivery.

Principle or concept	Social Investment Agency definition of IFSW	RBA
		• Whilst RBA is not a cost-benefit or return on investment framework per se, *carefully designed* data and narrative that flows from RBA frameworks can be used to inform and/or supplement other data used in these types of analyses.
Collective-focused	Built on partnerships and trust	• Clarifying accountability and systemizing how partners can work together for a common purpose, supports better partnerships and trust. • RBA supports practitioners to clarify two types of accountability: population (population-level outcomes) and performance (client-level outcomes). It supports practitioners to understand their roles and responsibilities within and between the twin accountabilities. At a population level, accountability is shared. At a performance level, accountability is held by responsible organisations. • Practitioners are encouraged to think about partners and the roles they play to improve outcomes. This creates opportunities to prioritise purposeful relationships based on an outcomes achievement lens rather than pursuing relationships that are solely about the means. • Accountability conversations support discussions about collective and/or individual leadership. This is particularly important when discussing how best to work with and across multiple stakeholders for a common purpose. Each stakeholder has a leadership role even when accountability is shared. RBA clarifies this. • Effective role discussions should translate into clearer leadership at population, systems and service delivery levels. • Shared roles and responsibilities requires development of a common language. This creates the ability to talk to each other, not past each other. RBA has created a common language across multiple stakeholders in the social sector (when it is used consistently).
Investment-focused	Investing for social wellbeing Evidence-based	• RBA focuses practitioner attention on developing customised strategies that improve outcomes. When applying the 7 Questions, practitioners are asked to consider: causal factors, partners, what works and the actions that are most likely to achieve success. When discussing causal factors and what works, practitioners are encouraged to choose actions that mitigate or eliminate negative causes as a matter of course. Early intervention and prevention become more transparent in these 'turn the data curve' conversations.

Principle or concept	Social Investment Agency definition of IFSW	RBA
		• Practitioners are encouraged to have evidence-based discussions as part of using the 7 questions. This includes understanding the costs and benefits of early intervention and investment (where possible). • RBA can then support investment decision-making based on proven what works.
Using data to measure effectiveness	Goals Robust measurement Using data, information and technology to measure success Direction setting Feedback loops	• RBA informs innovation by providing a structured way to develop and position ideas within an outcomes context. Innovative idea-generation is encouraged in the 7 questions. • RBA also supports considering 'what works', or proven solutions, as practitioners are encouraged to look at the existing evidence to inform decision-making. • Proof of what works is generated through data – at population, systems and service levels. Data is either designed specifically for the initiative or chosen as part of existing data sets. Practitioners are encouraged to analyse the data (trends over time, for example) and to use this to inform strategies and action for success. • System-wide capability is supported by RBA through many ways. Some examples include: shifting sector mindset from a sole focus on effort to a focus on effort and effect; skill building linked to how to measure outputs and outcomes and the differences between the two; the importance of using data to drive decision-making and analysis of effect; the relevance of causal analysis, evidence-based 'what works' and tracking performance; how to develop outcomes-focused strategic and operational planning and how to use data to inform feedback loops through commissioning. RBA supports practitioners to use indicator data (population-level) and performance measurement data (at a systems and service-level) to quantify whether outputs and outcomes are achieved. • Data is also used to inform a wide range of supplementary activities from service design, organisational planning and quality assurance through to return on investment analyses, research and evaluation (as noted earlier).

5.2.1. Potential use of RBA to support SIA and the wider social sector to achieve outcomes linked to investing for social wellbeing

At the time of writing this report, the SIAs role is to work across the social sector to support use of evidence, innovation and build capability to improve social outcomes. With the insight from the two reports written by us, it is suggested that it makes sense to leverage off RBA to effect social investment specific change, because of the following:

- **It is already being used, it has traction and scale**– RBA already has traction across whole of government; potentially 65% of government contracts with NGOs are using RBA[81]. In financial terms, this could easily equate to billions of dollars. As noted earlier, the Ministry of Health's use of RBA in contracts transitioned to the streamlined contracting framework (SCF) was reported as $1b in its own right.
- **It is a practical framework that aligns with investment principles**- there are considerable synergies between IFSW and RBA. They are complementary in many ways. There is opportunity to share new learnings about how to customise RBA practice to support emerging social wellbeing investment practice.
- **There is sector goodwill and willingness to advance optimal use linked to social investment** –stakeholders interviewed were keen to continue using RBA and expressed wider sector goodwill. There are acknowledged opportunities for improving the optimal use of RBA and even more, to consolidate its use alongside emerging frameworks that support investment.
- **It values work that has already been done** – several stakeholders saw value in embedding RBA practice and focusing on continuous improvement. Significant whole of government change has already occurred to upskill and enable government contracting to become more outcomes focused. Intelligent leadership is required to capitalise on this change.
- **It is scalable** –RBA is a scalable tool that can be used by one-person organisation through to a whole sector. SIA can scale use of the tool as it sees fit.
- **It is adaptable and flexible** – practitioners can use RBA to design data or existing data sets can be 'mapped' into the RBA framework (e.g. IDI sourced data). Other models and tools can also be used, as part of implementation, to enhance the utility of the model, for example, improvement science models like Fishbone diagrams, Plan-Do-Study-Act cycles, Pareto charts, process mapping can inform the 7 questions. If the overarching fidelity of the model remains intact, incorporating other models to enhance the final product makes sense.
- **It supports cultural specificity** – RBA does not prescribe the content; it simply provides the template. The practitioner defines the cultural content of the framework. In the authors view, this is one of the reasons why RBA has gained traction in New Zealand's social sector.
- **It supports equity, risk and strengths-based approaches**- the framework can support these approaches. The practitioner determines the context and the design flows from the starting point. It is worth noting that as population outcome statements are always focused on a positive future, the framework is automatically anchored on strengths-based narrative. Choice of data and strategies then depends on the practitioner.

