FINAL REPORT

Evaluation of prioritised virtual service (PVS)

For Whānau Āwhina Plunket

September 2020

Malatest International

whānau āwhina plunket

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Foreword

The COVID-19 global pandemic brought massive change to the everyday lives of all New Zealanders. Work, school, and home merged into one, our lockdown bubbles quickly becoming the new normal for eight weeks of 2020.

In response to the lockdown, Whānau Āwhina Plunket adapted our services rapidly to deliver virtual services for our whānau. With the Ministry of Health's support, we created a new approach called Prioritised Virtual Services (PVS) to prioritise Well Child Tamariki Ora services based on need and respond to the restriction on in-person contact.

I'm incredibly proud of our Whānau Āwhina Plunket people for stepping up to the challenge of continuing to deliver our Well Child service for thousands of parents and caregivers around Aotearoa during a near-unprecedented time.

It was important for us to also learn from this new way of delivering our services. Thanks to generous funding from the Gray Family and the Ministry of Health, we commissioned Malatest International to undertake an evaluation of the PVS.

Thank you to our staff and whānau who participated and contributed to the evaluation. With the insights we have gained here, we will be able to improve our service to all our whānau, and continue working to ensure all of our precious tamariki have the best possible start in life.

He waka eke noa
We are all in this together

Amanda Malu
Chief Executive
Whānau Āwhina Plunket

Executive summary

Prioritised virtual services are a new way of working for Whānau Āwhina Plunket

The Royal New Zealand Plunket Trust (Whānau Āwhina Plunket) Well Child Tamariki Ora (WCTO) service is based on the national WCTO schedule. The schedule contains seven core visits, completed in-person by a registered Whānau Āwhina Plunket nurse, and additional visits from the wider Whānau Āwhina Plunket team on the basis of assessed need.

Before COVID-19, Whānau Āwhina Plunket offered all whānau in-person contact with a Whānau Āwhina Plunket nurse for core visits one to seven of the WellChild Tamariki Ora programme as required by the Ministry of Health. In response to the COVID-19 pandemic, Whānau Āwhina Plunket agreed with the Ministry to change its service model to prioritise services based on need and to respond to the restriction on in-person contact. WCTO (Whānau Āwhina Plunket and all other WCTO providers) was considered an essential service but was required to be delivered virtually unless there was a health or safety concern that would warrant an in-person visit which could not be resolved virtually. The new approach was called Prioritised Virtual Services (PVS).

Under PVS, the aim was for all clients due to receive core contacts one to three of the WellChild Tamariki Ora programme to receive virtual core contacts by phone or video conference rather than in-person. Māori and Pacific whānau with short-term high-need and all whānau with long-term high-need would also continue to receive virtual core contacts. Other whānau were contacted to direct them to other sources of support including Plunket and other community services and other virtual resources like PlunketLine.

Because there were inconsistencies with how modes and types of contact with clients were documented during the lockdown period, this evaluation report uses the term ‘virtual cores’ to describe the contacts made with clients during lockdown that comprised components of a standard Core visit as defined by the WCTO service specifications. There were components of standard core delivery that could not be delivered virtually (e.g. growth assessments). The current WCTO service specification requires core contacts to be delivered face to face.

Whānau Āwhina Plunket attempted to contact all whānau and communicate plans for services. This provided an opportunity to check on all clients and where necessary re-assess need. Whānau who were not assessed as high needs were directed to other sources of support including Whānau Āwhina Plunket and other community services and other virtual resources such as PlunketLine.

Whānau Āwhina Plunket commissioned an evaluation of these changes, with support from the Ministry of Health to help inform short and long-term service decisions.

The PVS evaluation and methodology

The objectives of the PVS monitoring and evaluation were to:

- Assess how well PVS has achieved outcomes for tamariki and whānau Māori
- Assess how well PVS has improved outcomes for all other children and families.
- Assess how well Whānau Āwhina Plunket staff are supported to do their jobs
- Assess the effectiveness of the prioritisation
- Determine whether Whānau Āwhina Plunket met the PVS service delivery objectives.

Whānau Āwhina Plunket intends to use the learnings from implementing PVS to strengthen all Whānau Āwhina Plunket services.

This final report shares experiences of PVS implementation and support gathered through:

- Sentinel site visits including interviews with Whānau Āwhina Plunket staff (33 on the first visit and 28 on the second) and whānau (19 whānau on the first visit and 16 on the second)
- 18 additional phone or video staff interviews
- A survey of whānau with 3,614 responses (response rate of 27%)
- Surveys of Whānau Āwhina Plunket community staff (81 responses – 43% response rate) and Plunket Nurses (304 responses – 50% response rate)
- Analysis of Whānau Āwhina Plunket administrative data.
- The report also draws on a table-top practice guidance review completed by Whānau Āwhina Plunket.

How staff were supported to do their jobs

Almost all staff told us they had excellent support throughout the lockdown from their managers and teams. Virtual platforms such as Zoom and Teams bought Whānau Āwhina Plunket teams together regularly, and we frequently heard from staff that they got to know each other better over the lockdown period because they made the effort to touch base almost every day.

PVS was developed and implemented rapidly and some staff found the pace and volume of communication difficult to follow. Staff wanted fewer and clearer

communications and survey results suggested there may be opportunities to improve consistency in guidance.

Ultimately, the majority of staff reported they had practice guidance they needed to deliver WCTO virtually and were confident working with whānau virtually. More than half of the staff surveyed were positive about the quality of the practice guidance for safety, cultural guidance for working virtually, maternal mental health and breastfeeding. More staff were negative about the guidance around family violence and growth in the absence of weight measurement.

Staff described different personal situations where work was impacted both positively and negatively by working from home, including family and parenting responsibilities, physical space, access to resources and reliable technology such as wifi and phone signals.

Workloads were variable, with some staff working long hours and others unable to contact clients/whānau due to people not answering their phones. The majority of staff reported their workloads were manageable during normal working hours but one-quarter of community staff and one-fifth of clinical staff disagreed.

After lockdown, many staff reported increased workloads as a result of catching up on core contacts with whānau they had not been able to reach during lockdown. Contacts with some whānau who they had struggled to contact required dropping by or 'cold-calls'.

Prioritisation under PVS

The prioritisation was a combination of whānau level of need, age of their child and ethnicity. Most clinical and community staff reported they understood the PVS criteria but they varied in understanding and agreement of the kaupapa underpinning it.

Whānau Āwhina Plunket staff contacted whānau by phone to explain PVS and offer different modes of engagement. During these phone calls staff were advised to ask whānau if they were okay, providing an opportunity to revise the whānau priority group. The caseload management dashboard proved to be a useful tool in supporting staff to identify whānau in the wrong group.

There was little regional variation in staff accounts of explaining PVS to whānau. Some staff shared discomfort in using the word *priority* and focussed on a strengths-based approach to describing PVS to whānau. Some staff told us that whānau had received generic texts from Whānau Āwhina Plunket and whānau also accessed PVS information online.

Most staff understood the inclusion of ethnicity within the prioritisation criteria and some talked to us enthusiastically about the difference between equality and equity.

These staff were delighted that PVS afforded them the opportunity to prioritise whānau they knew needed them the most. However, a small number felt discomfort about the criteria and were concerned that some whānau who they saw as having higher levels of need were being de-prioritised. The discomfort was often focused on the inclusion of ethnicity as a prioritisation criteria.

Staff wanted to be able to identify higher priority whānau within their own caseloads rather than using fixed criteria. Some continued to work in a prioritised way after the lockdown ended.

Whānau Āwhina Plunket services delivered under PVS

Under PVS, staff were no longer able to see whānau in-person so they had to deliver care virtually, using phone or video conference depending on the preferences of each whānau.

Whānau Āwhina Plunket staff identified whānau access to technology, views on the value of virtual appointments and ability to stay on long-enough virtual contacts as being challenges to connecting by phone or Zoom.

Whānau reported a preference for in-person contact in the whānau survey but many were also positive about a mix. Staff thought virtual contacts would be more effective where they had already built a good relationship through in-person contact. Characteristics like transience, high level of need and speaking English as a second language could make it harder to engage whānau virtually.

Prioritisation enabled staff to work in a more whānau led way and to invest more resources in getting in touch with some harder to reach whānau.

Whānau Āwhina Plunket staff found it harder to identify some whānau needs without being able to visit whānau in their own spaces and see them in-person. Family violence, safe sleep and physical assessments were all identified as difficult.

Post-lockdown, some whānau who had been previously assessed as low-need were encountering challenges resulting from loss of income including inability to meet their basic needs.

How PVS contributed to seamless service delivery

Although the community staff we interviewed did not think clinical teams understood the work that they did, in some regions clinical and community team relationships strengthened over lockdown. For example, community teams across the Southern region worked together to unite isolated whānau. Working virtually was an opportunity to become more connected across Whānau Āwhina Plunket teams.

One in five of the whānau surveyed had engaged with at least one Whānau Āwhina Plunket community service. Feeling more connected to their communities was one of the outcomes from their contact with Whānau Āwhina Plunket, whānau were less positive about.

Some staff spoke about the need to refer whānau Māori to iwi providers where they were able to access kai, clothing and hygiene packs over the lockdown. Referrals to other services were managed in a way that gave autonomy to whānau, providing ability to assess and decide as a whānau what services would be useful.

Most staff agreed that it was necessary to work through a virtual service for the safety of staff and whānau over lockdown however some felt delivering the service virtually had a negative impact on relationships within the wider community particularly with Lead Maternity Carers who continued with in-person contact over the lockdown.

How well PVS contributed to improving outcomes for whānau

Improved outcomes for whānau depended on reaching and responding to whānau Māori, whānau with different levels of need, and whānau in different locations.

Whānau were positive about the outcomes from their contact with Whānau Āwhina Plunket during the lockdown period. Most reported Whānau Āwhina Plunket staff answered their questions about their child's health. Around two-thirds said Whānau Āwhina Plunket staff answered their questions about their own health and helped them feel more confident in their parenting.

Staff had different levels of knowledge and confidence working with whānau Māori. Clinical staff were more likely than community staff to say they felt less confident working with Pacific families.

While at the time of this report, outcomes cannot be measured, we focussed our lens on what worked and where there were challenges in implementing PVS, such as virtual engagement, communication and support for staff. PVS enabled more time to focus on high-priority whānau but contacting high-priority whānau could be difficult when whānau did not have reliable phones or other technology.

How learnings from implementing PVS can help strengthen all Whānau Āwhina Plunket services

Staff interviews have shown us there are opportunities for professional development across many roles to:

- To continue to build staff confidence in virtual consultations such as reassuring whānau about baby's growth, other aspects of working virtually

such as family violence screening required further training to build confidence of many staff.

- Strengthen staff knowledge about equitable health access and outcomes.
- Strengthen the understanding of the roles of the clinical and community teams. The strengthened relationships between clinical and community teams should be encouraged with documented processes to support continuity of care.
- Build confidence for Whānau Āwhina Plunket staff about the interface between health and social services.

Consistency in assessing and recording whānau level of need will help ensure whānau are placed in appropriate priority groups.

Continuing to build community relationships is important. Some relationships Whānau Āwhina Plunket held with community services strengthened over the lockdown but others suffered. Whānau Āwhina Plunket staff described how their relationships with LMCs were strained due to a lack of information and understanding of PVS, coupled with a high LMC workload in the community. Relationships with Police and other agencies and providers strengthened in some regions.

PVS did not create any barriers between Whānau Āwhina Plunket and iwi providers however it did highlight how in some regions there were opportunities to build and strengthen relationships between the two.

It was evident from the interviews that clinical teams connecting regularly through virtual platforms during lockdown created cohesion, promoted positive relationships and helped team members to recognise each other's strengths. Making time for these regular catch ups at the same frequency may not be sustainable in the long-term, but prioritising team meetings might keep up momentum in growing team cohesion.

When we interviewed staff in July, all thought that a mixture of virtual and in-person engagement was an effective way to deliver services and this could be tailored to the needs and preferences of each whānau. Lockdown had provided the opportunity for staff to gain confidence in virtual service delivery, and they were keen to keep this going, with the addition of in-person engagement for high-priority clients. However, when we re-visited the sentinel sites in August/September, staff were overwhelmingly engaging with whānau in-person. Staff told us that they much preferred this to virtual contact because it was more effective and efficient than virtual contact. Whānau also valued '*putting a face to the voice'* and physical assessments but some said virtual contact would be convenient to them sometimes, for example on a wet day or when they were juggling other whānau needs.

Staff in isolated rural communities reminded us that while virtual services worked well for staff and whānau who had technological resources, disparities were created for those who did not.

Māori were over-represented in communities without mobile phone coverage, and whānau who were struggling financially could not always afford to top up their phone or were sharing one device between multiple people.

Whānau Āwhina Plunket staff had clear direction from their service delivery documents and managers to move from a checklist-led to a whānau-led practice. Most staff embraced the *'what's on top'* approach of working with whānau instead of their reliance on going through a checklist. This enabled more whānau-led engagement and encouraged partnership and autonomy.

1. Background

1.1. Prioritised virtual services are a new way of working for Whānau Āwhina Plunket

On March 25, 2020, amidst the global COVID-19 pandemic, Aotearoa New Zealand entered Alert Level 4 lockdown.[1] Before COVID-19, the Ministry of Health contracted the Royal New Zealand Plunket Trust (Whānau Āwhina Plunket) to offer all whānau in-person contact with a Whānau Āwhina Plunket nurse for core visits one to seven of the WellChild Tamariki Ora programme as well as additional contacts based on assessed need.

In response to the COVID-19 pandemic, Whānau Āwhina Plunket, supported by the Ministry, made changes to its service model to respond to the restrictions the Ministry placed on in-person contact to limit the spread of COVID-19, reassign some staff to the wider sector response and prioritise services to ensure those who had the greatest need received services. WCTO (Whānau Āwhina Plunket and all other WCTO providers) was considered an essential service but was required to be delivered virtually unless there was a health or safety concern that would warrant an in-person visit which could not be resolved virtually.

The new approach was called Prioritised Virtual Services (PVS). Distribution and implementation of all PVS documents generated were managed by Whānau Āwhina Plunket's Pandemic Response team and Operations Leadership.

PVS used the data Whānau Āwhina Plunket held about whānau to prioritise them for virtual contact using their preference of phone, video, text or other remote communication. Under PVS, the aim was for all clients due to receive core contacts one to three of the WellChild Tamariki Ora programme to receive virtual core contacts by phone or video conference rather than in-person. Māori and Pacific whānau with short-term high-need and all whānau with long-term high-need would also continue to receive virtual core contacts. Other whānau were contacted to direct them to other sources of support including Plunket and other community services and other virtual resources like PlunketLine. Whānau were also alerted to other external community services such as Women's Refuge.

Whānau Āwhina Plunket commissioned an evaluation of the PVS changes to help inform short and long-term service decisions and to use the learnings from implementing PVS to strengthen all Whānau Āwhina Plunket services.

[1] Lockdown in this report refers to Alert Levels 3 and 4 when Plunket did not have in-person contact with whānau.

1.2. The PVS evaluation

Whānau Āwhina Plunket asked Malatest International to evaluate PVS to:

- Assess how well PVS has achieved outcomes for Māori
- Assess how well PVS has improved outcomes for all other children and families.
- Assess how well Whānau Āwhina Plunket staff are supported to do their jobs
- Assess the effectiveness of the prioritisation
- Determine whether Whānau Āwhina Plunket met the PVS service delivery objectives

2. Evaluation methods

Information for the evaluation was sourced from surveys and interviews with Whānau Āwhina Plunket staff, case studies that included Whānau Āwhina Plunket staff and whānau and analysis of Whānau Āwhina Plunket administrative data:

- Surveys of Whānau Āwhina Plunket staff including WellChild Nurses and Community Health Workers
- Phone interviews with Whānau Āwhina Plunket staff across the country
- Survey of whānau affected by PVS by having a virtual core contact due in the COVID-19 lockdown period
- Analysis of Whānau Āwhina Plunket administrative data
- Case studies of three sentinel sites, including interviews with Whānau Āwhina Plunket staff, whānau and key stakeholders shortly after the lockdown period and again two months later
- Table top review of the Whānau Āwhina Plunket practice guidance provided to staff

This final report incorporates findings from all evaluation activities.

2.1. Evaluation Approach

The evaluation began with the development of an evaluation framework and logic model in collaboration with Whānau Āwhina Plunket. They set the foundation for the evaluation and were the starting point for developing all data collection tools (Appendix One).

The evaluation approach was reviewed and approved by Whānau Āwhina Plunket internal research ethics group in addition to Plunket policy and leadership staff.

2.2. Surveys of Plunket staff

The evaluation included two surveys of Whānau Āwhina Plunket staff: clinical staff and community staff. The surveys were both distributed using email invitations and text message reminders. They were both short and focused on the evaluation questions. Table 1 shows the size of the staff groups surveyed the response rates.

Table 1. Whānau Āwhina Plunket staff survey responses numbers and rates.

Staff roles	Number of staff	Responses (response rate)
Clinical staff – first survey		
Well Child Nurse	438	204 (47%)
Clinical leaders	45	27 (60%)
Health workers: - Not specified - Pacific Community Karitane - Kaiāwhina	 - 97 31	 11 40 (41%) 16 (52%)
Other	-	6
Total	611	304 (50%)
Community staff – second survey		
Administrator	-	22
Coordinator	-	42
Team leader	-	16
Other	-	1
Total	186	81 (43%)

The clinical staff survey included Whānau Āwhina Plunket WellChild Nurses, Kaiāwhina, Pacific Community Karitane and clinical leaders. They were sent email and text-message invitations to participate in this survey online. The profile of responding staff was broadly consistent with Whānau Āwhina Plunket staff as a whole in terms of ethnicity, role, tenure and region (though the Northern region was under-represented – 29% of survey responses compared to 40% of Plunket staff)[2].

The community staff survey invitations were sent to Administrators, Community Service managers and team leaders, Community Services Coordinators (including a wide range of other specific coordinators of community services such as Coordinators of playgroups, parenting programmes and injury prevention) as well as a range of other staff.

[2] Whānau Āwhina Plunket Well Child Nurses and Pacific Community Karitane were slightly underrepresented in the survey responses compared to their proportion within the clinical staff workforce.

2.3. Survey of whānau affected by PVS

Whānau Āwhina Plunket distributed text message invitations and reminders to complete an online survey to a sample of Whānau Āwhina Plunket who had a virtual core visit due (whether it was later completed or not) at the start of the COVID-19 lockdown (23 March to 25 May). The survey was sent to 13,241 whānau by text message. A total of 3,614 responded (27%).

The profile of the responding whānau was a good match with the sample frame overall (Table 2). Due to an error in the dataset, demographic data were missing for 508 of the responding whānau. They have been included in all overall results but excluded from comparisons of whānau characteristics.

Table 2. Overview of the whānau survey sample frame and survey responses

		Sample Frame		Survey responses	
Number		13,241	-	3,614	100%
Missing demographics		-	-	508	14%
PVS Priority		10,805	82%	2,436	78%
PVS Non-priority		2,436	18%	670	22%
Core 1-3		10,515	79%	2,371	77%
Core 1-3 whānau characteristics	Māori	1,422	14%	280	12%
	Pacific	827	8%	160	7%
	Non-Māori Non-Pacific	8,266	79%	1,931	81%
	Short-term	2,739	60%	646	61%
	Long-term	643	14%	126	12%
	Low	1,190	26%	280	27%
	First time parents (FTP)	4,823	46%	1,192	50%
	Non-FTP	5,692	54%	1,179	50%
Core 4-7		2,726	21%	726	23%

2.4. Case studies of three sentinel sites

Whānau Āwhina Plunket also asked Malatest International to explore staff and whānau experiences of PVS across three sites: Kaikohe; Hawkes Bay; and East Christchurch. Their individual reports are published as a companion to this report.

Two of the sites had high Māori populations and all three sites had high levels of economic deprivation (Figure 1).

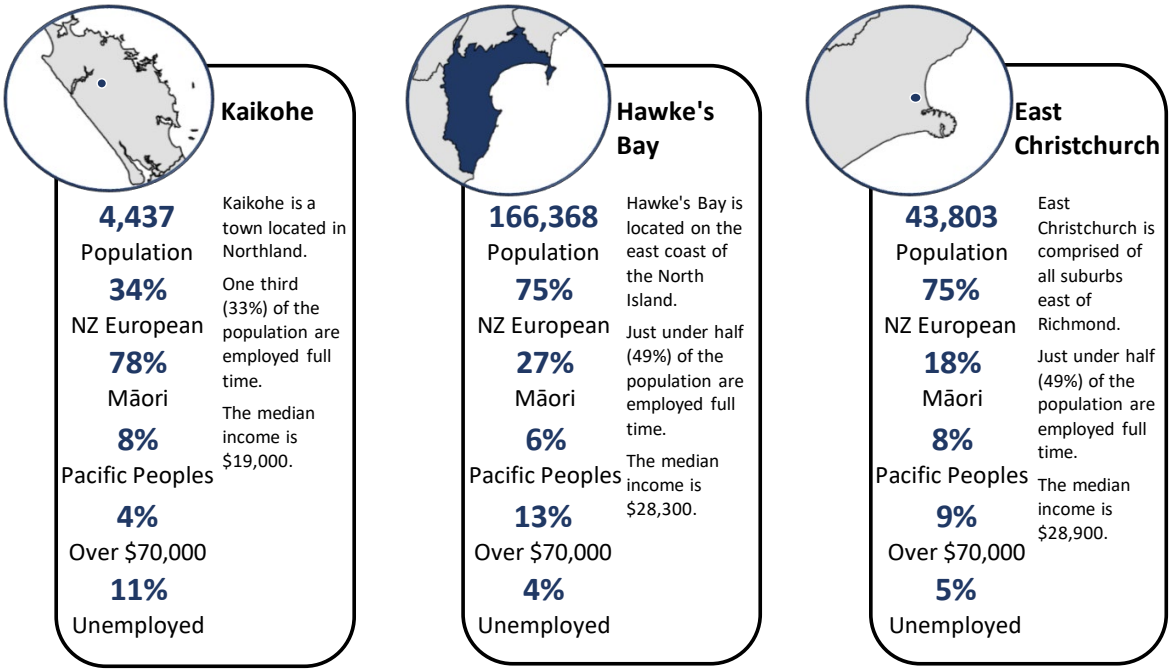


Figure 1. Overview of the populations in each of the three sentinel sites

We worked with Clinical Services Managers, Clinical leaders and Community Service Managers at each site to introduce the evaluation and recruit staff and whānau participants.

