Report prepared for the Ministry of Foreign Affairs and Trade

Evaluation of the Samoa Institutional Linkage Programme

Final evaluation report

25 March 2014

About the Authors

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Project governance

This evaluation was supported by a Steering Group comprising staff from the Ministry of Foreign Affairs and Samoa National Health Service. We would like to thank the members of this group for their input and assistance.

About Sapere Research Group Limited

Sapere Research Group is one of the largest expert consulting firms in Australasia and a leader in provision of independent economic, forensic accounting and public policy services. Sapere provides independent expert testimony, strategic advisory services, data analytics and other advice to Australasia's private sector corporate clients, major law firms, government agencies, and regulatory bodies.

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Abbreviations and acronyms

CD	Capacity Development
CEO	Chief Executive Officer
CMDHB	Counties Manukau District Health Board
CNC	Clinical Nurse Consultant
CSSD	Central Sterile Supply Department
DHB	District Health Board
GP	General Practitioner
GM	General Manager
ILP	Institutional Linkage Programme
MFAT	New Zealand Ministry of Foreign Affairs and Trade
MoH	Samoan Ministry of Health
MoU	Memorandum of Understanding
MRSA	Methicillin-resistant *Staphylococcus aureus* (an antibiotic-resistant bacterium)
MSC	Management Services Contractor
MTS	Medical Treatment Scheme
NICU	Neonatal Intensive Care Unit
NZ	New Zealand
NGO	Non-government organisation
NHS	National Health Service of Samoa
OECD DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee

ORS	Overseas Referral Scheme
Neonatal POINTS training	Six modules of neonatal care training, addressing: **P**ain control; optimal **O**xygenation; **I**nfection control; **N**utrition interventions; **T**emperature control; **S**upportive care
PBA	Programme-based approach
SHA	Senior Health Advisor
SoE	State-owned enterprise
SWAp	Sector-Wide Approach
TB	Tuberculosis
TTM	Tupua Tamasese Meaole Hospital, Apia
VMS	Visiting Medical Specialists Scheme

Executive summary

Background and context

The Samoa Institutional Linkage Programme (ILP) is a programme of support funded by New Zealand and delivered by Counties Manukau District Health Board (CMDHB) to build the capacity and capability of the Samoan National Health Service (NHS). It comprises capacity development support across governance, management and clinical services in the NHS, and provides clinical services to patients via the Medical Treatment Scheme (MTS). The MTS comprises a Visiting Medical Specialists scheme (VMS) that provides services by specialists from New Zealand to patients in-country, as well as an Overseas Referral Scheme (ORS) that allows for Samoan patients to be treated in New Zealand.

A distinguishing feature of the ILP model is its *talanoa* or 'peer to peer' element, whereby a 'sister hospital' relationship has been established to foster networks and collegial relationships between clinical and managerial staff in the NHS and CMDHB.

The context for the ILP is a health system that faces resource constraints and several complex challenges in terms of population health need. The Government of Samoa's *Strategy for the Development of Samoa* identifies four main sets of health issues for the system:

- Increasing levels of non-communicable diseases.
- The importance of reproductive, maternal and child health for the long-term health of the community.
- Emerging and re-emerging infectious diseases.
- Injury as a cause of death and disability.

The focus of the ILP has been on working alongside the NHS, the operational arm of the public health system, at its main facility – the Tupua Tamasese Meaole Hospital (TTM) at Moto'otua in Apia. The NHS was formed in 2006, being split off from the Samoa Ministry of Health (MoH) and established as a State-owned Enterprise (SoE) governed by a board. The *National Health Service Corporate Plan 2011-14* identifies six ongoing challenges for the NHS as an organisation, namely: human resources development; financial resource; emerging and re-emerging diseases (e.g. viral infections and disease resulting from behavioural/lifestyle changes); an ageing infrastructure, medical equipment; and the external environment.

The MoH remains focuses on legislative and regulatory directions for the health sector, including policy development and the monitoring and evaluation of all public health services.

Purpose and objectives of the evaluation

In late 2013, the Ministry of Foreign Affairs and Trade (MFAT) commissioned Sapere Research Group (Sapere) to conduct an evaluation of the ILP. The purpose of this evaluation was to assess the effectiveness of support and determine whether a further phase of New Zealand Aid Programme support is necessary, following the scheduled end of the ILP in June 2014. The timeframe for this evaluation includes the planning and design phase of the ILP over 2008/09, and the operation of the ILP from July 2010 to September 2013.

The four key research questions provided by MFAT were as follows.

- What has been the relevance, effectiveness, efficiency, and impact of the ILP (including key results, value for money, governance, and impacts on gender and human rights issues)?
- How well has the ILP been aligned / integrated with the Samoan Government health services including the MTS?
- How well has the partnership between Counties Manukau DHB and the Samoan National Health Service performed, specifically the *talanoa* (peer-to-peer) element?
- How does this compare with other models used elsewhere in the Pacific and, specifically, an ILP versus a Management Services Contractor model?