[81] This figure excludes RBA informed contracts being used by other funders e.g. DHBs.

6. Conclusion

This report provides a snapshot of why, what and how RBA has and is being used in New Zealand. It also provides an opportunity to explore how RBA, if used well, can support an investment approach for wellbeing. For example, there are existing levers in the social sector, such as streamlined contracting, that could be updated to enhance a wellbeing investment approach alongside a more purposeful use of RBA in that space. However, this will require dedicated sector leadership at multiple levels.

As the name of this report suggests, we need to mahitahi - work together and collaborate, to improve equity and increase social wellbeing for all. We need to find tools that support 'what works'. Stakeholders suggested that RBA provided multiple benefits and there were advantages to using the framework in order to showcase success. In particular, RBA is a framework that generates a common language, common purpose and common ground.

Overall, there seems to be a real opportunity for shared learning and advancing the use of RBA as a tool that supports a successful investment for social wellbeing approach.

Appendix 1: Stakeholders Interviewed

	Stakeholder Type	Name	Stakeholders Interviewed or engaged with
1.	Government Agencies	ACC	Brian Nevin, Category Delivery Manager Cath Williams, Programme Manager
2.	NGO – Pacific PHO	Alliance Health Plus PHO	Wayne Williams, Alliance Health Plus PHO, CEO Toleafula Ray Tuala, Programme Manager Pauline Sanders-Telfer, Nurse Manager
3.	District Health Board	Auckland and Waitemata DHB	Aroha Haggie, GM, Māori Health Gains, Waitemata and Auckland DHBs
4.	Government Agencies	Department of Corrections	Choyce Maere, Manager
5.	Other stakeholders	Impact Research NZ	Dr Annie Weir, CEO
6.	NGOs	MASH Trust (Palmerston North)	Rodger McLeod, Senior Manager
7.	District Health Board	Mid-central DHB	Claudine Nepia-Tule, Strategy Planning and Performance
8.	Government Agencies	Ministry of Business, Innovation & Employment	Justine Falconer, Senior Manager, Procurement Malcolm Morrison (ex MBIE, inaugural senior manager of Streamlined Contracting)
9.	Government Agencies	Ministry of Education	Karen Dawson, Chief Procurement Officer, Business Enablement and Support Alan Barrett, Senior Manager, Procurement (Acting) Shelley Hancock (former Senior Ministry of Education Manager) Trisha Turner, Strategic Advisor Māori | Bay of Plenty - Waiariki, Sector Enablement and Support
10.	Government Agencies	Ministry of Health	Adrienne Percy, Programme Manager, Streamlined Contracting, Operational Excellence, Service Commissioning Hayden Taylor, Development Manager Service Commissioning, Disability Support Services Jacqui Glazebrook, Manager
11.	Government Agencies	Ministry of Justice	Adrienne Martin, Manager Hayley McKenzie, Manager
12.	Government Agencies	Ministry of Social Development	Peter Galvin – General Manager Partnerships Peter MacAulay - Manager, Planning and Performance