For the first visits in July, the Whānau Āwhina Plunket national office team randomly selected a list of 24 whānau from a group of whānau matching characteristics of interest (for example, ethnicity, age of baby, contact with Whānau Āwhina Plunket during PVS) for each site. Whānau Āwhina Plunket staff contacted whānau to check their willingness to participate in an interview. They distributed information sheets and scheduled either in-person or phone interviews (depending on whānau preference) with up to eight whānau at each site, choosing from the random list based on whānau availability and circumstances. Most whānau who were scheduled for a kanohi ki te kanohi interview decided to talk by phone instead. We heard from 33 staff and 19 whānau across the three sites.

We re-visited the same sites in late August/early September. We conducted follow up interviews with 28 staff and we interviewed 16 whānau. We also invited key stakeholders from other community organisations to participate in an interview. Community organisations were very time poor and although we managed to interview representatives from two key stakeholders, five others declined to be interviewed due to time pressures.

2.5. Interviews with Whānau Āwhina Plunket staff

In total, across the first round of sentinel site interviews and the national sample, we heard from 51 Whānau Āwhina Plunket staff about their experiences of PVS (Table 3). For the case studies, all available staff (33) took part in an interview.

To provide broader perspectives from Whānau Āwhina Plunket staff we completed interviews with staff outside the case study sites. Whānau Āwhina Plunket support office generated a random selection of 35 staff and lined up their job titles with our requirements. We requested that the list included the following:

- Māori Whānau Āwhina Plunket nurse
- Pacific Whānau Āwhina Plunket nurse
- All WellChild Tamariki Ora nurse
- Clinical leader
- Kaiāwhina
- Pacific Community Karitane
- Whānau Āwhina Plunket national support staff members (selected by Whānau Āwhina Plunket leadership)

We sent staff an email and information sheet about the evaluation to 26 staff inviting them to complete an interview, stopping once we reached the targeted number of completions. Participation was voluntary. Interviews were undertaken in groups and individually. Of the invited staff, 18 participated in an interview, one declined due to limited time availability and seven staff did not respond to our initial email and follow up phone call.

Table 3. Staff interview participants by role

Role	Number of participants
Whānau Āwhina Plunket nurse	18
Māori Whānau Āwhina Plunket nurse	2
Pacific Whānau Āwhina Plunket nurse	2
Kaiāwhina	7
Pacific Community Karitane	2
Health worker	3
Community Services Manager	3
Clinical Services Manager	3
Clinical Leader	6
National office staff	5
Total	**51**

We sought consent from participants for their interviews to be audio recorded and notes taken from transcriptions. Our decision not to include labels on the staff quotes in the report is deliberate. While we were able to interview a large group of staff, the numbers of participants in some roles such as Clinical Service Managers, Clinical Leaders, Kaiāwhina and Pacific Community Karitane were small and as such, potentially identifiable.

2.6. Qualitative data analysis

The evaluation collected qualitative data from whānau and staff through open-ended questions in surveys and the interviews described above. We used a thematic analysis of the interview data to identify common themes and points of similarity and difference within and between respondents. The evaluation logic model and questions provided the theoretical framework for organising interview themes, linking them to evaluation questions. Leadership from senior Māori staff at Whānau Āwhina Plunket and Māori staff at Malatest International ensured their mātauranga and wider Māori worldviews were included in analysis and interpretation of data.

We grouped data under each topic area and then searched for similarities and differences within the themes in the data. Throughout this process the evaluation team met regularly to discuss and agree on thematic coding.

2.7. Analysis of Whānau Āwhina Plunket administrative data

Whānau Āwhina Plunket provided extracts from the ePHR database used by Whānau Āwhina Plunket staff to record data on their work with whānau. We used data related to two cohorts in our analysis:

- COVID-19 cohort: Whānau with a virtual core WCTO visit due with Whānau Āwhina Plunket during the lockdown period (March 23 – May 25, 2020)
- 2019 comparison group: Whānau with a core WCTO visit due for the same dates in 2019.

Our analysis aimed to describe the data recorded about whānau experiences during the lockdown period when PVS was in operation and compare them to the experiences of whānau a year earlier, unaffected by PVS or COVID-19.

Because there were inconsistencies with how modes and types of contact with clients were documented during the lockdown period, this evaluation report uses the term ‘virtual cores’ to describe the contacts made with clients during lockdown that comprised components of a standard Core visit as defined by the WCTO service specifications. There were components of standard core delivery that could not be

delivered virtually (e.g. growth assessments). The current WCTO service specification requires core contacts to be delivered face to face.

2.8. Tale top review of the Whānau Āwhina Plunket practice guidance provided to staff

Whānau Āwhina Plunket staff undertook a review of the practice guidance delivered to staff in relation to PVS. The evaluation team met with Whānau Āwhina Plunket to share the evaluation logic model and framework so the practice guidance review aligned with the rest of the evaluation. We also shared a list of themes emerging from the staff interviews to provide context for the practice guidance review. The results of Whānau Āwhina Plunket's review are included in this report (section 3.1).

2.9. Evaluation strengths and limitations

The evaluation was strengthened by the investment in the development of a logic model and an evaluation framework in consultation with Whānau Āwhina Plunket staff. These two evaluation foundations were the basis for data collection tools, analysis and reporting.

The evaluation included several modes of data collection from different stakeholder groups. Staff contributed to surveys, interviews (some in-person at sentinel sites and some over the phone or Zoom) and the review of practice guidance. Whānau participated in in-person interviews on sentinel site visits as well as phone and Zoom interviews and the online survey.

The evaluation's view of the impact on outcomes for whānau was limited by the relatively short time between the lockdown period and the end of the evaluation (four months). The evaluation may be strengthened by taking a wider view of outcomes (for example, adding analysis of Ministry of Health data to analysis of the Whānau Āwhina Plunket data) at a later date once differences between the COVID-19 cohort and other whānau have time to emerge.

The evaluation took place during a period of time where staff and whānau were all impacted by COVID-19, both personally and professionally. The influence of that context on staff views is unknown, so findings should be interpreted with that in mind.

3. How well staff were supported to do their jobs

Summary

PVS was developed and implemented rapidly and some staff found the pace and volume of communication difficult to follow. Staff wanted fewer and clearer communications and survey results suggested there may be opportunities to improve consistency in guidance.

Ultimately, the majority of staff reported they had the practice guidance they needed to deliver WCTO virtually and were confident working with whānau virtually. More than half of the staff surveyed were positive about the quality of the practice guidance for safety, cultural guidance for working virtually, maternal mental health and breastfeeding. More staff were negative about the guidance around family violence and growth in the absence of weight measurement.

Staff described different personal situations where work was impacted both positively and negatively by working from home, including family and parenting responsibilities, physical space, access to resources and reliable technology such as wifi and phone signals.

Almost all community and clinical staff told us they had excellent support throughout the lockdown from their managers and teams. Virtual platforms such as Zoom and Teams bought Whānau Āwhina Plunket teams together regularly, and we frequently heard from staff that they got to know each other better over the lockdown period because they made the effort to touch base almost every day.

Workloads were variable, with some staff working long hours and others unable to contact clients/whānau due to people not answering their phones. The majority of staff reported their workloads were manageable during normal working hours but one-quarter of community staff and one-fifth of clinical staff disagreed.

3.1. Practice guidance to deliver virtual services

Directly before and during the COVID-19 lockdown there were many communications to staff from Whānau Āwhina Plunket support office about PVS. Practice guidance and communications were in the context of a rapidly changing chain of events led by the Ministry of Health which flowed through to a large volume of communication and changing messaging.

> *For me it happened rather quickly, so it was like scrambling for the best information and drawing on resources I may have had already. This was new to everyone, especially if it had never been a way of delivery before.*

Information was available on the Whānau Āwhina Plunket website, intranet, frequently asked questions page and inbox for staff questions about PVS. Clinical Service Managers and Clinical Leaders described summarising information regularly to disseminate with teams. Staff who were able to provide more of a national perspective described the balance required between sending out generic messages about PVS and nuancing information for different groups.

> *We had varying feedback during that time about yes I want you to give all of the messages so I can go and do that with my team. And other cohorts of people said no I want to be able to nuance that for my team, but generally the messages were fairly consistent all the way through in terms of what we produced.*

When we asked staff if they felt they had all the practice guidance they needed to deliver virtual services, almost all commented on the high volume of communication regarding PVS. The need for communication to change to reflect the rapidly changing environment highlighted the need for brief communication that was consistent and accessible for staff. Most staff said they did not have enough time to read all communications.

> *There was confusion in the information, one day it was this, another day it was that. The information wasn't consistent so that created a bit of confusion. There was confusion in the expectation, one person would say this and another would say that. Things also changed. We needed to keep up to date. It was [frustrating] but we just decided we will just play it by ear.*

> *There was so much going on, and for us the guidelines were changing a little bit and some of the messaging from the top wasn't in alignment with what we were being told to deliver at the frontline and what was being communicated to the stakeholders.*

When we followed up with sentinel site staff in August/September, they reiterated wanting less and clearer communication from national office if there was another lockdown. Several staff from different regions suggested the need for further practice guidance on what to do when whānau they were worried about did not respond to multiple attempts at virtual contact such as phone calls and emails.

> *How many times we contact would be good. How many times is enough if we've contacted and constantly text and called consistently for the last three weeks and we've still got nothing and we've cold called and we've still got nothing. How many times do we keep trying before we stop?*

> *[When] I have emailed, texted, phone-called, tried to have Zoom meetings multiple times with a family and haven't been able to get hold of them. And I am really worried about them. Apart from doing a report of concern or ringing a GP how do we support that staff member with that?*

The staff surveys found the majority of staff had the information they needed to deliver WCTO virtually though they were slightly less positive about the consistency of the guidance they received (Figure 2). Community staff were provided with new

guidance around pre-screening, decision tree and referrals consistent with WCTO guidance.

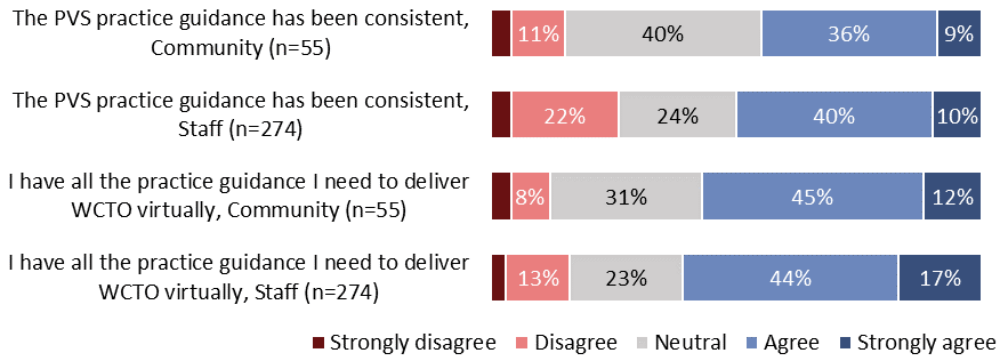


Figure 2: Clinical and community staff agreement regarding practice guidance

Most staff felt confident working with whānau virtually and results were consistent across clinical and community staff (Figure 3). However, there was a minority of staff who were not confident.

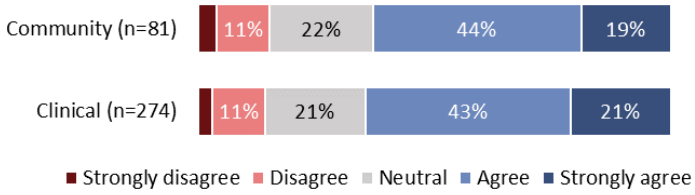


Figure 3: Community and clinical staff agreement with the statement "I am confident working with whānau virtually"

The list of practice guidance documents provided to staff is included in Appendix 2. Guidance on different topics was rated at either good or very good quality by at least half of staff surveyed (Figure 4). However, staff were more likely to see guidance around family violence and growth in the absence of weight measurement as lower quality. These two topics were more likely to be different working virtually.

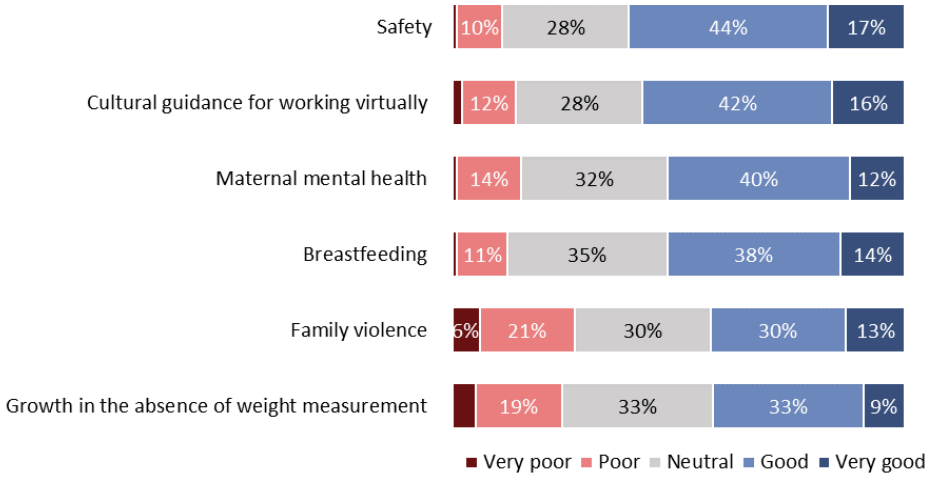


Figure 4: Clinical staff views on the quality of the following Whānau Āwhina Plunket guidance delivered during PVS (n=273)

Staff ratings of the quality of guidance appeared to be closely connected to their tenure with Whānau Āwhina Plunket. Positivity about maternal mental health guidance increased with tenure from 40% for staff of 0-1 years to 57% for staff of 10+ years and there were similar patterns in safety (50% to 66%), family violence (27% to 53%, though staff of 6-9 years were also less likely to be positive - 30%) and growth (19% to 51%).

Cultural guidance was an exception, with newer staff of under one year (57%) more positive than staff of 1-2 years (34%) but consistent with the other longer tenured staff (54-68%).

Whānau Āwhina Plunket reviewed their practice guidance documents and aligned them with our evaluation objectives. Table 4 describes the documents, their availability and timing, alongside the evaluation objectives and questions. Staff interviews also highlighted how communications and practice guidance were discussed in regular team meetings.

Table 4. Results of the practice guidance review undertaken by Whānau Āwhina Plunket

Evaluation objectives	Evaluation questions	Evaluation of PVS documents
Assess how well PVS has achieved outcomes for Māori	Has PVS achieved equity in outcomes for Māori?	• Clear and overt prioritisation of whānau Māori, using an approach that Whānau Āwhina Plunket has never used before. • Equity explained/defined in document released in Alert Level 4 'Guidelines Whānau Āwhina Plunket WCTO Prioritised Virtual Service'
	Do health outcomes improve for Māori whānau and tamariki?	
	What lessons can be learned about what works for Māori from PVS?	

Evaluation objectives	Evaluation questions	Evaluation of PVS documents
		• Equity was also evident in the prioritisation document focused on re-engaging at Level 2 'Scheduling priority whānau' and 'Whānau Āwhina Plunket guidance for service delivery recovery & engagement'. • Strategies to strengthen engagement with whānau Māori e.g utilisation of Kaiāwhina • Included key health outcomes were expected to be assessed or incorporated in key messages (Maternal mental health, SUDI and smoke free, family violence, breastfeeding and feeding/growth)
Assess how well PVS has improved outcomes for tamariki and whānau	Do Whānau Āwhina Plunket services support whānau aspirations? Do whānau feel confident in their parenting roles? Do health outcomes improve for tamariki and whānau?	• Practice guidance encouraged staff to take a 'what's on top' approach with whānau and family. • All of the documents provided to staff had a clear message regarding the importance of prioritising whānau Māori
Assess how well Whānau Āwhina Plunket People are supported to do their jobs	How well are Whānau Āwhina Plunket People working virtually? How supported are Whānau Āwhina Plunket People in their practice? How has PVS contributed to seamless service delivery by Whānau Āwhina Plunket clinical and community staff?	• Infection Prevention and Control (IPC) guidelines updated in timely manner to reflect changes in Alert Levels and advice given by the Ministry of Health. Documents covered all aspects of Whānau Āwhina Plunket work- e.g. home, clinic, office, car • All of the IPC documents had consistent messaging. There was some repetition of information so staff only needed to access one document. • Regarding technology- screenshots and step by step instructions were provided to enable staff. • Decision tree to support application of guidance into service delivery provided • There was a delay in the delivery of associated education packages (Te Māra and webinars). E.g. FV available week 3 or 4 of lockdown. This

Evaluation objectives	Evaluation questions	Evaluation of PVS documents
		may have impacted on staff confidence to address family violence with whanau.. • There were no documents provided to support continuity of care between clinical and community. Availability of Community Services varied across the country.

Staff survey results highlighted whānau Māori and Pacific families/aiga as groups clinical staff were less confident working with virtually (Table 5). They were more confident working with first time parents, whānau with new-borns and young parents.

Table 5: Confidence in working with different whānau virtually (clinical n=273, community n=58)

	Much less		Less		Neutral		More		Much more	
	Clin	Comm	Clin	Comm	Clin	Comm	Clin	Comm	Clin	Comm
First time parents	6%	2%	20%	14%	44%	47%	23%	32%	7%	5%
Whānau with a new-born	5%	2%	20%	16%	45%	52%	23%	29%	7%	2%
Young parents	5%	2%	19%	7%	45%	52%	24%	36%	6%	2%
Rural whānau	5%	5%	19%	7%	46%	60%	24%	25%	6%	2%
Whānau Māori	6%	4%	27%	16%	50%	63%	14%	16%	2%	2%
Pacific families/aiga	9%	2%	28%	16%	49%	66%	11%	13%	3%	4%

3.2. Staff confidence with and access to the tools/technologies for PVS

During the lockdown, (alert level 3 and 4), service delivery for Whānau Āwhina Plunket was completely virtual. Whānau Āwhina Plunket staff attempted to contact all whanau with a booked appointment and all high--priority whānau via Zoom and phone calls. All whānau were encouraged to contact PlunketLine and some staff emphasised the use of other Plunket community services such as virtual playgroups, parenting groups, coffee groups, and educational activities. The introduction of the PVS dashboard tool was a useful function for staff in being able to easily find which whānau were prioritised under PVS. Staff shared the simplicity of clicking a single button which generated a list for them to work with.

The PVS dashboard was good because it gave us a tool to very quickly visually drill down to our priority populations.

Few staff identified their access to the tools and technologies needed for working virtually as a barrier (Table 6).

Table 6: Extent the following factors were a barrier to engaging with whānau virtually (clinical n=81, community n=272). Note: the scale used for this question in the community survey was 5 point, thus answers '3' and '4' have been categorised as 'somewhat'.

	Extreme		Moderate		Somewhat		Not a barrier	
	Clin	Comm	Clin	Comm	Clin	Comm	Clin	Comm
Having correct contact details	25%	1%	24%	15%	31%	56%	20%	28%
Your access to technology (suitable device, adequate internet connection, etc.)	5%	1%	14%	19%	21%	60%	60%	20%

One notable regional variation was that the Northern region identified not having correct contact details as an extreme barrier to engaging with whānau virtually (43% compared to 19% and 13% for Central and Southern respectively). Nearly half (44%) of clinical leads identified not having whānau contact details as an extreme barrier.

In interviews, a few staff described how whānau were missed because contact details and crucial information was missed on the referral form. It was important for staff to track down the referral source and find out if the whānau had updated contact details. Staff focussed on looking for solutions and seeking help from other services instead of creating barriers and allowing whānau to miss out on services.

Sometimes it's around the referral. The information is not updated by the midwife, but I think as part of our learning as practitioners we actually need to think about how we try and find a whānau. For example, sometimes a new baby is referred, they haven't been contacted before, they will get sent to me. I will open up the ePHR file - where is their GP? Who is their midwife? I will go back to the nurse and say I actually contacted their midwife and got an updated contact, sometimes we create our own barriers because we don't look hard enough to find a solution.

Many staff described regularly working on their Whānau Āwhina Plunket tablets and navigating booking systems and calendars prior to lockdown. They carried that confidence into PVS and most had no problems with using the tablets. However, staff access to reliable wifi varied. Some staff, more commonly staff in rural areas, did not always have access to strong mobile reception or consistent wifi and phone reception was also not reliable for some.

Sometimes the internet stuff was pretty real and the overloading at the beginning on the phones made it tricky. I don't think we were under resourced, but I live rurally so sometimes the internet wasn't as reliable and a lot of the clients were in the same position.

A lot of the whānau that I currently work with are in emergency housing and a lot of their connectivity to the internet is really poor. We see a lot of whānau in emergency housing and they're very transient anyway.

A small number of staff found moving into a completely virtual service overwhelming due to their tablet '*crashing*' or lacking confidence in using online tools. Some staff were able to draw on the technology skills and support of whānau members.

One of my shortfalls was the technology. I had a tablet that wasn't working so I had to use my mobile phone. I still had access but it wasn't the same and now I've got a laptop.

When I first started, we didn't have much tech. It was more bookwork. Now… they encourage us to use tech. So I still have a hard time trying to use technology, I'm not too good at that, I'm still learning.

For a small number of staff, the impact of poor Information Communication Technology (ICT) meant they were unable to work at all. If there was another lockdown staff suggested flexibility so that they could travel to a space with the tools they needed such as making phone calls and Zoom meetings from a clinic.

[Our Kaiāwhina] had issues with connectivity, I don't know what the option is but even if we could get her to the clinic to do work when there is no other option.

Staff who participated in our second round of sentinel site visits said they continued to have the tools and technologies needed to deliver their services to whānau. For most, using their tablets and phones sufficed, but at least one staff member described having a new laptop with a longer battery life, and good support from ICT.

I am one of the lucky ones with the new laptops. Because the old ones, during lockdown the battery life was short. ICT are fantastic.

3.3. Social media was used to varying extents and provided learnings

Staff had different understandings around the use of social media platforms such as Facebook. Some staff were confident using Facebook to engage with whānau and families found it useful when they had exhausted attempts to reach whānau using phone, text and Zoom. Staff found that Facebook was a preferred option for some younger whānau and for other whānau without credit on their phones.