Evaluation methodology

The research took a mixed method approach, comprising quantitative and qualitative elements. The quantitative work focused on analysis of budgets and expenditure, and on service volumes – disaggregated by gender and age where possible. The qualitative research involved semi-structured interviews with stakeholders in New Zealand within the Samoan health system. It also included a week of interviews in Apia during November 2013.

Key findings and conclusions

The ILP is a relatively young programme, having been running for just three years. We found that to date, the ILP has achieved the following key impacts.

- **Patients have been able to continue to access services that offer clear benefit**. Although ORS treatments are provided to a relatively small number of individuals, these are typically children with life-threatening conditions who will experience lifelong benefits as a result of treatment. In the case of VMS, using the NHS in Samoa as the setting for care is enabling a greater volume of patients to be assessed in outpatient clinics and, in some cases, offered medical procedures and surgical treatments.
- **Trusted relationships have been established** – between the ILP office and the NHS leadership, between the General Manager and the Senior Health Advisor, and among visiting specialists and the clinical staff of the NHS. These relationships take time but their value is high in terms of the potential to influence individuals and systems and to help achieve changes that support improved capacity. This matters, given that the cultural context places a premium on known and trusted relationships.
- **Building blocks for quality and safety of patient care** – capacity building and systems development work to date has focused on many of the foundational elements within the hospital. These range from the establishment of new systems and processes in the cleaning, laundry, and sterile supply departments, to the development of standardised clinical protocols and formal clinical governance structures. These areas are among the essential building blocks that support the quality and safety of care for patients. The impacts of this investment are just beginning to be felt and will take time to fully accrue. It is generally too soon to tell what the overall capacity building impacts of the Programme have been, and whether they will endure.

A closer look at the ORS in relation to the Samoan MTS makes sense

How the ORS fits with the Government of Samoa's own Medical Treatment Scheme is unclear, as we were unable to sight documentation about the criteria and referral pathways for that Scheme. It would make sense to look closely at the role of the ORS alongside the Government of Samoa's Medical Treatment Scheme. Comparing the purpose, processes and eligibility criteria of each scheme would help determine whether the ORS is supplementing the Samoan Scheme (i.e. treating patients who may not otherwise be treated) or substituting for expenditure that might occur anyway.

This comparison could be done via a formal review, agreed by the Governments of Samoa and New Zealand, with the aim of determining how the ORS can best support the Samoan Scheme. Such a review could also consider the potential to make use of other models for delivering clinical services, for example, the use of telepresence technology to obtain offshore specialist input into patient diagnoses.

There is scope to improve reporting on patient outcomes

We found there is scope to improve the reporting of patient outcomes under the MTS, so as to better understand its effectiveness. NHS and visiting specialists, for example, could provide a summary report on patient outcomes at 90 days after each visit. The aim would be to reveal outliers, for example, if a patient died of infection a month after the visiting specialist left. A sample of patient outcome reports could be shared with the relevant visiting specialist, possibly on an exceptions basis (e.g. serious or unexpected clinical events) and then anonymised and shared with CMDHB for inclusion in the Annual Report. This approach would need to be sensitive to the limits of existing health information system and to any planned or likely future development of that system. As a principle, any reporting on outcomes should be done in a way that avoids establishing a separate system or process that may be likely to be an incompatible with a future NHS health information system.

A clear strategic vision for the medium term is needed

We found a lack of linkages between the ILP and a strategic vision for the NHS. In particular, the Programme could more clearly articulate how it can best prioritise its resources to support the patient health outcomes and capacity development outcomes that the NHS seeks to achieve over the medium term. With a clear strategic vision, the ILP could then prioritise areas for attention where capability development is required and work in a structured and sequenced way to ensure the necessary building blocks are in place.

There is value in continuing with the Programme

We conclude that there is value in continuing with the Programme, and in particular, with the peer-to-peer support element. This conclusion is subject to our recommended changes to how the Programme is designed, implemented and governed. Halting the Programme now, or making significant changes in approach or direction, would risk a loss of momentum and may mean that the emerging benefits that are beginning to accrue may not materialise.

In comparison with other approaches (e.g. project support, sector-wide approach (SWAp) and budget support approaches) we believe that this partnership approach is ideally suited to the context and the culture of the NHS, where relationships are paramount and need to be nurtured. If capacity building is seen as vital for realising delivery of a more clinically and financially sustainable end-state, there are clear benefits of operating a peer-to-peer model that offers access to a pool of centralised skills and knowledge within a 'sister organisation'.

On the NHS side, there is scope to improve internal communications and consultative processes with respect to ILP priority setting and subsequent activities, e.g. the selection of areas for VMS schedules, training programmes and service development directions, as well as reporting to stakeholders such as the NHS Board and the MoH.

Addressing the four research questions

Our findings and conclusions can also be summarised in terms of the four key research questions.