	Stakeholder Type	Name	Stakeholders Interviewed or engaged with
			Shelley Spencer – Lead Advisor, Planning and Performance Team Jayshree Patel – Lead Advisor, Partnering for Outcomes
13.	NGO – Māori PHO	National Hauora Coalition	Tereki Stewart, Chief Operating Officer
14.	District Health Board	Northland DHB	Dr Sunitha Gowda, Public Health Strategist, Acting Team Leader, Healthy Lifestyles Team
15.	NGO	Plunket	Helen Connors, Clinical Director, Plunket Karen MacGrath, National Service Advisory Manager Radha Balakrishnan, Chief Strategy & Performance Manager
16.	Iwi	Tainui Iwi	Michelle Nathan
17.	Primary Healthcare Organisation	Te Awakairangi PHO	Bridget Allan, CEO
18.	NGO	Te Kaha o Te Rangatahi Trust (South Auckland)	Natasha Kemp, CEO Debi Kapa, COO Te Ao Kapa, Manager
19.	NGO	Te Kupenga Hauora Ahuriri (Napier)	Audrey Robin, CEO Jen Robin-Middleton, Senior Manager
20.	NGO	Te Runanga o Te Rarawa (Kaitaia)	Naomi Austen-Reid, Manager Paulette Lewis, Team Manager
21.	NGO	The Salvation Army (National)	Jonathan Bell, National Practice Advisor/Manager
22.	Iwi	Tuwharetoa Māori Trust Board	Topia Rameka, CEO
23.	Other stakeholder	Whānau Ora Commissioning Agencies - Te Pūtahitanga o Te Waipounamu Whānau Ora Commissioning Agency	Helen Leahy, CEO

Appendix 2: Summary of stakeholder feedback on the definition of Social Investment

Note that feedback is not necessarily mutually exclusive to Concepts or System components.

Concepts	System components
• **Approach -** not an outcome, a model, service or programme; Social Investment is an approach • **Investment**– allocate funding based on a wellbeing approach • **Innovation and transformation** – increased opportunities to incorporate innovative approaches and ideas to transform systems and services • **Wellbeing** – about protecting the future; ensuring intergenerational success; outcomes focused • **Equity –** investment is targeted to improving equity • **Indigenous rights and Te Tiriti o Waitangi –** ensuring that the unique partnership and accountabilities associated with the Treaty of Waitangi are practically translated into action • **Future-focused –** about investing for a better future • **Social determinants –** an approach that considers the wide range of social determinants that impact on poor outcomes[82]; includes understanding social ecology (understanding the complex relationships between people and their environment)[83] • **Multiple perspectives –** need to recognise multiple perspectives and different viewpoints; not just government view.	• **Multiple stakeholders** – investors, intermediaries, providers, clients (individuals, family/whānau) • **Intermediary** – an organisation that brokers relationships, roles, accountabilities and overall approaches between two or more parties to design and deliver a social investment approach • **Multiple levels** – national, regional and local. • **Prevention** – early intervention • **Outcomes focused** – investments are based on effectiveness not just efficiency • **Cross-Agency** - where required, should be intersectoral; mitigate silos • **Population specific** – should contribute to population/community wellbeing • **Client specific** – should deliver individual wellbeing; client-level wellbeing – both individuals and families • **Māori specific** – should consider Māori specificity including whānau, hapū and iwi wellbeing • **Common agenda** – alignment of objectives and goals across multiple partners in the system • **Evidence based** – use research and understand which services, programmes, interventions 'work' • **Data driven** – use data to drive the investment approach from design and planning through to decision-making • **Targeted** – investment should be targeted to those who need it the most e.g. high-risk or high-needs; the 'second generation who are lost to the future'; 'vulnerable populations'

[82] Social determinants include "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels." (Source: World Health Organisation - http://www.who.int/social_determinants/sdh_definition/en/ accessed on 30 August 2017).

[83] For a definition see: http://social-ecology.org/wp/1986/01/what-is-social-ecology/. Accessed 10 September 2017.

Concepts	System components
• **Social[84] and Human Capital[85] –** investing to improve personal and social skills, competencies and networks that improve productivity and outcomes	• **Collaboration** – multiple stakeholders in the system working together for a common purpose; recognises that stakeholders have many roles to play • **Accountability** – clarity about who is accountable for what; including both shared accountability and accountability held by a dedicated party • **Needs-driven** – services, projects or initiatives should identify and respond to needs to improve outcomes • **Wraparound** – able to wrap multiple services around the client • **Disruptive technology** – use technology to find new solutions to persistent problems • **Investors** – thinking laterally about different types of investors ranging from government, philanthropic and private • **Investment types** – thinking laterally about different types of investment from financial through to intellectual and in-kind • **Integration** – ensuring services that are delivered are integrated across sectors and/or within a service delivery system (e.g. understanding the integration and interdependency between clinical and community services). • **Strengths-based** – associated with building sustainable change; more protective compared to risk-focused. • **Shifting mindsets & change management**– need to focus on change management techniques; not just an approach, new way of doing things; need shift mindsets

[84] Social Capital is defined by the OECD as "networks together with shared norms, values and understandings that facilitate co-operation within or among groups". Networks are real-world links between groups or individuals e.g. friends, family networks, networks of former colleagues. Together, networks and understandings engender trust and so enable people to work together. Accessed at https://www.oecd.org/insights/37966934.pdf on 2 August 2017.

[85] Human Capital is defined by the OECD as the "knowledge, skills, competencies and attributes embodied in individuals that facilitate the creation of personal, social and economic wellbeing."` Accessed at https://www.oecd.org/insights/37967294.pdf on 2 August 2017.