There are a lot of mums who like the messenger or Facebook. We have to find other ways to contact them and see if they're alright.

Some of mine I could contact on messenger but some of them no. I found it was the younger ones who were happy to contact on messenger because they don't have credit and that is how they contact each other anyway.

Although Facebook was easy to access, it was not always a straightforward process to find whānau. Some whānau had different names or profile pictures which made it harder to identify, therefore it was generally only used if a nurse had a pre-established relationship as they were able to identify names and pictures.

> *It was over the lockdown it came in and we were able to use Facebook messenger to try and contact them. If we had seen the person and knew what they looked like it worked really well because we knew who they were, so it wasn't a privacy breach and that was really good. But hard if you didn't know who they were.*

Some staff expressed concerns about privacy and safety using social media platforms and wanted more guidance around when and how social media could be used. Plunket provided staff with privacy and consent guidance from an earlier pilot.[3]

> *[Using social media] opened up a whole kettle of fish, because then people would start searching you on Facebook. It's such a privacy thing, so I didn't go near it.*

> *Over lockdown there was communication to say we could use messenger and a lot of people missed it because it was down the bottom. But there needs to be education and guidelines around using it.*

Staff we spoke with at one location had established their own Facebook page. A staff member was responsible for contacting whānau through the Facebook account and referrals would be sent to the designated Facebook staff member. As awareness grew, the page was inundated with demand from whānau who wanted contact via Facebook or its associated messenger app. Staff reflected months later that if they were to go through the lockdown process again, they would remove the designated Facebook role and each staff member would contact their own caseload.

> *We had to refer to someone to contact [via Facebook] and that person was understandably swamped and it took time. It's also double handling. There was one nurse who we could send a referral to [contact families on Facebook] ad because everyone used her it would take a while to hear anything back. If the mums prefer it, if the mum want it why can't we use it, as long as we're having contact with them.*

3.4. Staff views on working from home

Most staff struggled with working from home over the lockdown but this was in the context of sharing the home with others. Staff were mindful of work and personal boundaries and worried about not having privacy or quiet space for work in their

[3] Prior to PVS, Plunket was piloting the use of social media to engage clients. This pilot operated under specific practice guidance that was more widely used during lockdown to enable to practice to be part of the engagement methods available to staff. Plunket is continuing work in this area to ensure practice guidance on the use of social media is adequate and consistent.

homes. This reduced their confidence and ability to manage their workloads when they were working virtually.

I was reluctant at first, you know with privacy. So I positioned my camera so they could only see what I wanted them to see. I had everything set up so it could be as smooth as it could be.

I wasn't really confident working from home. Because of privacy and there wasn't space to work with the family around. We were all working from home during the lockdown and we were trying to find our own spaces to work from.

I personally didn't find it too bad because I use a variety of digital in my role from what staff do in their role.

I didn't mind it, but I'm a very hands on person I got very excited when I could do a Zoom call with someone because I could see the baby.

When we checked in with staff in September they had overwhelmingly chosen not to work from home. With space to reflect on their work/life balance over the lockdown, staff shared their struggles working from home and looking after their own whānau, particularly staff members who were single parents. The few staff who were working from home spoke about how much easier it was to work from home when children were at school.

I had to drop down a day because it was too much working and having my kids all in the one spot. But after dropping down a day from four to three it was a good balance.

Staff emphasised the culture shift in no longer being tempted to carry on with in-person engagements if they were feeling unwell. The experience of working through lockdown showed staff that they could work from home effectively. Most staff were confident in their ability to work from home if they were becoming sick or unable to come in to work and in these instances the virtual service continued.

It's a lot easier if they know you and your phone number. Sometimes you have to send a text and remind them who it is, plus they've met you. [In-person] is important because if you've had a chance to build a relationship prior then they're more receptive to talking to you on the phone because they know you. They know what you look like. They know who you are.

It [virtual engagement] only happens if someone is sick or someone can't work.

3.5. Minimising COVID-19 risk

After lockdown, we asked staff if they thought their COVID-19 risk was minimised. Most thought it was and felt well informed and resourced although some staff raised concerns about families playing down their symptoms so they could access the service.

No I don't think so. We're texting everybody when we're going to see them or when they're coming into clinic, is everybody well because they want the check done and they're minimising the symptoms because they want their check.

Most staff felt that they had enough information and resources to minimise COVID-19 risk to themselves and whānau. During home visits and other in-person engagements such as drop-in clinics, some whānau wanted reassurance about COVID-19 exposure risk being minimised and others valued seeing facial expressions over wearing masks.

It is a bit hit and miss. Sometimes you have clients who say actually I don't want you to wear a mask. They struggle with the limited facial expressions. I completely understand that, how it is hard to ready body language. Particularly when you are talking about things that might be a bit more of a sensitive topic.

3.6. Impact of PVS on staff workloads

Whānau Āwhina Plunket staff workloads were affected geographically and by the level of need of their communities. Across all roles, staff felt a responsibility to whānau, whether this meant having policies, strategies and communications ready or knowing that a whānau needed support at 8pm and taking their call.

I'm a [Whānau Āwhina] Plunket nurse for a rural area, I work two days a week in my rural area which is a small-town country. I have three different clinics and I go around them once a fortnight and I also home visit. One day a week I do relief, I go into the city or (name of town), which is a smaller town, rural area. I do a combination of home visiting and clinics for WellChild checks.

Different contexts influenced the extent PVS impacted on staff workloads. While the majority of staff agreed their PVS workloads were manageable during normal working hours, nearly one-fifth of community staff and one-quarter of clinical staff disagreed or strongly disagreed (Figure 5).

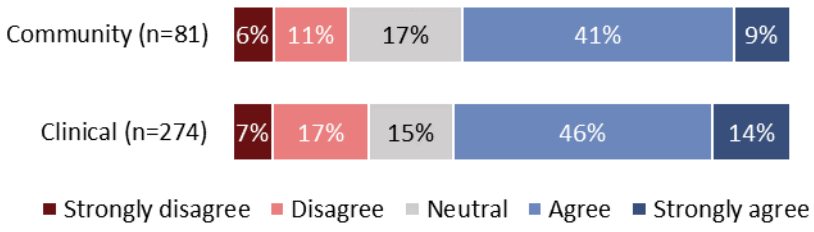


Figure 5: Clinical and community staff views on whether their workload during PVS was manageable within normal working hours`

Some staff were not able to engage remotely over the lockdown due to their own whānau responsibilities such as childcare, or a lack of workspace, access to wifi or

other issues with technology. Some had lower workloads because they were not able to contact whānau on their caseload. Other staff worked very long hours and the boundaries between home and work became blurred.[4]

> *I was the face that they [whānau] knew. They knew my phone number and they were constantly being told in the media PlunketLine is very busy you might be on the phone for two hours waiting for it to be answered or Healthline so use that service. They're not going to use that service because I know she will answer me. Again, it felt like you were never away from work, people calling outside of hours that happens a lot.*

Workloads were a challenge for some national office staff as well as Whānau Āwhina Plunket clinical and community staff.

> *All of us worked all weekend, all the week, trying to think about how do we get everything done, how do we make sure our people are safe and how do we support them as well as what is our response likely to be?*

> *I don't think they [external Comms contractors] really respected how hard the team had been working. I was logging in at 7am to get emails done and going right through until 5pm at which point we were in the middle of a pandemic. It's not really sustainable. They were emailing at 5 o clock saying we need this done by tomorrow morning. At which point I went back and said look if you need something and it's urgent you have to call us because we're not checking our emails all evening, we have to look our own health.*

In one rural location we heard Whānau Āwhina Plunket hired more staff during the lockdown which was appreciated by staff as this decreased their feelings of isolation. Staff valued the ability to work together, debrief and complete peer support and supervision with other nurses.

> *The staff have never been faced with so much stress and the hard part is the majority of the staff are new. They've been through a pandemic. They've started a new role during the pandemic. They've come out and in a way been fast tracked. That is a massive trial and on top of everything we've got the stressors of the social needs for whānau increase and the increase in reports of concern (ROCs). They've got peer supervision and they know they can contact me any time but it's massive. We also have counselling.*

> *My best support is having another nurse here. Looking at my caseload before [my colleague] started I was totally overwhelmed but knowing that [my colleague] was coming and eventually going to be able to do some mahi that's what I was looking at.*

During our second round of staff interviews, we heard that working virtually did not necessarily free up extra time for staff. Staff felt that phone calls were no quicker than an in-person appointment and required considerably more concentration than being in the same room as whānau. Gains from not having travel time were limited by higher non-response and the need to follow up with whānau through multiple modes of communication.

[4] Plunket has a workforce project underway to address caseload equity.

[virtual engagement] You are doing a half job in the same amount of time.

It was quite tiring. It is actually more tiring over the phone. Because you are not using your senses. You have got to really, really concentrate. You haven't got the sight, the touch, smell, visual.

3.7. Re-deployment to other roles

A small number of staff we spoke with had been re-deployed over the lockdown. The prospect of re-deployment was considered likely for staff, as Whānau Āwhina Plunket had a large nursing workforce. Some staff were excited by the idea of a new challenge but many worried about working in hospital environments they had never experienced before, or the difficulties of leaving their families to work in other regions.

For the first few weeks we were told you are going to be redeployed and that is that. That caused a whole lot of anxiety around lots of us who may not have been in the hospital. There was a lot of anxiety around that and across the board about not knowing where we were going.

Most of my staff were re-deployed very quickly before the lockdown. So I had to give them all a call and relieve anxiety and people got on board because it was a shared effort. They knew what was happening in the rest of the world. It was almost like a war effort…I had to articulate calmly that they were required in other areas, but they would be well looked after by good people. I kept in touch each week, that was right at the beginning.

Taking on additional responsibilities meant some staff had less time for their WellChild Tamariki Ora engagements.

The relationships that I had established were critical. It was reasonably difficult to deliver remotely and I got redeployed to other roles during that time, I took on a new baby triaging role that took a lot of my time away from delivering WellChild remotely.

If Aotearoa New Zealand were to go into another lockdown, staff suggested Whānau Āwhina Plunket limit communications around redeployment unless there was certainty this was going to take place. Reflecting on their experiences, some staff said the prospect of redeployment caused unnecessary stress for many and they felt it would be more appropriate to raise redeployment conversations once the process and deployment was finalised.

The threat of redeployment was a huge negative on the team. It crushed people and they were living in fear of being redeployed. That had a negative impact on work practice.

3.8. After lockdown, staff had different approaches to managing their caseloads

When we re-visited the sentinel sites in August/September, staff reported their workloads were noticeably heavier. Staff were busy responding to whānau needs

which had been heightened by the lockdown or that had emerged as a result of the lockdown (for example, loss of income putting pressure on housing and ability to meet basic needs). Staff were also working on their back-log of client visits post-lockdown combined with administration for both Whānau Āwhina Plunket visits and for other organisations and agencies.

> *Oranga Tamariki as well, is under huge pressure because all their Family Group Conferences (FGCs), all their meetings had to be put off [over lockdown] and it is really difficult. We tried to do one by Zoom but it was just really difficult to do. Everyone trying to put their bit in but into in an organised way so that is not how we are seeing it has come full circle so now it is just endless FGCs that is just catch up from before.*

Staff took different approaches to prioritising caseloads after lockdown. Some staff worked with whānau they felt were in the wrong priority group. Some staff were very clear in only working with whānau with high and long-term needs and other high priority whānau. Other staff struggled to leave their low-needs whānau and continued to address their entire caseload which resulted in feeling overwhelmed and overworked.

> *We're not staffed for [full PVS caseloads] and we're a caring profession so we're not going to say no to people but we're running ourselves down at the same time.*

Some staff shared the stress of working through a worldwide pandemic and then returning to demanding caseloads. A few staff said they were exhausted and at breaking point.

> *There needs to be more nurses. Our caseloads are so unmanageable. Our higher demand*
>
> *more complex cases which [Whānau Āwhina] Plunket have acknowledged the complexity of people and people need more time spent with them but we can't, we're burning ourselves out at the other end.*
>
> *I had so many people off sick! And I think it was just exhaustion, fatigue, not getting well again.*

3.9. How well supported staff felt in their roles

In response to the staff surveys, around two-thirds of community and clinical staff felt well supported in their roles with a small proportion taking the opposite view (Figure 6).

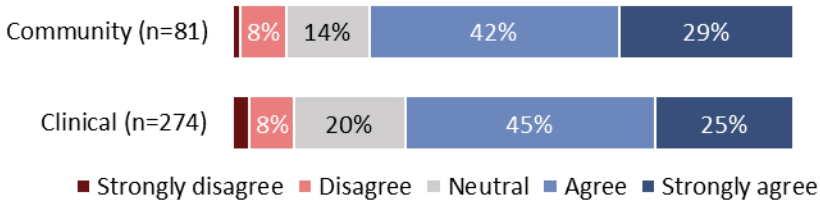


Figure 6. Whānau Āwhina Plunket clinical and community staff agreement with the statement "I feel well supported in my role"

Whānau Āwhina Plunket staff were supported by their local and national management but also valued the support of their colleagues. Staff reported changes in how they worked together during PVS. Pre-lockdown, it was difficult for Whānau Āwhina Plunket teams to get together. Staff had busy schedules with home visits, clinics and other engagements with whānau taking time and moving staff around the community. Teams in rural areas experienced additional barriers to connecting with their wider teams, especially if they included staff based in a city or town centre.

Despite being separated physically over the lockdown period, Whānau Āwhina Plunket staff felt more connected to their teams. Zoom was their main mode of communication. Staff who lived alone or were single parents spoke about the importance of the daily Zoom catch-ups. It enabled them to interact with familiar faces and encouraged them to check in and talk about their wider wellbeing.

> *We had daily Zoom meetings with our staff where staff came on where everyone would have a bit of kai and a drink and some days at the staff meetings there were nurses in tears. And then there were individual Zoom sessions and that's where people really opened up and were honest.*

> *Microsoft Teams was really pivotal in making sure we still felt connected as a team. We used to have a morning meet up every day just to have a chat. Not chat about work but check in it was really lovely to be able to chat to each other when you're not in the office.*

Almost all staff described how powerful Zoom had become to re-connect and in some cases establish bonds within the teams.

> *I made new relationships in the organisation through different ways of communicating because we were now having to do Zoom, Skype, ringing.*

One staff member noted the situational aspect of staff banding together and supporting each other through Zoom hui but wondered whether it would be sustained in the long-term.

> *Naturally you lose some of that stuff, it's in a context that drive people to be closer because of the circumstances, naturally people knot together.*

The regular meetings opened opportunities for staff to recognise each other's expertise and strengths which would be used more widely in the future. This

improved awareness and cohesiveness applied to both clinical and community teams.

> *Our individual skills have been heightened during that time. Now they're thinking I know who I can go to if I've got somebody with eczema because you're really good with that.*
>
> *We started our hui with karakia and we did whakawhanaungatanga and you get to learn a little bit more each day about everyone's likes and dislikes so that was really beneficial to all of us.*

Clinical managers shared the importance of affirmation and supporting their staff during this time, however some also noted that staff did not use the meetings to talk openly about their struggles contacting whānau.

> *Our role was to support and acknowledge and do what we could to reduce their stressors. We kept talking about how proud we were of our staff and we got feedback from our staff saying 'you made it easier for us by being who you are' which was really awesome to hear that.*
>
> *The cracks started to show when we came out of the lockdown and the levels changed. I particularly looked at dashboard information and I was overwhelmed at some of the work that we thought was being done that had not been.*

The opportunity for daily staff Zoom catch ups ended with the lockdown. Although staff no longer had the time for these regular meetings, they continued to support each other. Zoom was not generally used to seek or give support, but staff would often come together and meet in the lunchroom or catch up in the clinics.

Staff reflected on the ways the lockdown influenced the way they work now. For some, working virtually provided the opportunity to explore different ways of engaging wider team members.

> *We have a hui coming up [provider] and their team are bringing up some wahakura and the hui is over three days. That would be a great opportunity to bring the team together for something really positive. It's an opportunity for staff that aren't so confident with protocols and tikanga to have exposure. We need more opportunities for exposure. If we're going on this pro-equity journey and we're really prioritising our whānau Māori and Pasifika we need to be exposing our staff to more culture as well.*
>
> *Especially with the whole rebranding, it's Whānau Āwhina Plunket. The whole brand is changing and for whānau to want to engage with us we have to be relatable and we have to be pono in our mahi and knowing each other face to face [in-person] is a good step.*

Working together throughout lockdown had enabled Kaiāwhina and health worker roles to be highlighted. It displayed the ways in which their roles can be adaptive and the need for clinical staff to utilise their Kaiāwhina and health workers to their fullest capability.

> *Some people use them very well. Some health workers are very resourceful and although it's a delegated role, it doesn't take away the common sense of health workers and Kaiāwhina to be able to contact clients. To check in, how is it going? have you got*

everything you need?... We're not making an assessment. We're just simply checking in with the family and seeing whether they need referral for extra resources. And just to say we are here, we care, you're on our mind. And for some families that is as important as offering other things during a time when they're a bit fearful and isolated.

4. Prioritisation under PVS

Summary

The prioritisation was a combination of whānau level of need, age of their child and ethnicity. Most clinical and community staff reported they understood the PVS criteria but they varied in understanding and agreement of the kaupapa underpinning it. Some staff saw PVS as a catalyst for change and PVS raised their awareness around equity.

Whānau Āwhina Plunket staff contacted whānau by phone to explain PVS and offer different modes of engagement. There was little regional variation in staff accounts of explaining PVS to whānau. Staff shared discomfort in using the word *priority* and focussed on a strengths-based approach to describing PVS to whānau. Some staff told us that whānau had received generic texts from Whānau Āwhina Plunket and whānau also accessed PVS information online.

Most staff understood the inclusion of ethnicity within the prioritisation criteria and some talked to us enthusiastically about the difference between equality and equity. These staff and were delighted that PVS afforded them the opportunity to prioritise whānau they knew needed them the most. However, a small number felt discomfort about the criteria and were concerned that some whānau who they saw as having higher levels of need being de-prioritised. The discomfort was often focused on the inclusion of ethnicity.

Staff wanted to be able to identify higher priority whānau within their own caseloads rather than using fixed criteria. Some continued to work in a prioritised way after the lockdown ended.

4.1. Understanding prioritisation and associated service levels

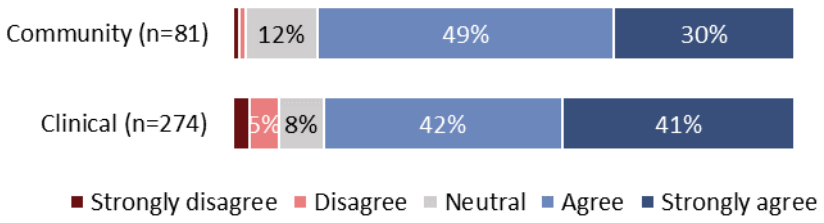


Figure 7: Whānau Āwhina Plunket clinical and community staff agreement with the statement "I understand the prioritisation of whānau under PVS"

Most community and clinical staff understood the prioritisation of whānau under PVS (Figure 7). Interview feedback was consistent with that result.

Most staff felt that they had a good understanding of prioritisation and associated service levels. They learnt about PVS from emails and discussion with their managers or Clinical Leaders outlining what PVS meant and how it would be applied to their caseload. Staff emphasised the importance of collective discussion about PVS to ensure there was a shared team understanding.

> *Our boss emailed it to us and we had a read and then she explained it. In a nutshell that was prioritising the high-needs-long-term and trying to get in contact with them, for the nurses that was their priority.*

The prioritisation was a combination of whānau level of need, age of their child and ethnicity. While all staff felt they understood what the PVS criteria were, they varied in understanding and agreement of the kaupapa underpinning it.

> *I think I understand what is being asked of us. I don't agree with it though, so I don't necessarily practise it. I do agree with being available to prioritise our high-needs family and our Māori and Pacific but they are wanting us to drop our low-needs and short-term high clients and I don't agree with that because I still think we are such an important service to them and they want our service.*

Most staff understood the inclusion of ethnicity within the prioritisation criteria and some talked to us enthusiastically about the difference between equality and equity. These staff were delighted that PVS afforded them the opportunity to prioritise whānau they knew needed them the most. However, a small number felt discomfort about the criteria and were concerned that some whānau who they saw as having higher levels of need were being de-prioritised. The discomfort was often focused on the inclusion of ethnicity.

> *What I understand about our priority service is that all ethnicities come under high priority if they're high long-term that is what I understand. All Māori and Pacific Islanders that come under high long-term are a priority, if they're low-need then they're not, well that is my understanding.*

> *I strongly believe in a pro-equity organisation from understanding what the health impact for whānau is. We know statistically that Māori whānau have poorer health outcomes so we need to realise prioritise and focus all areas of health so that physical, spiritual, whānau and mental health. I do not believe that that should become another parent's worry. I think we go into every whānau and say this is the beautiful service that we have to offer, tell me about yourself and then decide with that whānau about how we might best serve their needs. … everyone should get care that is specifically focussed to their whānau needs with a population pro-equity lens.*

> *I'm not anti any culture. I'm non-Māori but suddenly I'm being held accountable and we've got all this Māori stuff coming towards us I feel like I'm working for an entirely different organisation.*

Some staff questioned the absence of Māori frameworks in assessments and considered it to be deficit based, while others thought that prioritising whānau

Māori meant that Whānau Āwhina Plunket staff could solely focus on their prioritised caseload and redirect their resources to whānau Māori.

> *We were trying to address and ensure that inequities were not increased because the ones who want got, or the noisy got, while our whānau sit quietly in the back and go we'll just look after ourselves because they're not coming anyway – that was the intent.*
>
> *I do think they need to move it out of an assumption that if you're Māori that you're all in that same waka. I would also like to see them move away from a needs based assessment that is so deficit based, if that is what they want to do the strengths and weaknesses then do it holistically, get some Māori frameworks like Te Pae Mahutonga, Te whare tapa whā, Te Wheke.*

Some staff noted the importance of having whānau assigned to the correct level of need (low-need, high-need: short-term, or high-need: long-term) because that could determine whether they were prioritised or not. It was clear to staff that whānau who had been assigned as high-need: long-term through a needs assessment would be prioritised during lockdown and other whānau were directed to other Whānau Āwhina Plunket supports such as PlunketLine or other community supports.

> *With the priority virtual service, if we had analysed people as high-need then that is absolutely different, but if you just happen to fall into a criteria that you're not really high-need then we might have been wasting a fair bit of time and resource where it wasn't wanted or needed. I don't think how we went about it and the time was quite right.*

It was not uncommon for staff to continue contacting all whānau they previously engaged with rather than focussing on just high priority whānau. Some staff struggled to accept the prioritisation of their caseloads and this was usually because they had built relationships with whānau and it was not easy to stop engaging.

> *Yes I did [continue contacting low-priority whānau], I wasn't comfortable not contacting families. I work in a rural area and you really get to know your families and they expect to be seen at certain times and I also have an expectation to the service.*
>
> *Yeah, a lot of them were doing the reaching out and others might not have met the criteria strictly through a computer system but through various means they might have been highlighted as a priority to me and I could probably justify that clinically if I had to.*
>
> *Some did because people were contacting them, it comes down to relationships.*
>
> *Yes, I did. I wanted to be fair – I could see people gunning for [Whānau Āwhina] Plunket nurses.*

A few months after lockdown, staff seemed to have a greater awareness of equity and PVS. Many staff had shifted in their way of thinking and better understood the importance of addressing the needs of high priority whānau to improve the inequities that exist Aotearoa New Zealand.

Some staff described COVID-19 and the lockdown as the catalyst for change. Many recognised that Whānau Āwhina Plunket needed to respond to inequities and

highlighted the importance of prioritising high-needs whānau who are over-represented in negative statistics.

> *Yeah, we work with priority clients which is core 1-3, high-short-term Māori and Pasifika or high-long-term whānau.*
>
> *I think the switch with the language and the equity lens, it's something that has been a long time coming and COVID helped moved that forward significantly. So I think that is good. I think the PVS system as such is the right way to be thinking about service delivery. Fine tuning around how do we meet the needs of everyone if we're still going to be a universal service.*
>
> *I've heard the language in people say they're doing core 1-3, first time mums and the high-needs. They've been starting to think who will I go to first. I do think there has been a shift in how people are thinking about prioritising.*

We heard from staff at all three sentinel case study sites who work solely with high-needs whānau, Māori and Pasifika. Staff at one site described their commitment to helping address inequities that exist for their whānau.

> *We are 100% on a pro-equity journey, in regard to we are 100% prioritising our priority clients. All of the girls have high priority caseloads. There is no extra resource or any time or energy extra and above going towards our low-needs whānau. We 100% need to pour our resource and time into our priority whānau and we have to create an unequal service to bring up the inequity that has been there for such a long time.*

4.2. How staff explained prioritisation to whānau

Whānau Āwhina Plunket staff contacted whānau by phone to explain PVS and offer different modes of engagement. When they explained PVS to deferred whānau, staff focussed on whānau strengths, reminding them of their capability and reinforcing that their children were well and healthy. Staff also focussed on the complex needs of some whānau and explained the impact COVID-19 had on these whānau such as job loss, overcrowded homes, lack of food and resources. Our interview data showed little regional variation in staff accounts of explaining PVS to whānau. Staff shared discomfort in using the word *priority* and focussed on a strengths-based approach to describing PVS to whānau. Some staff told us that whānau had received generic texts from Whānau Āwhina Plunket and whānau also accessed PVS information online.

High priority whānau were introduced to PVS in a way that tailored visits around how whānau would like to work.

> *I offer additional support…I highlight the visits in the WellChild book for them. I say yes you have got this amazing page on this side where we can have as much contact as you need. So it is more of a wrap-around approach instead of a fragmented timeline where I only see you at these stages.*

Whānau responded in different ways when they were informed about PVS. Although staff tried to explain prioritisation in an inclusive and strengths-based way that highlighted whānau capability, staff told us the message was not often received well by whānau assessed as low-need. Staff reported continuing to receive regular complaints from whānau who expected contact from Whānau Āwhina Plunket. Most were not in the high-priority group.

> *So some of the calls I receive, they start with: I haven't been seen since February. Instead of: during lockdown I received a call and now I am wondering when my next one is.*

Staff observed some whānau responding negatively when told they would not be seen by Whānau Āwhina Plunket. Many staff received negative feedback from whānau after a Whānau Āwhina Plunket Facebook post which provided bullet points describing PVS. Some staff used the word *backlash* when describing reactions to the post. Staff found that it could be difficult for well-resourced whānau to comprehend why they would not be seen by their Whānau Āwhina Plunket nurse or wider staff.

> *We did have a lot of whānau that struggled with [PVS] a lot of them were getting angry because as we went longer and longer into lockdown they wanted a nurse or Kaiāwhina to go and awhi them face to face [in-person]. How we explained it to them was in a very respectful way… So it was how you approached it in kōrero was being gentle and respectful.*
>
> *People accepted over lockdown it was a tough time and they had other options, they could join a virtual music and movement, or playgroup so that met their needs.*
>
> *Others were like I can't believe you're not essential … why aren't we able to see you. They were really frustrated.*

A few staff expressed difficulty explaining PVS to whānau. Some were not confident in their own knowledge of equity and it was particularly hard for them to explain the reasons behind why whānau Māori and Pacific with younger children were automatically prioritised under PVS. Health inequities and negative statistics for Māori and Pacific whānau were highlighted but staff found their wider communities did not have a strong understanding of equity. Staff also struggled with the word *priority* and the implied deficit around this language.

> *I'm not comfortable saying, 'well no actually you're not a priority'. In fact I don't say that. I've been continually working the normal service that I would give and of course I always did it anyway if my high-needs clients needed another visit I would make it happen or I would put the additional [Pacific] Community Karitane in.*

PVS highlighted a need for more professional development so that staff could confidently explain PVS including health equity and build their capability with high priority groups.

> *A lot of learnings came out of it. A lot of PD required on what equity is and how to whakawhanaungatanga properly instead of just ringing them up and expecting them to*

tell you over the phone. That is not how you need to work if you want them to engage with you.

When we checked in with sentinel site staff months after lockdown, they were continuing to explain PVS to whānau. Staff did not use the term PVS and tried not to say 'prioritised'. Staff continued to tailor their PVS kōrero to the whānau they were working with.

Staff were managing whānau and societal expectations around a universal service offering. Some managers expressed concern about staff capability in having difficult conversations with whānau and wanted national guidance and resources for staff in building staff capability around healthy conversations.

For our staff there is a real lack of education from a national level around how to manage those difficult conversations. We helped our team by participating in healthy conversations but it hasn't helped in that they haven't got dialogue to be able to pull out of their kete to use when talking to clients that are quite stroppy on the phone and are quite demanding about having a visit.

4.3. National consistency of guidance for whānau about prioritisation

Most staff could only speak to their own experience of PVS and did not feel able to comment on how prioritisation was explained or promoted from region to region. Staff suggested it would have been useful for Whānau Āwhina Plunket or the Ministry of Health to release messages from one platform so that they did not have to be information disseminators. Timing was important, and some staff struggled with hearing messages about PVS at the same time they were released to the public

The nurses are feeling like they are at the coal face and that they're having to put that message out and they would like to see the organisation, or the Ministry of Health put that message out.

We had text messages that went out unbeknownst to us as case managers to our clients communicating something that we weren't really aware of. Your appointment has been cancelled. And then as we went down levels your [Whānau Āwhina] Plunket nurse will be in touch. But we could potentially have hundreds of people.

All staff said that in another lockdown they would want to see communication from national office before it was sent to whānau. This way they would be prepared for questions from whānau.[5]

[5] Some regions sent emails, text messages and social media messages to clients communicating directly about PVS however this approach was inconsistent with guidance from Plunket national office and was addressed immediately.

Maybe a day's warning that this is going to go out and this is how it is going to read. It might not be that they are inviting us to give a whole lot of feedback around that but at least we can mitigate it.

Staff agreed that wording would need to be clear, concise and in a language that reflected how staff communicate with their whānau.

Yes, that bulk text that was sent out to all, we wouldn't do that again. I would not recommend that. It created a lot of confusion. The very first Facebook post that went up on the [Whānau Āwhina] Plunket national page caused a lot up upset for people but the second post was very well written and a lot clearer. If we had of done that first we would have saved ourselves a lot of trouble.

Other suggestions were made around how the communication to low-needs whānau could be strengthened. Low-needs whānau were often proactive in keeping up with Whānau Āwhina Plunket Facebook posts or communication, and staff felt it would have been useful to have an online hub for any material related to low-needs. This would enable low-needs whānau to be completely informed about Whānau Āwhina Plunket's support, and offer further guidance to whānau who were deferred during the lockdown.

4.4. Reflecting on the criteria for prioritisation

Months after lockdown, staff reflected that they would not change PVS criteria but they would want clinical judgement and flexibility in prioritising. Almost all staff considered that the current priority criteria targeted whānau with the highest need which helped manage staff caseloads.

Our complex families should always be a priority because things change. First time parents are now in that dashboard as a priority and that is really important. First time parents don't know what they don't know. I think high-need full stop are really important.

I personally think it should stay the same. Those families who didn't quite fit into the criteria made noise … They're very capable of advocating for themselves. If we opened it even more the workload would be ridiculous, and it already is at the moment.

While staff saw the benefits of prioritisation in supporting whānau with higher need, some wanted flexibility in extending the high priority group, for example older babies of first-time parents.

At five months, introducing solids. Some people were muddling through that. They may have been searching the internet for information about that which may or may not have been helpful to them.

I would add first time parents but not in the high-needs long-term section but as a keep in touch with these people. Not necessarily that they need the full service. I don't think after three months they're ready to be on their own.

Staff reiterated the isolation experienced by new-migrant whānau who were expecting family support when baby arrived but could not have international visitors because of the border closures. Cultures where new mothers were taught by older family members after the birth of baby were particularly affected.

> *What they have missed is their support - that is their right. I know that my mother or my mother in law will be coming over for three to six months so I don't need to know anything. I don't need to know what happens after I have the baby. That is all done for me. That is my cultural right. So if there was some way to support those migrant families.*

Whānau for whom English is a second language struggled to engage through a virtual service. If whānau were not able to use Zoom their only other way of contact was through phone and this removed the ability to use hand signals and body language to communicate. Staff lost many clients as it was difficult to communicate and interpreter services during the lockdown were scarce.

> *We have quite a big refugee population. That group very much struggled with [communication] and there is only one interpreter that can speak [their language]. So while we moved to a virtual space and trying to get that interpreter on the phone in a three-way conversation was really, really hard so we lost a lot of engagement with that population.*

Some staff identified the need to support parents who were technically not 'first time parents' but had large gaps between their children. Parents in this situation were feeding back to Whānau Āwhina Plunket staff about the need for support.

> *The first thing I would do is parents who have had a gap between their children of five years or more I would classify them as new parents again. We had quite a lot of feedback from that group who were having a second child or third child quite late saying 'hey so much had changed am I still doing the right thing?*
>
> *There are the families that you know they're definitely in but you've got all of the first-time parents which don't fit into it but they still have a lot of questions and you don't know what you don't know so I think they should be in it.*

5. Whānau Āwhina Plunket services delivered under PVS

Summary

Under PVS, staff were no longer able to see whānau in-person so they had to deliver care virtually, by phone or video conference.

Whānau Āwhina Plunket staff identified whānau access to technology, views on the value of virtual appointments and ability to stay on long-enough virtual contacts as barriers to connecting by phone or Zoom.

Whānau reported a preference for in-person contact in the whānau survey but many were also positive about a mix. While not possible in COVID-19, staff thought virtual contacts would be more effective where they had already built a good relationship through in-person contact. Characteristics like transience, high level of need and speaking English as a second language could make it harder to engage whānau virtually.

Prioritisation enabled staff to work in a more whānau led way and to invest more resources in getting in touch with some harder to reach whānau.

Whānau Āwhina Plunket staff found it harder to identify some whānau needs without being able to visit whānau in their own spaces and see them in-person. Family violence, safe sleep and physical assessments were all identified as difficult.

Post-lockdown, some whānau who had been low-need were encountering challenges resulting from loss of income including inability to meet their basic needs.

Prior to lockdown, all core delivery contacts with whānau were in-person and only in-person visits could be counted as core contacts for the WellChild Tamariki Ora schedule. Staff described home visits and seeing whānau in clinics and other Whānau Āwhina Plunket activities such as parenting and play groups.

Under PVS, staff were no longer able to visit whānau so they had to deliver care virtually by phone or video conference as preferred by each whānau. Whānau Āwhina Plunket staff told us before PVS they built good rapport with whānau by spending time getting to know them, although this was sometimes difficult when they had limited time for in-person engagements. PVS enabled more time to focus on high-priority whānau.

Staff comments on meeting service delivery objectives focused on how PVS affected their ability to reach and engage whānau virtually, how well they could identify and assess whānau needs and how PVS supported a whānau-led approach to care.

5.1. Reaching and engaging whānau virtually

In the staff surveys many clinical and community staff identified whānau access to technology, seeing a virtual contact as less valuable and ability to stay on a long enough phone or video call as barriers to working with whānau virtually (Table 7). Half of clinical staff saw all three factors as either moderate or extreme barriers.

Table 7: Barriers to working with whānau virtually (clinical n=272, community n=81)

	Extreme		Moderate		Somewhat		Not a barrier	
	Clin	Comm	Clin	Comm	Clin	Comm	Clin	Comm
Whānau access to technology (e.g., suitable device, adequate internet connection)	25%	14%	30%	24%	33%	34%	12%	29%
Whānau seeing a virtual appointment as less valuable	22%	14%	32%	22%	31%	35%	15%	30%
Whānau ability to stay on a long enough phone/video call in their circumstances	18%	6%	31%	26%	32%	36%	19%	32%

Staff feedback in interviews changed from the first to second site visits, shortly after lockdown and a three-months later. In the first site visit, staff told us that given a choice, staff would opt for a mixture of virtual and in-person contact. However, in the second visit, it was clear that most staff and whānau preferred in-person contact. They had moved back to engaging almost exclusively in-person and thought virtual engagement had only worked for a small portion of the high-needs population over lockdown. Most staff thought the limitations of in-person contact meant they were constrained in their ability to work in a way that worked best for whānau.

> *They wanted face to face [in-person contact]. They were starving for it. I had one mum put it to me why would I want something sub-par when I can have the real thing?*

> *Clients don't necessarily want the virtual model. Our priority population where we know there is a lot of inequity, it's not always the medium that they want and they don't necessarily like it.*

Staff found many whānau were happy to wait for an in-person appointment. Staff noted a few months after lockdown that whānau were less likely to pick up the phone. Whānau were re-integrating back into communities, re-engaging in work and schooling and did not pick up phone calls. Staff thought that over the lockdown period whānau had no choice but to stay home and were therefore more likely to answer their phones but post-lockdown whānau had less time to connect.

When you're talking about more personal stuff like breastfeeding or your birth it seemed [impersonal]. When we're calling we're trying to get as much information as we can over the phone and if they really want an appointment to arrange one. But most of them say I'll arrange the appointment and talk to you when I see you. They don't see the point [in a virtual service].

It's so much harder now because people don't pick up the phone now that we're out of lockdown. During lockdown they wanted that contact but now life has started back for them.

Whānau gave their views on different methods of contact in response to the whānau survey. In-person contact was most strongly preferred but nearly two-thirds of whānau were positive about a mixture (Figure 8).

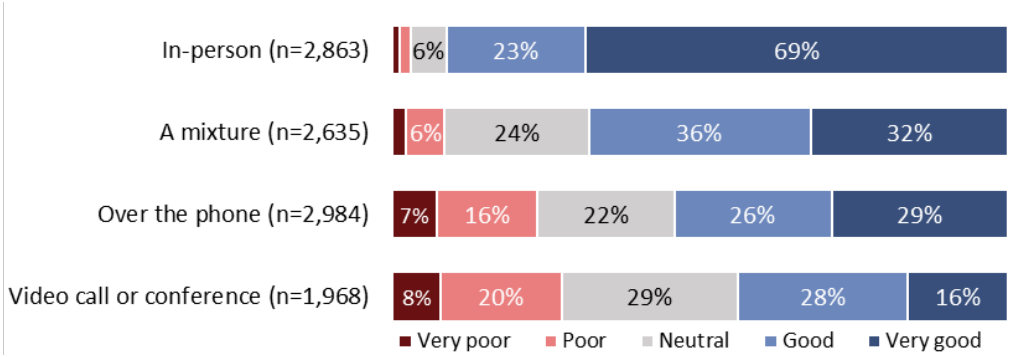


Figure 8. Whānau reports on what they thought of different methods of contact for Whānau Āwhina Plunket services pre-COVID-19.

When we spoke with whānau in July they thought they would prefer a mixture of in-person and virtual contact in the future. Whānau interviews in August/September were much the same. Those in the high priority group were generally receptive of a virtual service but preferred an in-person service.

I would like it as another option, I would prefer face to face [in-person] but if a lockdown meant everyone's safety then yeah [I would not mind a virtual service]. I would prefer Zoom or group chat something like that …. (Whānau)

5.1.1. Staff identified barriers for whānau characteristics in virtual contact

In interviews staff discussed factors they thought made whānau more or less difficult to reach virtually:

- Whānau access to, knowledge and support for ICT: The luxury of reliable, unlimited wifi and data or access to a phone that had video functions was not always a reality for whānau Māori. Many whānau changed cell phone numbers regularly or did not have a phone to be able to engage virtually. Even if whānau did have devices, Whānau Āwhina Plunket staff thought some were reluctant to engage this way. For many koroua and kuia who were looking after their mokopuna, virtual methods were not particularly

useful[6]. They had limited access, knowledge and support around how to use online resources and generally preferred to speak over the phone.

Sometimes they were hard to contact, Zoom wasn't always possible because they had to have data so that was an issue or they didn't have a tablet or anything. Sometimes they didn't want to Zoom for other reasons, the privacy or who else was there.

- Reluctance to engage with unknown callers: Staff reported that whānau were often reluctant to answer a phone call from an unknown number and would screen the call.

  Calling people is not the preferred method of communications from what I've learnt… I don't know how that works and also wifi, there is that inequity around money for texts how does that translate to wifi to be able to Zoom or make a phone call.

  Staff discussed the risk of whānau being able to 'hide' from services, particularly whānau who needed the help but were too whakamā to ask.

  During the lockdown most of them said they're okay but I don't know whether it's pride especially when they know I'm a Pacific… they say they're okay but then I look through the notes and it's a family that needs help.

- Younger parents: Staff found that younger parents who understood and felt comfortable using technology were far easier to engage with virtually. A small number of staff also shared the advantage for whānau of being able to attend a virtual group session anonymously and without having to speak to people. This worked particularly well for māmā who may not want to engage in a in-person setting.

  I had one māmā who video called me to show me baby's rash over his body, so we do have the younger generation who know how to access IT services so that was good.

  We make the assumption that kanohi ki te kanohi will be the best way. What we found is that some wāhine in particular found the ability to turn up to something particularly in a group setting and not be seen but be able to listen and not share or share, almost like an observer. And still get something out of that was of value and they wouldn't get to that group delivery if it was face to face [in-person]. That surprised us in areas where we thought wānanga was the only way to go.

- English as a second language: Whānau Āwhina Plunket staff faced challenges in engaging with parents for whom English was a second language. Hand gestures and body language did not work over the phone.

[6] However, this was not the experience for all Māori grandparents. We heard from a staff member who had also experienced a virtual consultation with Whānau Āwhina Plunket as a grandmother. She was impressed by the way the Whānau Āwhina Plunket nurse was able to talk with her on screen, ask safety questions, see baby and go on a tour of the whare.

Our problem with a lot of those families is they spoke English as a second language and we did have problems with interpreter services. A lot of their staff weren't available, so it was really hard.

- Rural areas: Some whānau who lived in rural areas were harder to reach as there were not always reliable means of communication. Whānau in isolated areas were sometimes cut off from services particularly in the context of COVID-19.

  I might have had one family that I know they live in a poor cell phone service area and they don't have a landline and they would normally get their texts when they would drive out every couple of days and they never got back to me the whole of lockdown.

- High-need: Staff felt that whānau who were assessed as high-needs-long-term often responded better to in-person communication. Staff discussed how valuable unscheduled drop-in visits were for whānau in this priority group. During the lockdown this was not able to happen and instead, staff had to rely on calling, texting and emailing whānau and there was often no response.

  Nah not for my whānau no way, as soon as I knew we could go out and do cold calls I was like yes, where is the car.

  There were some of the very highest need that did not answer their phone. I text and text them to see if it was okay for me to phone them but often they wouldn't respond to text or the phone.

- Transience: Some whānau in the high-priority group were transient, moving through different homes and constantly changing their cell phone numbers. Staff thought not being able to contact whānau was one of the major reasons whānau did not receive the intended level of service. Staff discussed how they contacted other health professionals and to see who was in contact with whānau.

  Some genuinely had moved out of the area and if you only had one phone number and that number is not available, I definitely had situations like that. What I done in the meantime was communicated with the other people like Family Start to say I can't reach them are you reaching them.

Staff reported some low-need whānau who had not been contacted liked the idea of having a virtual service. They felt that phone calls would be convenient and Zoom chats could still cover the same aspects as an in-person visit. Some whānau who were confident their tamariki were thriving were less likely to be willing to make an effort to engage.

I wouldn't be too bothered about [a virtual service]. It's just trying to find a time to [answer the phone] when all my kids aren't screaming over the phone. At the moment I wouldn't be too bothered because she's meeting all of her milestones for the weight and height so it would be alright going online. (Whānau)

I think they could be handy if that's all you can do rather than having someone come into your house. I think it would be quite good if you could video call them in some way so you can see who you're talking to and they can visually see you and baby to make sure you're okay. I think that's better than nothing if you can't have someone in your house. (Whānau focus group)

5.1.2. Benefits of prioritisation for engagement

Separate from the virtual aspect of PVS, some staff saw the prioritisation as an advantage for engaging whānau who could benefit most from the service. The prioritisation component of PVS enabled staff to work in a way that was whānau-led. Staff told us they felt more able to spend extra time and resource with vulnerable whānau. The new way of working supported genuine conversation and authentic partnership between Whānau Āwhina Plunket staff and whānau. However, as noted above, they also often thought virtual approaches to doing so were not as effective as in-person contact.

I feel like we're making more of a difference. The stories I'm hearing from the team, yes the hardship is out there but I think these good news stories. I'm hearing those every single day. Even though it doesn't feel like it because it's this big steep hill, I know the mahi that the girls are doing is making a difference. They're doing really impactful outcome-based work but it's just not measured.

Prioritising high-needs whānau removed the pressure and stress to see an entire caseload and allowed staff to work in a space and pace that suited whānau.

You spend quite a lot of time. It's good quality mahi but it takes time and when you get whānau like that you can't say okay I'm really sorry I've got another whānau. It's really hard because it has an impact on all of the other whānau.

To have better outcomes for whānau Māori we have to be in the home and we have to maintain a face to face [in-person] strong service delivery model.

Strengths-based conversations continued to be a key feature in Whānau Āwhina Plunket's communication with low-needs whānau. Staff shared how low-needs whānau felt entitled to a Whānau Āwhina Plunket visit but could be connected with Whānau Āwhina Plunket via a drop-in clinic, PlunketLine or a virtual group.

If you've been having our service a certain way for multiple children over years then of course it's going to be hard to swallow the fact that you can't get the nurse that you really like. But they're getting pretty good now when you highlight to them their strengths and the resilience that they do have they're a lot of more understanding.

People just want to be told they're doing a good job and you'd be surprised at how many mums we talk to have never been told that they're doing a good job. … That is easy we can totally do that in a drop-in clinic.

5.2. Identifying whānau needs was key for accurate prioritisation

Whānau Āwhina Plunket staff viewed identifying whānau needs as both a core skill and a strength in their work. They shared examples of linking whānau with other services to meet needs such as warm, safe housing. Most staff described assessing needs and understanding each whānau within their individual context. Each whānau situation was different and determined what their goals and aspirations looked like.

> *Our families all have different needs. If our whānau are struggling with kai with their budgeting because they don't have much at all, then their goals are going to be completely different to this one that wants to get a degree and join the gym.*

> *I would go into whānau houses and deliver my delegated work to them but on top of that I would also be able to gauge what else is going on in the house and connecting with whānau and supporting them in other ways as they need it.*

> *I visited her again when she was having issues bottle feeding, and the house was not very nice, it was cold and damp. She talked about it as well. In the end I reached out to [Housing provider] and asked them and they gave me an application form which I took to her and asked her to fill out. Sent it back to [Housing provider] to try and help her get some housing.*

Partnership was a key term staff explored when discussing how they worked with whānau. Staff spoke about the importance of completing an accurate needs assessment but completing it in a way that was whānau led and ensuring a partnership was established and whānau were able to express their needs. A few staff explained that whānau who were assessed without a partnership approach could have potentially ended up in the wrong priority group or received resources they may not have needed.

> *We've got to be really careful to be very client led. To me we should prioritise Māori whānau but let's find out what is it that you would like from me. It's not saying you're going to have all these now and they're going I don't want all these visits. It's about, tell me about yourself, let me truly learn about you, and let's wonder together about what is the best service for you from us.*

Staff described needing to build trust with whānau before whānau were able to be transparent about their situations. WCTO nurses complete their first assessment based on what whānau initially feel comfortable sharing. Assessing virtually meant that staff were not able to use their full senses to scan the whare or environment whānau were in. They relied heavily on the information whānau volunteered and as a result some whānau have ended up in the wrong priority groups.

> *If one person doesn't give you full disclosure of exactly how high it is then you might think that someone else [has more of a need] so you're working on the assessments of what you see at the time and sometimes people are forthcoming and sometime they're not…*

> *It was terrible. You just felt bereft of actually being in the house. Seeing the house, smelling the house.*

Although Whānau Āwhina Plunket staff built strong relationships with their whānau, during the lockdown staff identified that Plunket were not necessarily a priority for whānau either because of other pressures or because they did not need Plunket.

> *For some [whānau] it was food, safety and jobs and Plunket was not a priority.*

> *A lot of our whānau who live in the bush and actually our high-long-term-needs whānau that I did get in contact with and speak with lockdown wasn't any different for them because they only come into [town] once a week to do their shopping. Sometimes they will go up the bush and go for three months living off the land, so we weren't too worried about those ones…*

Prioritisation was complicated by changes in whānau situations over lockdown. Staff noted increased maternal mental health need and other pressures as people were laid off from work, whānau with limited resources had little kai, supermarkets were flooded with panic buyers, and online shopping and access to clothes was limited. With the rapid change in situations for whānau it was clear that their needs would likely change week-to-week and for some day-to-day. Staff acknowledged that some whānau may have ended up in the wrong priority group because their needs assessment was completed before the lockdown.

> *Maternal mental health [need]. … you don't necessarily have postnatal depression at six weeks, that can come in at nine months or ten months even though everything was fine. So things can change.*

> *I guess we can have low-needs clients, but every day is different. There only needs to be something to happen to trigger off… that puts them straight into a high priority category - like the lockdown.*

5.2.1. Family violence

Plunket reported their guidance to staff was not to complete family violence screening and most staff did not feel confident in safely performing a family violence assessment through virtual platforms. When staff were able to go into homes they could use visual cues, read body language and facial expressions when screening for family violence. Many whānau who were in the high-priority group were not able to have Zoom calls. Whānau who engaged via phone calls could not be viewed by Whānau However, staff continued to have those challenging conversations with whānau. Āwhina Plunket staff had to rely heavily on what whānau were saying about who was in the room and whether it was safe to raise family violence screening questions.

> *A little bit of trepidation. Not because they mind doing the screening but who else was there. So we had discussion about how you could phrase things to try and suss out who was in ear shot before you asked those questions.*

> *Earlier on I had to do one report of concern… I didn't even start the conversation. The mum started it. But what was difficult was not knowing when it has changed. You pre-*

empt them and ask who is around, are you in a quiet space, no one else is there but then you would hear someone walk into the room.

The administrative data included the records of family violence screening for the 2019 comparison cohort and the 2020 COVID-19 cohort (Table 8). There was a higher proportion of whānau with no record of a family violence screening being recorded during the COVID-19 lockdown period. The proportion of whānau with concerns identified or a disclosure was higher after the lockdown as well, suggesting staff caught up with screening for whānau after the end of the lockdown period as in-person contact resumed.

Table 8. Records of family violence screening before, during and after the lockdown period for each cohort looking at core and virtual core contacts only.

	2019			2020		
	Pre-lockdown equivalent	During lockdown equivalent	Post-lockdown equivalent	Pre-lockdown	During lockdown	Post-lockdown
No record	53.3%	41.8%	43.1%	42.6%	59.9%	44.6%
No disclosure or identification	44.7%	56.1%	55.0%	55.1%	38.0%	52.6%
No disclosure - concerns identified	0.9%	1.0%	0.9%	1.1%	1.1%	1.5%
Disclosure	1.1%	1.2%	1.1%	1.3%	1.0%	1.3%

5.2.2. Physical assessments

Physical assessments were a significant feature of Whānau Āwhina Plunket service delivery before PVS. Whānau Āwhina Plunket staff said there was an expectation in the community that a core function of Plunket's engagement with whānau was weighing and measuring baby. This expectation stemmed from whānau observing Whānau Āwhina Plunket nurses visiting their homes over multiple generations to weigh babies and complete growth assessments.

Both staff and whānau emphasised the anxiety that could be carried by whānau around baby's growth and the need for reassurance by Plunket that baby was growing and healthy. Many whānau shared their worries with staff about not having their children weighed or measured.

Staff had to completely reassess their way of practice and tailor their questions and engagement with whānau to a more open approach. Whānau Āwhina Plunket nurses explored different questions and probed different themes whānau would raise. Whānau Āwhina Plunket staff described being adaptive in their approach.

It was tricky, people want to know what their baby weighs and I didn't find that easy. I tended to work more on question and answer. I don't think the kid has been seen until you physical see them in my opinion.

You had to rely on more open-ended questions. Has your baby grown out of their nappy? How many wet nappies has baby had? Do you need more clothes? what size are they in? You had to rely on what they were telling you.

A few staff discussed the opportunity to continue this creativity and encourage whānau to look for signs of a happy healthy baby without the need for weighing.

We've been so used to physical assessment and the growth measure by weight that sometimes they put pressure on themselves and that they don't believe in their own confidence to do it any other way.

Why do you need numbers? It is interesting because it doesn't actually tell you if the baby is doing well. It's one indicator but you could have a baby that is doing well and a mother with severe postnatal depression.

The administrative data included records of referrals for concern about growth or nutrition. Staff did not do in person growth measurements during the 2020 lockdown period. Comparing the pre-, during and post-lockdown periods in 2020 to the 2019 cohort showed little difference to suggest Plunket staff were less prepared or able to make referrals for concerns (Table 9). A higher proportion of the virtual core contacts in 2020 before, during and after the lockdown resulted in growth referrals. The higher rates of referral during and post-lockdown may have resulted from staff operating on the side of caution while unable to undertake complete assessments themselves.

Table 9. Proportions of core and virtual core contacts before, during and after the lockdown periods with a referral recorded for nutrition or growth

	2019			2020		
	Pre-lockdown equivalent	During lockdown equivalent	Post-lockdown equivalent	Pre-lockdown	During lockdown	Post-lockdown
Nutrition referral	5.1%	5.3%	6.2%	6.0%	5.1%	6.0%
Growth referral	1.4%	1.9%	2.1%	1.9%	2.4%	2.7%

5.2.3. Safe sleep

Staff shared how difficult it was not being able to drop off safe sleep devices such as Pepi Pods and wahakura to whānau during the lockdown. It was particularly challenging for nurses who were aware of whānau co-sleeping and bed-sharing and did not necessarily have appropriate education around safe sleeping practices. Staff were able to refer to different community services and DHBs however like many other services they were extremely busy and had long waiting times.

If another lockdown occurred, staff suggested contactless drop offs of safe sleep devices and an education pack that could be explained to whānau from the letter box or at an appropriate distance.

> *But if we were to go in [to lockdown] again we would have Kaiāwhina drop off safe sleep devices, clothing or food. There would be a lot more discussion around that this time, they were open to that rather than a complete ban of all in -person services and everyone stay at home.*

One community provider wanted to work alongside a Whānau Āwhina Plunket staff member who would be able to address whānau needs in the safe sleeping space. This provider felt it would be a seamless delivery if a Kaiāwhina from their organisation was able to respond to Whānau Āwhina Plunket whānau needs and coordinate with Whānau Āwhina Plunket nurses in their rohe who needed safe sleep devices for their whānau.

> *I would have some [staff] redeployed to me. On reflection, for me to service our whānau on my own during that time it was a lot whereas strategically I would have preferred a Kaimahi from Plunket that was redeployed to my area … and then I would be able to co-ordinate. (Key stakeholder)*

Whānau Āwhina Plunket staff recorded notes about several aspects of safe sleep for whānau including whether they were co-sleeping and where baby was sleeping. Staff completed a consistent number of fields on safe sleep before, during and after the lockdown, suggesting they continued to deliver safe sleep assessments and information in a consistent way.

5.3. Changes in whānau needs after the lockdown

As well as changes during lockdown, Whānau Āwhina Plunket staff described changes in whānau needs after emerging from lockdown. The changes were still evident months later, with some whānau experiencing new forms of hardship. Examples included the impact of lost jobs during and after lockdown, closure of community support services and whānau did not have access to kai or clothing.

When Whānau Āwhina Plunket re-started their in-person engagement after lockdown, they received a high volume of calls from low-needs whānau as well as text messages and turning up at clinics asking for appointments. Although staff tried to prioritise their high-needs-long-term clients it became difficult to manage some whānau with low-needs who were vocal about their entitlement to the Whānau Āwhina Plunket universal service. As a result, some staff started to offer appointments to their low-needs whānau as this was the easiest way to respond.

> *In a busy world if people don't reach out to you or are not available to you then they drop off the radar and conversely the other people who have less issues but have louder voices are ringing up saying I want another [Whānau Āwhina] Plunket nurse, 'I've only had one visit since COVID'. So you see a lot of pressure on people trying to juggle that and at the*

end of the day we're still a WellChild universal service that has a commitment to our clients.

There is a misunderstanding around what needs are and you can explain to people until you're blue in the face so that is why our front-line staff have struggled to explain it.

5.4. Contacts with whānau

In analysing contacts with whānau we have combined core/virtual core and additional contacts (excluding non-care delivery contacts – non-CDC) to consider the total provision of service to whānau. Whānau Āwhina Plunket staff recorded their contacts with whānau in different ways, especially in the early stages of lockdown before they were able to be given clear guidance. Comparison of the 2019 cohort and the 2020 COVID-19 cohort highlight the difference in how Whānau Āwhina Plunket made contact with whānau (Figure 9). The lockdown period saw slightly fewer virtual core and additional contacts for the 2020 COVID cohort alongside a substantial spike in the number of non-care delivery contacts used for booking, re-booking, deferring and providing information to whānau. The difference reflects the changes to practice and whānau availability in the lockdown period but may also reflect factors affecting the 2019 cohort (for example, the 2019 measles epidemic).

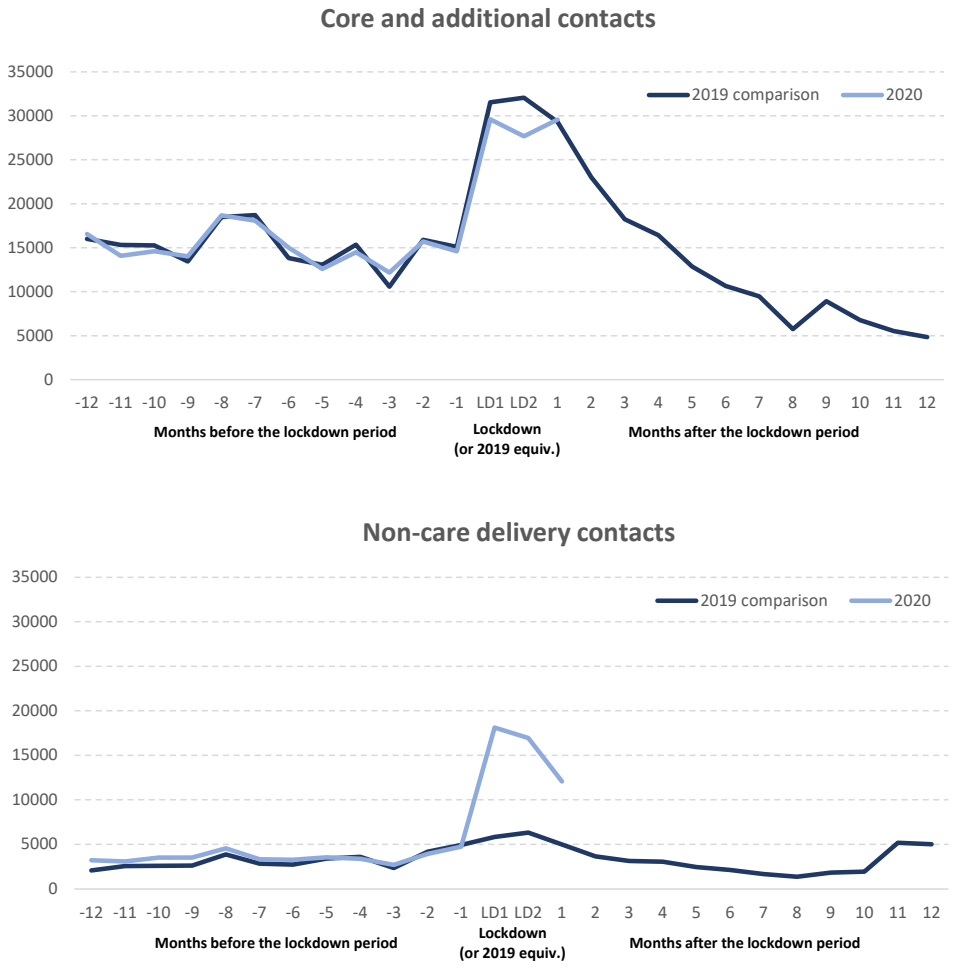


Figure 9. Contacts per month of different types recorded for the 2020 COVID-19 cohort and the 2019 comparison cohort.[7] The x-axis shows the number of months before, during (LD1 and LD2) and after lockdown and the equivalent period in 2019.

The group of whānau prioritised under PVS received a similar number of core and additional contacts in the period leading up to the lockdown but received more contacts during the lockdown period (Figure 10). The increase in virtual core and additional contacts was accompanied by a substantial increase in the number of non-CDC contacts for both the PVS and non-PVS groups, though the increase was greater for the PVS group. The increases in numbers of contacts should be

[7] When considering charts of contacts, it is important to note the impact the selection of the cohort has on the overall pattern of contacts. The cohorts were selected because they had a core contact due within the COVID-19 lockdown period (or 2019 equivalent) so there is an spike in the number of contacts during that period compared to before and after. The increases and decreases in contacts matching across both cohorts at other points in time reflect periods where other core contacts were due for parts of the cohort.

considered alongside feedback from staff that the PVS group included whānau who were more likely to be considered harder to reach.

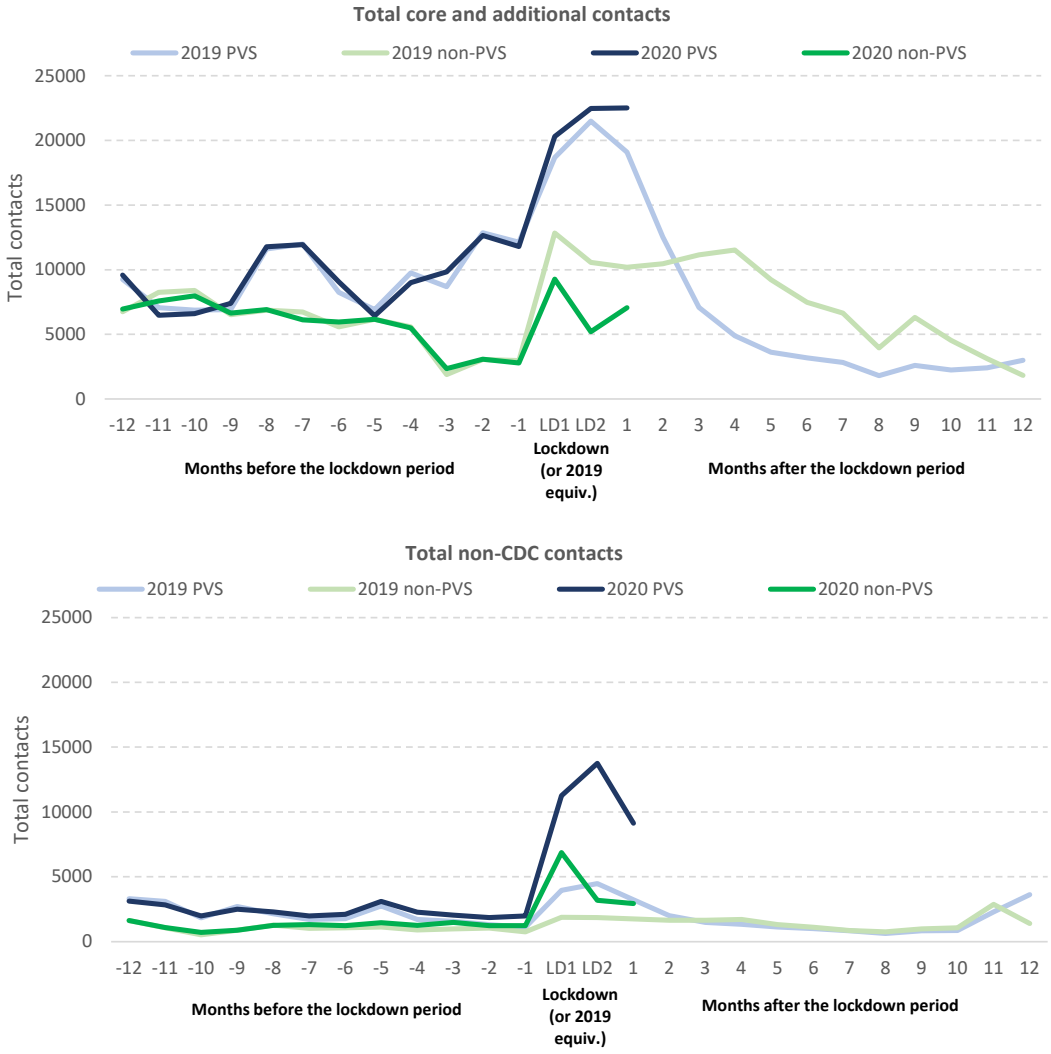


Figure 10. Total core/virtual core and additional contacts and total non-CDC contacts recorded for the PVS priority and non-priority groups in the 2019 and 2020 cohorts per month spanning the period from 12 months before the lockdown (and 2019 equivalent) and 12 months after.

5.4.1. Differences by ethnicity

Comparing 2019 and 2020 on the mean number of contacts (combining core/virtual core and additional contacts) during the lockdown period showed whānau Māori and Pacific families had more core/virtual core and additional contacts on average than non-Māori non-Pacific families (Figure 11). Whānau had more contacts on average in 2020 than 2019.

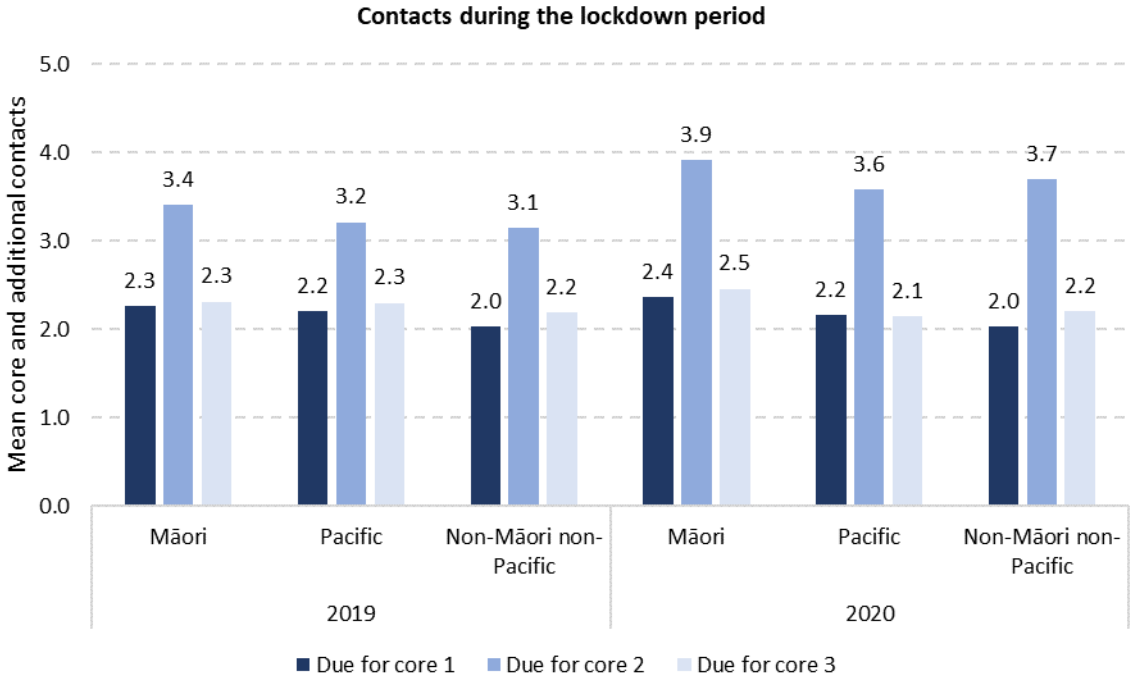


Figure 11. Mean contacts (core/virtual core and additional) during the lockdown period (or 2019 equivalent) by ethnicity for whānau due for core 1, 2 or 3 at the start of the lockdown period

5.4.2. Contact methods

Whānau reported the different ways they had been in touch with Whānau Āwhina Plunket over the lockdown period in the whānau survey. Phone and text were the most common, with only a small proportion (10%) in touch by video (Figure 12). Almost all video and phone contacts were used to discuss how whānau and their tamariki were doing. Video calls had the highest rate of Plunket staff offering to support whānau to get in touch with other services or describing how Whānau Āwhina Plunket could support the whānau.

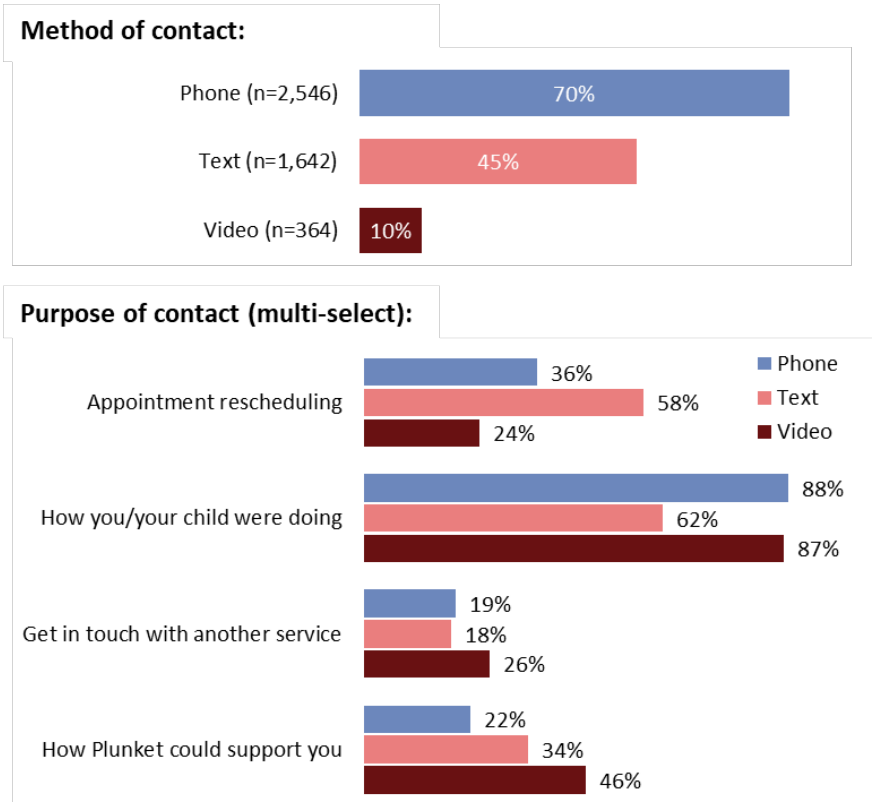


Figure 12. Proportion of whānau in touch with Plunket over the lockdown period using different methods of contact and proportion of contacts of each type used for different purposes.

5.4.3. Quality of contacts

Whānau were very positive about their contact with Whānau Āwhina Plunket over the COVID-19 lockdown period (Figure 13). Almost all felt respected and listened to, trusted the Whānau Āwhina Plunket staff member they spoke with and thought Whānau Āwhina Plunket spoke with them in a meaningful way. Though still very positive, whānau were more likely to disagree they understood the support they could get from Whānau Āwhina Plunket.

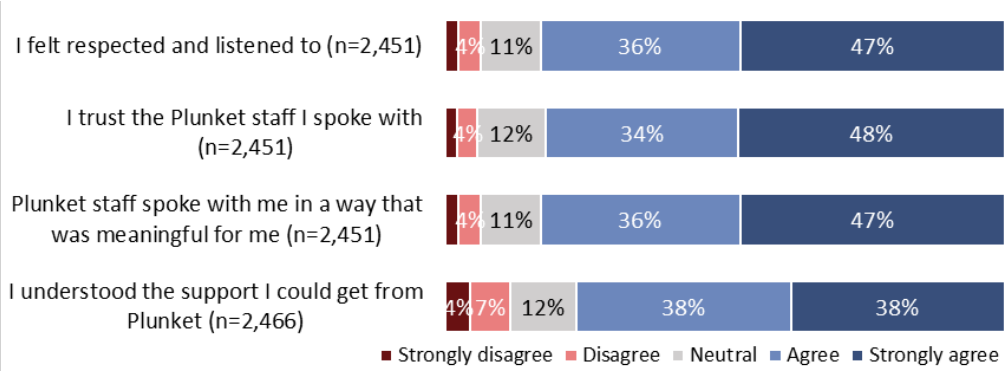


Figure 13. Whānau views on their contact with Whānau Āwhina Plunket over the lockdown period.

Staff wanted flexibility in the virtual aspect of PVS with provision for 'front gate' visits or drop offs to a small number of whānau they were worried about. Some staff felt Kaiāwhina and health workers in particular would be able to carry the role of contactless drop offs if the country were to go into another lockdown.

> *Being able to drop off resources especially for us in these rural areas. You can do a lot at the letter box, you don't need to go into someone's home to give them support. Sometimes especially when you're really rural and you haven't seen anyone for ages it's quite nice having contact and you definitely have better relationships [in-person] than over the phone.*

> *I thought that the health workers or Kaiāwhina could have been supporting other social services and that might have been doing contactless drop offs and I think they would have loved to do something like that as well.*

5.5. Whānau-led practice

An important aspect of PVS was whānau-led practice, both in how staff communicated with whānau and how they delivered WCTO. Using a whānau-led approach meant Whānau Āwhina Plunket WCTO nurses responded to issues raised by whānau, as opposed to a nurse-led approach, where the nurse prioritises a list of planned care components according to the national WCTO schedule. Some staff described the nurse-led approach as a *tick box* or *checklist* approach to engaging with whānau. The practice guidance review showed that service delivery documents encouraged staff to take a *what's on top* approach in their contacts with whānau and this was also emphasised by clinical leaders with their teams. Almost all staff embraced whānau-led service delivery and a few reflected on how the *old way of working* did not always allow for authentic conversation and exploration of whānau goals and aspirations.

> *It more became about what the whānau needed from us which I think was good because for a lot of my colleagues they had to start thinking differently. They had to start focusing*

and being more client or whānau led rather than them holding any of the power. Taking from the lockdown, that is what should remain the same. Making sure that when we go into see a whānau, when we walk out of that house the whānau feel listened to, heard, respected and that we've met their needs…

In interviews, staff described feeling less pressure to complete their WellChild checks and more freedom to be led by what whānau wanted to discuss. Kaiāwhina and health workers embodied this approach in their non-clinical roles. Kaiāwhina and health workers engaged in conversation and addressed whānau needs however they still felt the limits of capacity and the need to work virtually.

The whānau-led approach could work for low-need whānau as well. One Whānau Āwhina Plunket nurse said that she told low-need whānau *we will make the WellChild programme work for you* and offered drop-in clinics and community activities, as well as the range of virtual options such as PlunketLine.

… because I want her to get something out of those contacts rather than she is just turning up for the sake of it. I do emphasise it is a voluntary service.

This offering of wider Whānau Āwhina Plunket resources instead of focussing on traditional WellChild visits was described by other Plunket nurses.

Once the first three cores are done, I offer drop-in clinics and I don't say it's a priority I just say this is what we do on a Thursday, come in when it suits.

Responding to whānau need: Ashley's story

Ashley had a hard time during her pregnancy. She was diagnosed with hyperemesis and suffered severe nausea and vomiting. When she was discharged from her midwife and referred to Whānau Āwhina Plunket, a Whānau Āwhina Plunket nurse was quick to make contact to start supporting her.

I was actually really impressed because I pretty much had my midwife who referred me on a Monday and by that Friday I had a phone call from them. I was then being seen by them within the two weeks. It was a pretty quick turn over. (Whānau)

Ashley was impressed by her Whānau Āwhina Plunket nurse during their first visit. The medical staff at the hospital had focussed on Ashley's physical health but nobody had asked about her overall wellbeing.

… nurses, midwives and doctors, they were worried about my health, not me mentally and emotionally. She (Whānau Āwhina Plunket) was the first one to question if I had postnatal [depression] and that was really cool to be able to say yes I think I do.

Ashley liked how her nurse was warm and approachable and she trusted the nurse's referral to a community support worker who could direct Ashley to groups and activities that might benefit her.

I had my first appointment with [my nurse] who is absolutely lovely. She came out to the first appointment [at my home]. She also referred a support worker to come out and talk

to me about any support groups or parenting groups that I might have been interested in doing.

Ashlely felt comfortable sharing her experiences of depression and the effects of her pregnancy. Her Whānau Āwhina Plunket nurse suggested a community service that would help Ashley to express her feelings and acknowledge her journey.

I got referred to Mothers and Babies and that was due to me going through the hyperemesis. She offered me a whole year of psychology [appointments] which has been massive. I do that every Wednesday and that's been really good because I fell into deep depression through my pregnancy… I've found it really helpful being able to talk to someone.

Overall, Ashley has felt well support by her Whānau Āwhina Plunket nurse. Her Whānau Āwhina Plunket nurse created a safe space where Ashley felt like she could openly discuss issues and be supported to make decisions in her parenting.

I want to say a special mention about [my Plunket nurse]. She is absolutely awesome. She is not one of these people who comes in and tries to tell you how to do it… She's very open minded and that definitely helps not having someone come in [and dictate what I should be doing].

When we followed up with sentinel site staff in August/September, staff shared that while they had always worked within a context of social determinants of health, they were increasingly addressing greater social needs post-lockdown. Most staff said they were still working in a whānau-led way. They considered this a more effective mode of engagement as working with health services was not always a top priority for whānau, for example if they did not have enough kai. An emphasis on whānau-led care assisted staff in providing broader social support.

In a way it's a good way to engage with whānau as well. You're supporting and helping them with their needs. It's a lot of work and we're not trained as social workers but it's one way to engage. That's when networking and connections in your community are really important.

It meets their needs a lot better now and they're directing that appointment, it's what they want to talk about, it's not that they're being asked 101 questions.

Kaiāwhina and health workers recognised the importance of their roles and their ability to engage and create authentic partnerships with whānau. They described their role as a navigator within the social context and a bridge directly to the clinical nurses within Whānau Āwhina Plunket. Kaiāwhina and health workers acknowledged the complexities and increase in workload but understood that they had a place in assisting whānau with social services.

Rural staff understood that they would organically respond to a wider range of needs and some overlapped with the role of a social worker. Services in rural areas were scarce and distances between townships and services varied.

Are we nurses? I feel like it's been like that in these rural areas for a long time. We're more social workers than we are nurses but we've never been trained as social workers.

Other staff strongly identified their role as clinical. They understood the inequities that high priority whānau experienced but were not comfortable taking a wider social lens. Some nurses were passionate about nursing practice and felt being whānau-led could stray too far into social support.

The nurses are rumbling 'I'm not a social worker, why aren't other services picking up the slack'. So we've had to [educate nurses around] this is how you frame your visits, this is part of your job linking with other services.

I feel like it's important but at the same time I feel like it's changing a lot what our role is. It's more social work rather than nursing and that's not really what I want or signed up for. Of course, I want to improve equity but if they're not engaging or they need social services we shouldn't be that person. They should have social workers or there are other services that could support them.

Some staff suggested the need for a Whānau Āwhina Plunket social worker role as the social needs of whānau continued to increase. This role would enable a single service for whānau to access and would take away the pressure for nurses to address needs some felt were not a significant part of their role.

Plunket need our own social workers in our own internal team. If we could work with our own social workers in Plunket that would be really awesome.

One whānau we spoke with who became at risk of family violence over the lockdown appreciated the consistency of virtual contact from Whānau Āwhina Plunket during lockdown and shared with us the elements she values in her interactions with Plunket.

Practical support and information during difficult times: Whetu's story (*real name not used and composite demographics)

Whetu has three tamariki and her youngest is six months old. Over lockdown Whetu's home became unsafe for her and the children, and she left her partner. Whetu and the kids have been staying at Women's Refuge but just moved into their new whare last week. Whetu's Whānau Āwhina Plunket Kaiāwhina visited her in the new place. She dropped off some baby clothes and supplies.

Whetu enjoys the company of her Whānau Āwhina Plunket nurse and Kaiāwhina. She feels comfortable with them and not judged. In the past, health workers have made Whetu feel as if they are judging her.

They are like you are an older mum and you don't know what you are doing. I am like, well I am also Māori and I have nine brothers and sisters so I do know what I am doing.

The Whānau Āwhina Plunket nurse and Kaiāwhina always ask Whetu what she would like to talk about and they connect her with other supports and activities in the community.

Whānau Āwhina Plunket told Whetu about a clothing exchange service and she has donated and received clothes there.

> *I like how they ask me what I want to know about and stuff. They give me information and tell me what is happening in the community so I like that they are there for support.*

Whetu values the knowledge that Whānau Āwhina Plunket can provide and she listens to the Whānau Āwhina Plunket nurse and Kaiāwhina because they explain things well to her.

> *They will tell me if they think I am doing something wrong and I will take that on board. Like when baby was little I gave him yoghurt because he saw me eating yoghurt and he wanted it. And they explained to me why he shouldn't be eating yoghurt. And was like oh well it is done now. But they weren't all like oh you shouldn't do this because of … they were like oh, he shouldn't have it.*

Whetu's whānau and friends share stories about Whānau Āwhina Plunket with each other. She is proud to have been a Whānau Āwhina Plunket baby herself and she has reflected on the things she likes about her Whānau Āwhina Plunket nurse and Kaiāwhina.

> *I like my ones because they are not up themselves. I have heard stories about other ones that are up themselves… The ones I am working with now don't make assumptions about me. They just come in like they are whānau. … you can be yourself around them.*

6. How PVS contributed to seamless service delivery by Whānau Āwhina Plunket clinical and community staff

Summary

In some regions clinical and community team relationships strengthened over lockdown, although the community staff we interviewed did not think clinical teams understood the work that they did. For example, community teams across the Southern region worked together to unite isolated whānau. Working virtually was an opportunity to become more connected across Plunket teams.

One in five of the whānau surveyed had engaged with at least one Whānau Āwhina Plunket community service. Feeling more connected to their communities was one of the outcomes from their contact with Whānau Āwhina Plunket whānau were less positive about.

Some staff spoke about the need to refer whānau Māori to iwi providers where they were able to access kai, clothing and hygiene packs over the lockdown. Referrals to other services were managed in a way that gave autonomy to whānau, providing ability to assess and decide as a whānau what services would be useful.

Most staff agreed that it was necessary to work through a virtual service for the safety of staff and whānau over lockdown however some felt this had a negative impact on relationships within the wider community.

6.1. Links between Whānau Āwhina Plunket clinical and community staff

The practice guidelines review showed that there were no documents provided to support continuity of care between clinical and community staff. We interviewed a small number of Whānau Āwhina Plunket community staff and overall they thought clinical staff did not have a thorough understanding of their community roles.

> *No, [clinical staff have not understood the community role]. I've had similar conversations with our regional manager… it is not well understood and again it is about coming together, creating the conditions to have shared conversation so we understand not only what the organisation wants from us but we understand what the value is and what we each bring to the organisation and how those things work and how we work together.*

During the lockdown, community staff were responsive to whānau needs by offering virtual playgroups, educational activities and different forums around parenting practice.

Whānau Āwhina Plunket community staff told us about the clinical community referrals system which helped connect whānau with community staff over the

lockdown. A community referral pathway was created for clinical staff to refer their whānau. This pathway enabled clinical staff to better understand the programs and activities that community staff provide for Whānau Āwhina Plunket whānau.

> *Community has opened up their service so that we can refer to them but when it comes to services the community team has not changed. There has always been quite a disconnect there.*
>
> *During lockdown there was that ability to refer and community would touch base with the in a virtual space which was great. That has also died down now that people have gone back to work. The clinical and community staff are interacting face to face [in-person] on the daily now instead of via Zoom but in terms of community the input back into the whānau I think has decreased.*
>
> *The community staff have been communicating a lot more now. Most of the community groups are happening virtually but in order to get clients for those groups they're sending out a lot more emails to nurse and health workers to recruit and promote.*

COVID-19 lockdown provided an opportunity for clinical staff to understand what support and resources were available from their community counterparts. In some regions clinical and community team relationships strengthened over lockdown. For example, community teams across the Southern region worked together to unite isolated whānau.

> *For example, if the Plunket nurse was doing a call with someone and they said I am feeling really isolated and I need some connection, they would send that through to the community team and they would make contact. They worked in the area of setting up virtual groups and webinars so they could hook people into those later.*

When Whānau Āwhina Plunket nurses were unable to contact whānau they relied on Kaiāwhina, Pacific Community Karitane and health workers to follow up with whānau. During the lockdown, some Kaiāwhina were delegated whānau to contact outside of the PVS criteria. This was generally a phone call to see how whānau were doing.

> *Yes, there were a few low-needs. They were referred to me by their case manager or registered nurses just because some of them would switch off from their nurses and wouldn't respond to them. So they would use me now and then to re-engage whānau that weren't responsive.*
>
> *If I've got space the nurse will delegate me to make phone calls to catch up with the [low needs families]*

Staff from at least one region identified a disconnect between the pro-equity journeys of clinical and community teams and opportunities to strengthen community team awareness.

> *Community is not quite at the same space that we are in regard to pro-equity. I think a lot of the resources are still getting targeted to our low needs whānau whereas actually that is not where we are heading so I think there is a bit of work to do there. The community referrals are more for our low-needs clients to give them extra support.*

I think when messaging comes out we have two different ways of interpreting it and because we have to adhere to the clinical guidelines and they don't have to so there was a lot of confusion.

However, some community team staff we spoke with were mindful of inclusiveness in their service and had ongoing relationships with other organisations supporting high-needs populations such as prisons.

6.2. Whānau access to community services

Just under one in five (18%) of the whānau who responded to the survey had accessed one or more of Whānau Āwhina Plunket's community services. Most often, they had participated in topic specific parenting support or PEPE groups (Figure 14).

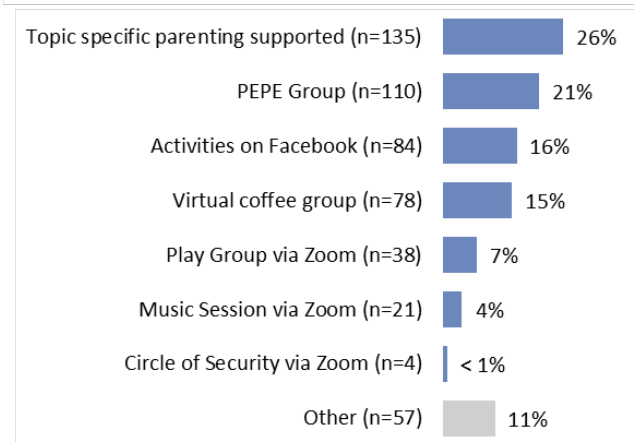


Figure 14. Whānau use of community services (n = 527)

While the majority (51%) of whānau agreed or strongly agreed Whānau Āwhina Plunket support had helped them feel more connected to their communities, this result was not as positive as whānau views on other measures outcomes from their Plunket contacts.

Some staff spoke about the need to refer whānau Māori to iwi providers where they were able to access kai, clothing and hygiene packs over the lockdown.

We had a lot of the iwi providers that were working really hard. I found that is where a lot of the resourcing for our families came from.

I was doing heaps of referrals over lockdown. It was about resourcing the community and making the community work for them. Food parcels getting delivered by Civil Defence or getting delivered by the food bank for a lot of our whānau with no transport. Frozen meals being delivered from a voluntary service, getting clothes dropped off for whānau.

Both key stakeholders and Whānau Āwhina Plunket staff told us about the increased demand for community services over and after the lockdown. Many organisations such as foodbanks were run by volunteer retirees who were a vulnerable group due

to their age and therefore unable to provide their service. While Whānau Āwhina Plunket were delivering their virtual service, their community partners were just as busy. Some had such great demand for their service that they were unable to take on any more whānau and had to start turning people away.

I definitely think there is more pressure on externals. We've had externals come back to us and say we're at capacity. [name of community service] providers across the area we've got a four week waiting list. Our iwi provider in [location] which is our Tamariki Ora provider they have shut their shop. They said we can't take anymore we're so sorry. People that birth in [location] now only have the option of Plunket there is no other option. We have a Food Bank locally ad they hand out food at four o clock and they've had more and more demand- they've never handed out so much food ever.

A few staff shared the importance of building partnerships with whānau to properly understand their needs and ensure an informed referral. Referrals to other services were managed in a way that gave autonomy to whānau, providing ability to assess and decide as a whānau what services would be useful.

[I only make referrals to community services] if they want me to. They need to be the driver rather than me telling them you need to do this, and you need to have that. That will not help a whānau member, they will just cut you off and that is why they disengage.

6.3. Relationships with community stakeholders

Most staff agreed that it was necessary to work through a virtual service for the safety of staff and whānau over lockdown. However, some staff shared how their whānau and friends did not believe that Whānau Āwhina Plunket were not providing an in-person service. Some felt this had a negative impact on relationships within the wider community. For example, some Lead Maternity Carers (LMCs) said they did not understand why Whānau Āwhina Plunket were engaging virtually. Some Whānau Āwhina Plunket staff told us midwives continued to see whānau throughout the lockdown and felt alone and swamped with work. Midwives were directed to the Plunket 0800 number which also caused frustration. Whānau Āwhina Plunket described working with the College of Midwives during the COVID-19 period to agree a process and prepare guidance for staff around transfer of care, specifically on supporting higher-need whānau. This included a provision for LMCs to refer to Plunket for in-person contact in exceptional circumstances.

I think anybody who was out there face to face [in-person] would have felt let down that we weren't. Whether you're a lactation consultant, a GP, a midwife. I don't think it did us any favours.

Our understanding was that from a national level communication had gone to the College of Midwives and it had filtered out to the LMCs. It wasn't until after the six weeks by the time people had got back to face to face on June 2nd that we realised that some LMCs were feeling quite disgruntled, so I managed that situation.

When staff reflected on the lockdown and the way their community partners were informed about Whānau Āwhina Plunket's PVS response, they identified the need for communication directly to partners within their community. If another lockdown occurred, staff wanted more regional communication to complement nationwide messages. This would assist management in each region and community to engage directly with community partners to ensure there was no confusion around what Whānau Āwhina Plunket service delivery entailed.

> *Learnings from this is next time, if something comes out from a national level, I will also be sending an email out to all of the LMCs to the DHB, to any of my stakeholder groups saying who the local contacts are.*

> *The messaging wasn't very clear from the start. The midwives thought Plunket had shut up shop and they thought that they had to do all of this extra work. We should have done a media release on the tele and to the College of Midwives a bit sooner.*

Some staff had good relationships with iwi and Māori health providers in their rohe. This was particularly important as some iwi continued to work in the community delivering resources to whānau in need. Staff described that it was easier engaging and referring whānau to iwi providers if there was a pre-existing relationship.

> *We have a good relationship with [a Māori health provider] and they delivered hygiene boxes and they were delivering baby essential boxes so we were able to refer in via email to that service and they would deliver based on need.*

In some regions, relationships with iwi and other community organisations strengthened. In other regions, PVS highlighted opportunities to strengthen relationships between iwi organisations and Plunket. Māori Whānau Āwhina Plunket staff who had insight into iwi activities through their own personal and whānau networks highlighted the need for Whānau Āwhina Plunket to engage with Māori services.

> *I was hearing it [information about iwi support for whānau] from whānau and not being the one sharing that information with them.*

> *I don't feel like [Whānau Āwhina] Plunket were connected with iwi providers and I felt like we could have been doing more. We had all of those baby boxes that were sitting there. We had a heap that could have been delivered for our first time parents or our new-borns. I know there were restrictions, but we weren't doing practical stuff.*

We asked staff how relationships between Whānau Āwhina Plunket and iwi, Māori providers and community services could be strengthened. Staff highlighted the importance of networking and showing their willingness to engage and establish meaningful working relationships. In smaller communities, staff felt it would be powerful working together with community providers and supporting each other to collectively respond to whānau needs.

> *Our Māori providers, our Kaiāwhina need to be going and visiting our Māori providers to see if they have any initiatives going where we can support them. We need to get in there*

and get to know them and work with them so they're able to hear about the mahi we're doing and so we can support the mahi they're doing. That is definitely something we need to work on.

There is definitely room for improvement with external agencies however the girls have been absolutely under the pump.

I think it's actually better and they've seen that we're making a conscious effort to prioritise Māori and Pacific and that's great. It's not you're amazing yet it's at about time but it's been good to link in with [iwi providers] at some of the meetings at our level and it's been like this is great what you're doing.

Staff felt it would be useful to attend antenatal classes to inform whānau about Whānau Āwhina Plunket and introduce what the service offers.

I think my staff need to connect with the midwives, but I think we need to get in their faces and get out there to the antenatal classes and introducing [Whānau Āwhina] Plunket and the service and telling mums at that point what to expect I think that could be a good thing to do.

Staff who have focussed on pro-equity and implemented prioritisation reported having positive feedback from midwives and iwi providers within their communities.

I've met with some midwives recently and when we told them about our new way of service and the journey we're on. They were incredibly receptive and they said this needs to happen. If we keep continuing this journey and keep talking like we're talking it creates a reflection for other organisations and people to reflect on what am I doing to change the way that I work.

7. How well PVS contributed to improving outcomes for whānau

Summary

Improved outcomes for whānau depended on reaching and responding to whānau Māori, whānau with different levels of need, and whānau in different locations.

Whānau were positive about the outcomes from their contact with Whānau Āwhina Plunket during the lockdown period. Most reported Whānau Āwhina Plunket staff answered their questions about their child's health. Around two-thirds said Whānau Āwhina Plunket staff answered their questions about their own health and helped them feel more confident in their parenting.

Staff had different levels of knowledge and confidence working with whānau Māori. Clinical staff were more likely than community staff to say they felt less confident working with Pacific families.

While at the time of this report, there was limited data available on outcomes for tamariki and whānau, we focussed our lens on what worked and where there were challenges in implementing PVS, such as virtual engagement, communication and support for staff. PVS enabled more time to focus on high-priority whānau but contacting high-priority whānau could be difficult when whānau did not have reliable phones or other technology.

Improved outcomes for whānau are dependent on reaching and responding to whānau Māori, whānau with different levels of need, and whānau in different locations as discussed in section 5.1. Some staff thought it was too early to comment on how PVS contributed to improving outcomes for whānau.

7.1. Whānau views on the outcomes from their contact with Whānau Āwhina Plunket

Whānau were positive, with around three-quarters of survey participants agreeing their interactions with Plunket over the lockdown period answered the questions they had about their child's health and supported them to feel more confident in their parenting (Figure 15). Though still positive, more disagreed that Whānau Āwhina Plunket had met their own physical health needs (18%) or helped them to feel more connected to their communities (26%).

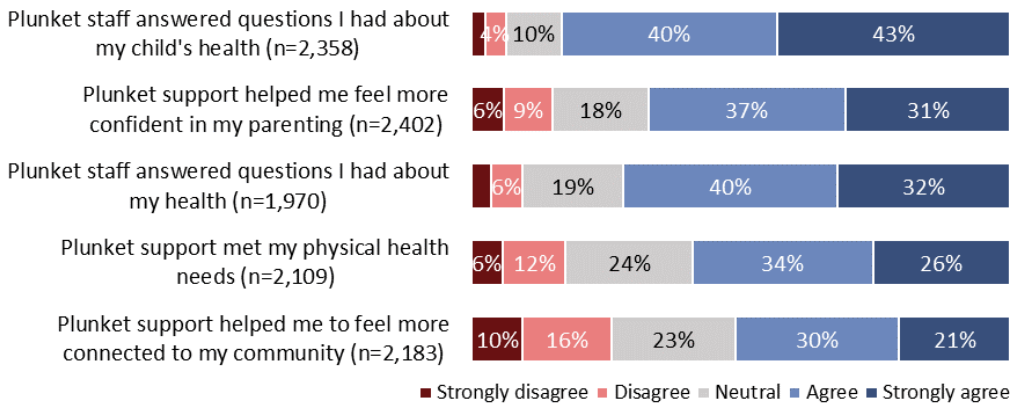


Figure 15. Whānau views on the outcome of their contact with Whānau Āwhina Plunket.

During interviews with whānau we explored how confident they felt about their parenting in general. Most māmā found this question quite humorous and explained that no two days of parenting were the same. Some days whānau felt like they were *nailing it [parenting]* and other days they felt like they were *back to square one with no idea*.

> *I am really confident. I am resilient and so is my baby. When we left [ex-partner] and went into refuge it didn't change him [baby] or anything. So I know I am doing my best. That is all I can do. (Whānau)*

7.2. How staff supported whānau Māori to achieve their aspirations

Staff had different levels of knowledge and confidence in their work with whānau Māori. Most described the importance of getting to know whānau and being led by each whānau in the way they would like to work together but some thought that it was important to *treat everybody the same way* and wanted to talk about supporting all groups in their aspirations.

Caroline's story (below) is a composite example of engaging in a culturally safe way and being led by the whānau. It incorporates interview quotes from a mixture of staff and whānau to protect confidentiality.

Cultural safety: Caroline's story (*real name not used)

Caroline is a health worker who engages and supports whānau on their parenting journey. Caroline recognises her role as a navigator and works hard to create partnerships with whānau and work in a way that is led by whānau. Caroline is grounded in her own Pasifika culture and this helps her to work with whānau across a range of different cultures. Although Caroline is not of Māori descent, she works in a way that enhances whānau mana.

I firstly work on building whanaungatanga and connecting through our shared experiences and taking it from there. I have a deep understanding and I feel it in my heart, I love going to visit Māori whānau.

Whānau who work with Plunket and health workers like Caroline appreciate awareness of culture and cultural practices. One māmā spoke about how Caroline supported her and accepted her whānau way of parenting.

I'm Pacific Islander and my husband is Māori. I guess them [Plunket] being culturally welcoming, not feeling out of place and feeling accepted with the way I parent, and the way we do things with our daughter… She's very supportive and open and is never judgemental of things that we do. (Whānau)

Caroline really took the time to understand the whānau she served and observed the environments that her whānau lived in. She was able to identify a cultural practice and naturally implement and participate in the practice.

When we came in contact with Plunket, she was so thorough and genuine. She would sit on the ground if I was on the ground. If there were people in the house she was aware when cousins were around, she would go to the room and ask 'how are you feeling' she was genuine, I didn't feel pressure. (Whānau)

One māmā shared the importance of understanding whānau structures. She explained how Caroline did not see her as a 'client' and instead recognised and acknowledged her wider whānau.

Feeling comfortable with her and recognising that my child is part of a whānau… She recognises that. She asks where my older child goes to day-care, how is he and still today remembered that he was with my mum up north fishing and asked how that went. [She understands that my daughter] is part of a whānau and if my whānau is not alright then she is not going to be alright. She acknowledges us as a whole. (Whānau)

Ultimately, Caroline puts whānau at the centre of what she does. She connects in meaningful ways and ensures the mahi she does is culturally responsive and led by whānau.

I would also gauge what else is going on in the house and connect with whānau and support them in other ways as they need it. I love being in whānau homes and talking and letting the conversation flow.

We asked staff what whānau want to get out of working with them and whether whānau shared their aspirations and goals. Whānau Āwhina Plunket staff told us the prioritisation under PVS had increased their ability to build trust and maintain relationships with whānau. PVS enabled more time to focus on high-priority whānau. We heard many examples of Whānau Āwhina Plunket staff feeling they had permission to be tenacious and channel resources towards whānau who were more likely to benefit from support.

Building trust: Hinemoa's story (*real name not used)

Hinemoa is a young Māori māmā who just had her first pēpi. She lives with her pēpi and her partner in a small rural town. Hinemoa's home is in a remote part of town that is often cut off by flood waters in the winter and isolated from community services. Most services do not provide outreach to Hinemoa's community, but PVS has enabled a Whānau Āwhina Plunket nurse and Kaiāwhina to prioritise their time for whānau in this area.

Hinemoa does not have reliable phone reception. She often runs out of phone credit and she changes numbers regularly. The Plunket nurse and Kaiāwhina travel over an hour around winding corners and gravel roads to get to Hinemoa's community. Often they would travel to see Hinemoa and her whānau but no one would be home.

> *I have a young Māori mum who is 15 and multiple times I've been there week after week where she's either not there or she's gone for a walk and doesn't want to see us or she's just leaving.*

Hinemoa and her whānau have been assessed as having high-needs so the nurse and Kaiāwhina were consistently going to visit Hinemoa regardless of whether they could have a kōrero with her or not. For weeks Hinemoa was apprehensive about engaging with Whānau Āwhina Plunket, but the Whānau Āwhina Plunket staff did not give up despite repeated failed attempts to connect with her. Finally, after a long period of constantly showing up, week after week, Hinemoa started to trust them.

> *It has taken weeks, we've been there so many times and finally she's completely changed and she's engaging so that's a success to me. It has taken a long time but it's being able to continuously do it.*

The Whānau Āwhina Plunket nurse and Kaiāwhina were aware of Hinemoa co-sleeping with her pēpi and wanted to educate her whānau on safe sleeping practice. When staff started to engage with Hinemoa they were able to build up a trusting partnership and Hinemoa disclosed alternative contact details. She gave the Whānau Āwhina Plunket staff her new phone number and her mum's landline.

> *Her and her partner have given me another contact number now and they're completely engaging. That is a huge amount of resource but totally warranted.*

Although most staff thought in-person engagement was the best way to establish relationships with whānau Māori, the nature of intensive travel to homes before PVS created time constraints. Whānau Āwhina Plunket staff described a normal working day which was packed from beginning until end meeting whānau and moving from home to home. Staff shared the difficulty in being able to build strong relationships with whānau as the *old way* of working did not always allow enough time for this. Staff described this way of engagement negatively impacting how confident they felt working with whānau Māori.

> *It takes longer to build the relationships [with Māori whānau) so that is the part that makes it harder to feel confident about it. And that goes a little bit to how we worked in*

the past, you've got half an hour to see a new baby case. So we've got all of these questions that we're required to answer. So we've gone in with a big agenda and you've got limited time to achieve that agenda plus build that relationship. The past focus of the organisation and the contact has impeded that.

Māori staff were very confident working with whānau Māori, particularly Kaiāwhina who described their role as bringing cultural flavour to their day to day engagement with whānau. Many staff continuously highlighted the importance of relationship building and understanding whānau Māori.

Good, I feel quite confident… I think it's about establishing a relationship and them trusting or knowing who they are talking to and trusting.

We talk like we've known the family for a long time. You have to make yourself connected to them. It's all about the beginning, you have to [start it like that] otherwise they just switch off and they don't want to see you again. But if they know you whenever you ring they're [open to seeing you].

In response to the staff survey, around one-third of clinical staff said they were less confident working with Pacific families and whānau Māori (Figure 16).

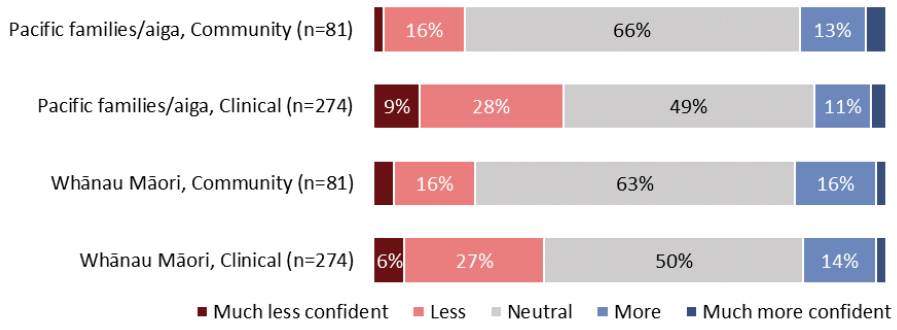


Figure 16: Proportion of clinical and community staff who felt more or less confident working with whānau with different characteristics.

Staff discussed the importance of working in a way that gives power to whānau to make decisions about their journey with Whānau Āwhina Plunket. Staff cultivated strong partnerships with whānau and were led by them.

The partnership, trying to develop partnership and [rapport], with Māori clients we really work on the relationship so they trust me and that they can see me as someone they can relate to… With Māori clients I work more on the relationship, ensure they are informed and they can make decisions for themselves.

Most staff articulated how they worked with whānau Māori to help them achieve aspirations, but some said that they treated all families in the same way. Whakawhanaungatanga, manaakitanga and working in ways that enhanced one's mana were themes that emerged when most Whānau Āwhina Plunket staff talked about supporting whānau Māori to achieve aspirations. Some staff acknowledged their own position of power, and were careful to build authentic relationships with

whānau, understanding the whānau context and the importance of wider whānau input.

> *I think the trust thing is massive... I work really hard to be acceptable as I can be given that I'm not Māori and getting it right, listening, being non-judgemental... Working alongside them in regard to parenting and trying to be mindful of the role that extended whānau play often in Māori families and taking that into account and the need to involve the extended family.*

Māori staff discussed the importance of mapping out whānau aspirations and incorporating navigation tools through te ao Māori concepts. This was particularly important for whānau Māori where it encouraged autonomy in their journey with Whānau Āwhina Plunket.

> *That is the essence of what we do in our space. It is around whanaungatanga, connections and relationships. It's about goals and working towards what good health looks like to them for themselves, tamariki and their partners. Even though I'm a Plunket nurse I call myself a Kaiarataki so a guider. I navigate, it's very whānau led it's based around what their need is and how do we get from A to B.*

There were mixed views around how well PVS worked for whānau Māori compared to other whānau. Successful engagement over virtual platforms varied from whānau to whānau. Many staff knew their whānau Māori and felt kanohi ki te kanohi was best and most effective way of engaging. While the virtual aspect was necessary during the COVID-19 lockdown, for some whānau Māori this method did not work.

> *Yes I think so because we were prioritising Māori families. That it did work for them because we made ourselves more available though there was a few of my Māori clients that are never good on the phone. We couldn't get a hold of them anyway. Some of those higher needs clients don't like to talk on the phone and a lot of the time they don't have texts available so those are the clients who I would normally need to go and home visit and just call in.*

> *I think it depends on the whānau Māori and where they come from and whether they feel comfortable with the virtual service. A lot of the whānau that I work with personally prefer face to face [in-person], that authenticity of being in their home, that manaakitanga environment.*

7.3. The extent PVS helped improve outcomes for whānau Māori and Pacific compared to normal Whānau Āwhina Plunket Services (pre-COVID-19)

When we asked staff about PVS improving outcomes for whānau Māori and Pacific they focussed on barriers to access via virtual engagement and the potential negative effects on outcomes of not being able to engage. Not being able to knock on doors and spend time in the same room with whānau meant staff were not as effective in reaching Māori and Pacific families compared to normal Plunket services.

No, when we were remote only, no I don't. I think often if I'm on the doorstep or they're happy to let me in the door we can work to a place where maybe they can trust me enough and they can chuck in a question or concept by just quietly checking. That happens because of the time and face to face [in-person], relationship and trust.

The ability to resume cold-calling and kanohi ki te kanohi contact after lockdown was welcomed by staff and the prioritised aspect of PVS meant that they could focus on their higher-priority whānau. Almost all staff were positive about the prospect of a mixture of engagements to fit whānau need.

I think the online virtual service absolutely has its place where people want it but also that scenario where it might be the school holidays and there is that preference. A lot of appointments are not kept because of sickness or horrible weather or school holidays -why don't we just do a Zoom?

The Whānau Āwhina Plunket administrative data included breastfeeding status for whānau. We compared the proportion of whānau recorded as fully or exclusively breastfeeding as at each of the first three core/virtual core visits. Rates were consistent across whānau comparing 2019 and 2020 (Figure 17). Comparison of breastfeeding rates should be done with caution because in addition to PVS they are impacted by a wide range of factors not evident in the data used for this analysis. Examples include other changes in nurse practice, differences in whānau level of need or behaviour, other public health initiatives targeting breastfeeding, the measles epidemic, changes in whānau behaviour, access to other supports and midwifery practice. Further work (for example, creating comparisons between whānau matched on social and demographic factors or looking at longer term breastfeeding data once available) may help to answer further questions on the effect of PVS on breastfeeding rates.

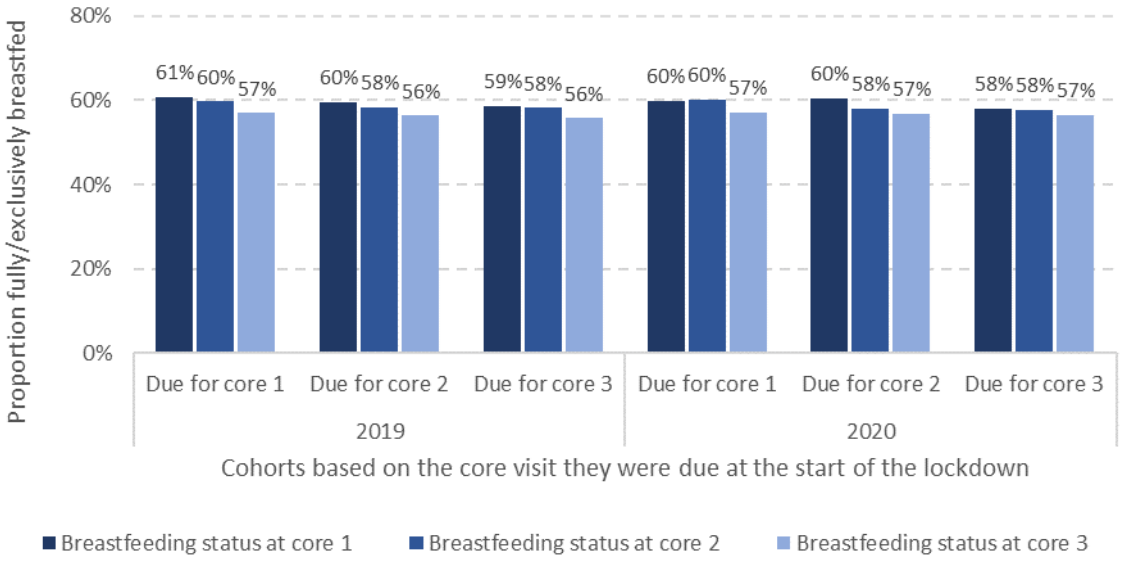


Figure 17. Proportions of whānau fully or exclusively breastfeeding in core/virtual core 1, 2 and 3 by what core visit they were in at the start of the lockdown period.

The pattern was consistent for each ethnicity, though full and exclusive breastfeeding rates continued to show a disparity of around 10 percentage points between Māori, Pacific and non-Māori non-Pacific whānau (Figure 18).

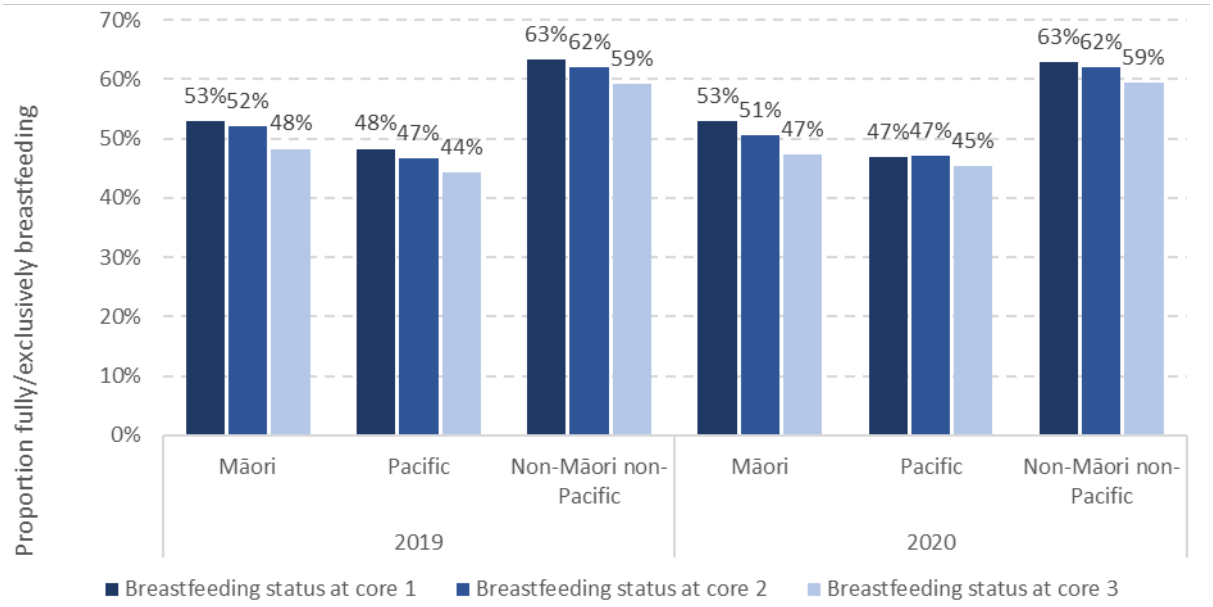


Figure 18. Full or exclusive breastfeeding rates at core/virtual core visits 1, 2 and 3 for whānau who were due for core 1, 2 or 3 at the start of the lockdown period.

8. How learnings from implementing PVS can help strengthen all Whānau Āwhina Plunket Services

The COVID-19 lockdown required changes in the way Plunket staff engaged with whānau. Under PVS, the aim was for all clients due to receive core contacts one to three of the WellChild Tamariki Ora programme to receive virtual core contacts by phone or video conference rather than in-person. Māori and Pacific whānau with short-term high-need and all whānau with long-term high-need would also continue to receive virtual core contacts. Other whānau were contacted to direct them to other sources of support including Plunket and other community services and other virtual resources like PlunketLine.

Whānau Āwhina Plunket commissioned an evaluation of PVS and intends to use learnings from the evaluation about implementing PVS to strengthen all Whānau Āwhina Plunket services. The main learnings from PVS are summarised below.

8.1. Prioritisation

Prioritisation enabled staff to invest more time in reaching and working with the whānau who were assessed as needing greater levels of support. In some cases, that meant persisting with attempts to make contact through the usual channels of phone and text as well as others like Facebook messaging.

The prioritisation was a combination of age of child, ethnicity and level of need. Accurate prioritisation was dependent on being able to accurately assess whānau level of needs. Many staff noted the importance of continually reassessing needs to respond to changes. Some changes related to maternal and child health whereas other changes arose because of the impacts of COVID-19 such as loss of employment and changes in family situations.

Consistency in assessing and recording whānau level of need will help ensure whānau are placed in appropriate priority groups. The caseload dashboard tool proved to be a useful tool in identifying whānau in the wrong group. Staff were able to identify whānau whose circumstances changed. Some staff described whānau who appeared well resourced but lacked parenting confidence and knowledge. While these whānau could call PlunketLine, staff also thought some required virtual engagements.

Prioritisation and criteria for prioritisation were challenging for some staff. Many understood the need to focus on Māori and Pacific to improve outcomes and reduce disparities. However, some considered the criteria to be too blunt and expressed that the criteria did not recognise the variation of needs within whānau from different ethnic groups. Others were faced with pressure from whānau with low-needs and struggled to explain prioritisation.

More flexibility for staff to identify needs would recognise staff knowledge of the whānau they work with. However, the opportunity to add nuance to the prioritisation was limited by the rapidity of the implementation of PVS. Increased community awareness of Whānau Āwhina Plunket services changes during COVID-19 and prioritisation may have helped Whānau Āwhina Plunket staff with explaining how services were being delivered.

8.2. Professional development opportunities

Findings from staff interviews articulate Plunket's large and diverse workforce of people who are committed to ensuring the best possible outcomes for whānau. Plunket staff have varying levels of knowledge about equity, and confidence regarding engagement with Maori. This resulted in some staff embracing pro-equity and others feeling challenged by facing questions about PVS from their communities that they do not feel equipped to answer. Staff interviews have shown us there are opportunities for professional development across many roles to strengthen staff knowledge capability about equitable health access and outcomes. The survey also highlighted a need for some staff to develop their confidence in working with whānau Māori and Pacific aiga. Further cultural safety training such as Kawa Whakaruruhau would support staff in recognising historical and contemporary contexts for Māori, including structural violence, loss of land and ability to access Te Ao Māori.

While staff confidence grew over lockdown in virtual consultations such as reassuring whānau about baby's growth, other aspects of tele-health such as family violence screening required further training to build confidence of many staff. There were also opportunities to provide further guidance on what to do when staff were worried about whānau who did not respond to multiple attempts at virtual contact. The practice guidance review showed that delays in delivery of education packages, including family violence not being available until up to week four of lockdown, may have impacted on staff confidence.

Overall, more enquiry of virtual mode is needed and more preparation for delivering in this way so that staff are confident in the time-management aspect of virtual augmenting in-person contact.

8.3. Communications and practice guidance

Like the whole country, Whānau Āwhina Plunket was required to move swiftly when Alert Level Four lockdown commenced. Some of the Whānau Āwhina Plunket workforce were re-deployed and the majority of staff adjusted to a new normal, working from home and contacting high-priority clients through phone and virtual platforms. Communications about re-deployment caused anxiety among some staff.

In hindsight it would be more be more appropriate for Whānau Āwhina Plunket to raise redeployment conversations once the process and deployment was finalised as this would prevent unnecessary stress for staff.

Staff, whānau and community services relied on timely information about PVS which was not always able to be achieved in perfect synchronicity in a changing environment. In their practice guidance review, Whānau Āwhina Plunket noted:

- The pandemic practice context was dynamic and changing very quickly, so there was an awareness that documents would need to be updated in response to the changing context. Whānau Āwhina Plunket aimed to achieve a balance of providing enough information for newer staff, and not to be patronising to experienced staff, while also being aware of the continuum of capability across staff.
- Distribution and implementation of all documents generated was managed by the Pandemic Response team and Operations Leadership.

How the documents were interpreted by staff will have been influenced by messaging given at team meetings by frontline leaders (CLs), which came through in staff intervews.

8.4. Whānau-led practice

Before COVID-19, family violence assessments and SUDI interventions including housing referrals were part of the support undertaken by Whānau Āwhina Plunket staff. Although nurses are educated to provide holistic support, since March 2020, the PVS focus on whānau with high-needs coupled with the immediate, negative social and economic impacts of lockdown on communities meant that Whānau Āwhina Plunket staff were increasingly exposed to greater social needs. Whānau Āwhina Plunket staff had mixed views about the extent they felt equipped to provide social support with a few telling us they felt like social workers. There are opportunities to provide more social determinants of health training such as family violence education to staff.

However, strengths-based and whānau-led practice inherently includes social support and good connections with other providers who can support social needs. Several staff described strengthened connections between Whānau Āwhina Plunket clinical and community teams. A potential topic for professional development is the role of the community teams and the interface between wellbeing and health.

8.5. Whānau Āwhina Plunket teams

It was evident from the interviews that clinical teams connecting regularly through virtual platforms during lockdown created cohesion, promoted positive relationships

and helped team members to recognise each other's strengths. Making time for these regular catch ups at the same frequency may not be sustainable in the long-term, but prioritising team meetings might keep up momentum in growing team cohesion.

In some regions, clinical and community team relationships strengthened over lockdown. For example, community teams across the Southern region worked together to unite isolated whānau. The practice guidelines review showed that there were no documents provided to support continuity of care between clinical and community staff.

8.6. PVS and wider community relationships

Some relationships Whānau Āwhina Plunket held with community services strengthened over the lockdown but others suffered. Whānau Āwhina Plunket staff described how their relationships with LMCs were strained due to a lack of information and understanding of PVS, coupled with a high LMC workload in the community. Relationships with other agencies and providers strengthened in some regions.

PVS did not create any barriers between Whānau Āwhina Plunket and iwi providers however it did highlight how in some regions there were opportunities to build and strengthen relationships between the two.

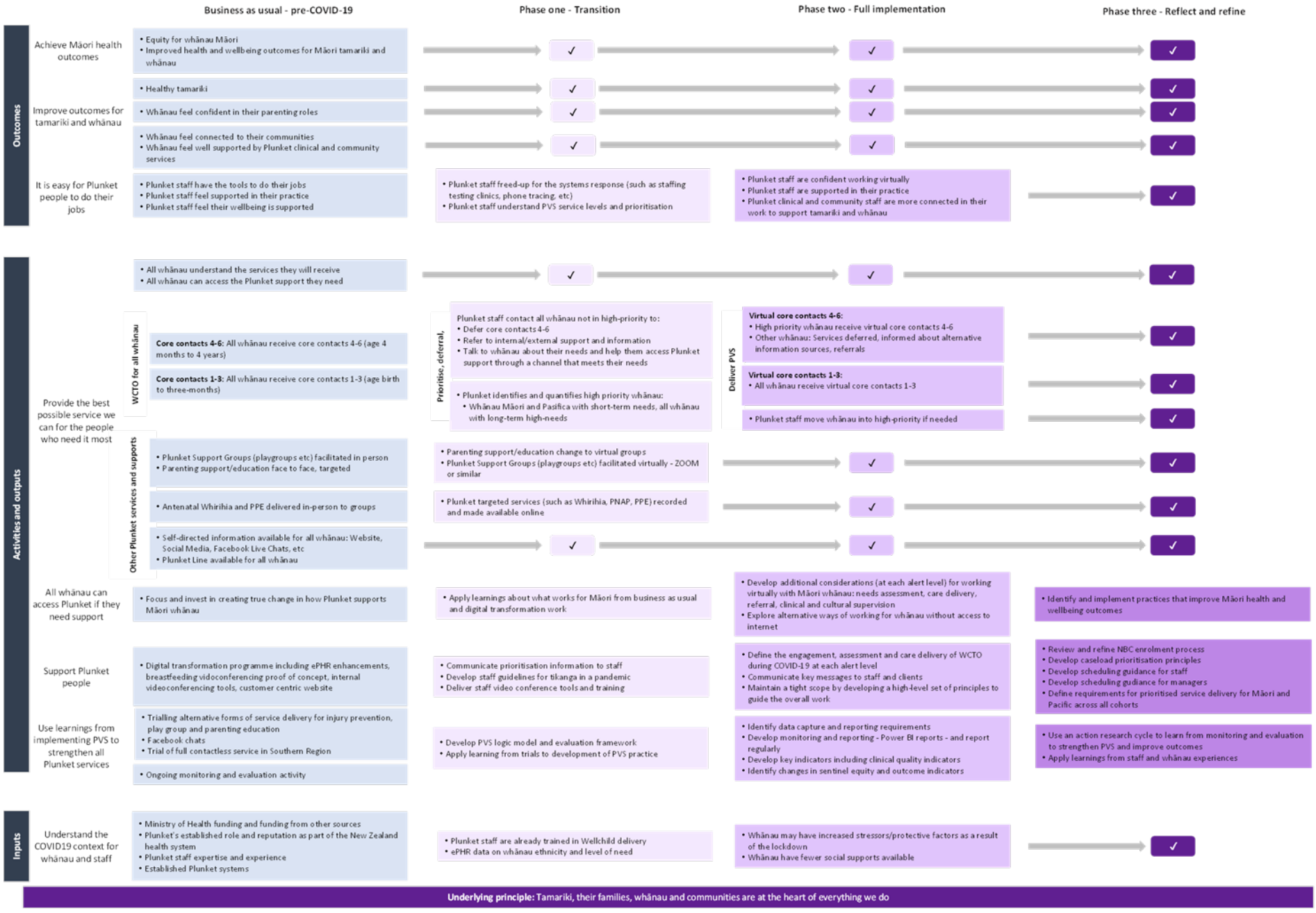
8.7. Working virtually

COVID-19 required Plunket staff to work with whānau almost exclusively through virtual channels. If circumstances allowed, many staff and whānau told us a combination of virtual and in-person engagement would be most effective. Staff and whānau thought the mixture of virtual and in-person engagement was an effective way to deliver services and this could be tailored to the needs and preferences of each whānau. Lockdown had provided the opportunity for staff to gain confidence in virtual service delivery, and they were keen to keep this going, with the addition of in-person engagement for high-priority clients.

Options for virtual contact could be well suited to whānau who have barriers to attending in-person appointments such as a sick child at home or transport issues. . Both staff and whānau would prefer their first contact to be in-person so whānau could build trust and Whānau Āwhina Plunket staff could get a good understanding of whānau circumstances before opening up to virtual contact. Staff acknowledged limitations imposed by the COVID-19 lockdown which meant that in-person contact was not possible.

Staff in isolated rural communities reminded us that while virtual services worked well for staff and whānau who had technological resources, disparities were created for those who did not. Māori were over-represented in communities without mobile phone coverage, and whānau who were struggling financially could not always afford to top up their phone or were sharing one device between multiple people.

Appendix 1: Evaluation framework and logic model



Evaluation objectives	Evaluation questions	Indicators	Data sources
Assess how well PVS has achieved outcomes for Māori	Has PVS achieved equity in outcomes for Māori?	• Analysis of WCTO QIF outcomes, broken down by ethnicity (Māori, Pacific, non-Maori non-Pacific)	• Admin data analysis
	Do health outcomes improve for Māori whānau and tamariki?	• Improvement in WCTO QIF outcomes for all and for Māori	• Admin data analysis
	What lessons can be learned about what works for Māori from PVS?	• Identify and implement practices that work for Māori	• Whānau voice – interviews • Admin data analysis
Assess how well PVS has improved outcomes for tamariki and whānau	Do Whānau Āwhina Plunket services support whānau aspirations?	• All whānau feel well supported by Whānau Āwhina Plunket to achieve their aspirations	• Whānau voice – interviews and survey • Staff voice – interviews
		• Whānau Māori feel well supported by Whānau Āwhina Plunket to achieve their aspirations	• Whānau voice – interviews and survey • Staff voice – interviews
	Do whānau feel confident in their parenting roles?	• Whānau are confident in their parenting roles	• Whānau voice – interviews and survey
	Do health outcomes improve for tamariki and whānau?	• Improvement in WCTO QIF outcomes for all tamariki and whānau	• Admin data analysis
		• Timeseries comparison of WCTO QIF outcomes	• Admin data analysis
		• COVID-19 risk to tamariki and whānau is minimised	• Admin data analysis

Evaluation objectives	Evaluation questions	Indicators	Data sources
Assess how well Whānau Āwhina **Plunket People are supported to do their jobs**	How well are Whānau Āwhina Plunket People working virtually?	• Whānau Āwhina Plunket staff are confident with tools/technologies needed	• Staff voice – interviews and survey
		• Whānau Āwhina Plunket staff are confident working with whānau virtually	• Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Whānau Āwhina Plunket staff are confident working with Māori whānau	• Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Whānau Āwhina Plunket staff have all the practice guidance they need to deliver services	• Staff voice – interviews and survey
	How supported are Whānau Āwhina Plunket People in their practice?	• Whānau Āwhina Plunket staff have access to tools/technologies needed	• Staff voice – interviews and survey • Review of documentation and resources for staff
		• Whānau Āwhina Plunket staff feel supported in their roles	• Staff voice – interviews and survey
		• COVID-19 risk to Plunket staff is minimised	• Staff voice – interviews and survey
		• Whānau Āwhina Plunket staff report manageable workloads	• Staff voice – interviews and survey • Admin data analysis
		• Whānau Āwhina Plunket staff capacity is available to support the wider health sector	• Admin data analysis
	How has PVS contributed to seamless service delivery by Whānau Āwhina Plunket	• Whānau Āwhina Plunket clinical and community staff are more connected in their work for whānau	• Staff voice – interviews and survey • Whānau voice – interviews • Community stakeholders - interviews

Evaluation objectives	Evaluation questions	Indicators	Data sources
	clinical and community staff?	• Referrals to community services for high-priority whānau	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey • Community stakeholders - interviews
		• Whānau outside the PVS high-priority group receiving core contacts	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey
Assess the effectiveness of the whānau prioritisation	How effectively have Whānau Āwhina Plunket staff applied the prioritisation to their caseloads?	• Whānau Āwhina Plunket staff understand the prioritisation and associated service levels	• Staff voice – interviews and survey
		• Whānau Āwhina Plunket staff contact and explain the prioritisation to whānau	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Guidance to whānau was consistent nationally	• Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Whānau are correctly prioritised	• Admin data analysis • Staff voice – interviews and survey
		• Whānau Āwhina Plunket staff work with whānau in the way that works best for whānau	• Whānau voice – interviews and survey • Staff voice – interviews and survey
		• All whānau understand the service channels available to meet their needs	• Whānau voice – interviews and survey

Evaluation objectives	Evaluation questions	Indicators	Data sources
	Has prioritisation been equitable?	• Whānau Māori completion of all contacts (core and additional) improves	• Admin data analysis
		• Prioritisation enables Whānau Āwhina Plunket staff to be responsive to whānau Māori aspirations	• Whānau voice – interviews
		• Whānau Māori internal/external referrals to community supports improve	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey • Community stakeholders - interviews
		• High-priority whānau engage with community services	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey • Community stakeholders - interviews
		• Whānau outside the high-priority group who want WCTO support in core contacts 4-6 get it	• Admin data analysis • Whānau voice – interviews and survey
Determine whether Plunket met the PVS service delivery objectives	Did all whānau receive the intended level of service in core and additional contacts?	• All whānau receive timely virtual core contacts 1-3	• Admin data analysis
		• High-priority whānau receive timely virtual core contacts 4-6	• Admin data analysis
		• Time series comparison of contact completion/ timeliness for each group compared to expectations	• Admin data analysis
		• Reasons for whānau not receiving the intended level of service (for example, whānau choice, staff capacity, etc)	• Whānau voice – interviews and survey • Staff voice – survey

Evaluation objectives	Evaluation questions	Indicators	Data sources
			• Staff voice – interviews
	Did whānau access internal/external community supports?	• Referrals to internal/external services for high-priority and other whānau who need them	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Changes in use of other Whānau Āwhina Plunket supports by high-priority and other whānau (Plunket Line, parenting supports, etc)	• Admin data analysis • Whānau voice – survey
Use the learnings from implementing PVS to strengthen all Plunket services	How have variations in how Whānau Āwhina Plunket staff have implemented PVS impacted whānau experiences and outcomes?	• Description of variation in models of implementation	• Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Comparison of outcomes/experiences for Māori whānau and other whānau arising from variation	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey
		• Comparison of outcomes/experiences for whānau with different levels of need and in different locations	• Admin data analysis • Whānau voice – interviews and survey • Staff voice – interviews and survey
	What effect has implementing PVS had on barriers between Plunket teams, and with Māori	• Whānau Āwhina Plunket staff (clinical and community) and whānau descriptions of practices which have reduced barriers and demonstrate partnership with Māori health and disability providers	• Whānau voice – interviews • Staff voice – interviews and survey • Community stakeholders - interviews

Evaluation objectives	Evaluation questions	Indicators	Data sources
	health and disability providers?	• Whānau Āwhina Plunket staff build connections with iwi, kaupapa Māori and other providers to strengthen support for Māori whānau	• Staff voice – interviews and survey • National staff – interviews • Community stakeholders - interviews
	What learnings from implementing PVS can be applied more widely?	• Identification of learnings which have potential to be applied more widely	• Whānau voice – interviews and survey • Staff voice – interviews and survey

Appendix 2: Overview of Whānau Āwhina Plunket practice guidance released during the pandemic

Practice Guidance Review: Documents

Note the bullet points below link to documents available on the Plunket intranet.

Alert Level 1

- Guidance for Managers - Leave in the time of COVID-19
- Pre-screening Alert Level 1-home or clinic contact and cold call visits

Alert Level 2

- Considerations for channel delivery
- ePHR core documentation
- Plunket guidance Level 2 overview
- Pre-screening before home or clinic contact and cold call visits
- Scheduling Priority Whānau
- Guidance for service recovery of non-WellChild contracted services
- Overview of the Level 2 approach
- Considerations for channel delivery

Alert Level 3

- Plunket guidance for in-person consultations
- Plunket decision tree for in-person contact

Alert Level 4

- Manager Guide - How to request Pandemic Leave for your staff - 24 March
- Prioritised virtual service FAQs
- Guidelines Plunket WCTO Prioritised Virtual Service
- Pandemic Client Prioritisation BI Dashboard User Guide
- Privacy statement
- Working from home checklist
- Redeployment Frequently Asked Questions

Miscellaneous

- Cultural Safety and Cultural Responsiveness to COVID-19
- Health Equity - Advancing Māori Health 2020
- Cultural Considerations Engaging with whānau COVID-19

Pre-alert level documents

- Plunket decision tree for community
- Plunket decision tree for home or clinic visits
- COVID-19 Poster for outside door
- Plunket clinic closure poster - 21 March
- ePHR and COVID-19
- Toy library COVID-19 closure poster
- Toy library COVID-19 closure poster - Chinese
- COVID-19 Poster for outside door - Chinese

Employment

- COVID-19 Questions and Answers on Employment Matters
- Plunket Employment Principles - COVID-19

IT guidance

- How to get set up on Zoom
- Zoom - handy tips
- How-to: Zoom tips
- How-To: Organise and lead a group session on Zoom
- How to send a text message from Plunket email

Infection Prevention & Control

- Plunket approved hygiene & product purchase list
- Plunket cleaning principles for COVID-19 infection prevention
- Clinic infection prevention & control procedures
- Home infection prevention & control procedures
- Office infection prevention & control procedures
- Playgroup infection control policy guidelines