- **The relevance, effectiveness, efficiency, and impact of the ILP** – the Programme has clearly been relevant, with senior NHS leaders working alongside visiting members from the ILP office at CMDHB to set priorities for the annual work plan. The role of the Senior Health Advisor has also enabled the ILP to be responsive to emerging issues. In terms of effectiveness, as noted above, there is scope to improve the reporting of patient outcomes under the MTS so as to better understand the impacts and the quality of the treatments being delivered. In terms of efficiency, the focus of the ORS on children and young people allows for a relatively long timeframe for benefits to accrue from the major surgery undertaken. This allocation of resources can therefore be seen as providing relatively good value for money. In terms of overall impacts, the quality and safety benefits from the various initiatives to strengthen the building blocks of hospital care are just beginning to be felt and will take time to fully accrue.
- **Alignment and integration with Samoan Government health services** – as noted above, the Programme could better articulate how it can prioritise its resources to support the patient health and capacity development outcomes of the NHS. A medium-term funding commitment to the Programme, of five-to-ten years, could also be aligned with a strategic planning milestone in Samoa (e.g. the Samoa Health Sector Plan). Furthermore, a joint review of the ORS and the Samoan Government's Medical Treatment Scheme could more closely examine each scheme to ensure that they are complementary to each other.
- **The performance of the partnership between CMDHB and the NHS** – the pattern of responses from interviewees suggests that the partnership approach, with its peer-to-peer emphasis, is appreciated by both partners. The partnership model has led to increased clinical networking with CMDHB staff and the emergence of a 'sister institution' that is responsive in meeting the emerging or unexpected needs of the NHS.
- **Comparison of an ILP versus a Management Services Contractor model** – the ILP is a Programme-Based Approach to delivering development aid 'with a twist'. The use of CMDHB as the Management Services Contractor (MSC) and ILP partner enables relationships among clinical, technical and management peers from institutions that are similarly focused on planning and delivering health care for their populations. These features may be less likely in an arrangement with an MSC that does not share a similar mandate and structure as the NHS. Our conclusion is that, subject to some strengthened performance accountabilities, this partnership model should be continued.

Summary of recommendations

On balance, we see that there is value in the continuation of the Programme – subject to some refinements. We have developed a series of specific recommendations in the form of **a 26-point plan** of practical steps that cover Programme vision, design, implementation and accountability. If implemented, we believe this would improve the efficiency, effectiveness and ultimately the impact, of the Programme.

Recommendations – Programme vision

1. Require the Contractor (by the end of the contract period) to articulate how a future plan for the ILP should link to the strategic vision for the NHS (drawing on the most recent version of the NHS Corporate Plan, the NHS Workforce Development Plan and the Samoa Health Sector Plan). This vision should explain how the ILP could best prioritise its resources and sequence its activities to support the patient health outcomes and capacity development outcomes that the NHS seeks to achieve over the medium term (for example, the next five-to-ten years).

2. Refocus the Programme on the delivery of a more structured, prioritised and sequenced set of interventions that will support the achievement of the NHS strategic vision, with input from the Contractor. The focus should be on capacity development actions that will support the NHS in the change programme required, in addition to provision of services to address the needs identified currently.

3. Retain the peer-to-peer relationship approach as the key element for enabling the activities of the Programme to remain responsive and flexible to NHS needs.

4. Consider a medium-term funding commitment to the Programme, of five-to-ten years, that is aligned with a strategic planning milestone within the Samoan Health Sector (for example, the Samoa Health Sector Plan 2008-2018). This should be subject to a clearer set of Programme outcomes being mapped out for the period of that commitment.

Recommendations – Programme design

5. Require a Programme Governance Committee to be established, with oversight for approving Programme Work Plans and Annual Report. (This action links to the requirement to improve accountability for performance below.)

    (a) The committee should comprise managerial and clinical representation from the Contractor and the NHS, as well as a standing invitation for the MFAT desk officer.

    (b) Ensure that there are clear decision-making processes for the committee.

    (c) Align the meeting schedule for the committee with reporting requirements.

6. Retain the ORS and VMS as discrete components with fixed budgets and consider setting measurable performance benchmarks for the service outputs, subject to the outcome from recommendation 7, below).

7. Consider a joint review of the ORS and the Government of Samoa's Medical Treatment Scheme, to be agreed by the Governments of Samoa and New Zealand, and which examines the purpose, processes and eligibility criteria of each Scheme with the aim of determining how the ORS can best support the Samoan Scheme.

8. Consider other models for delivering clinical services, for example, the use of telepresence technology to obtain specialist input into patient diagnoses.

9. Retain the capacity development components of the Programme, and require the Contractor to ensure that planned activities align with the NHS strategic direction.

10. Ensure that capacity development components of the Programme address the three areas of governance, management and clinical leadership, and that the design of individual capacity development activities draws on best practice principles to ensure that activities are tailored to the environment and to the learning needs of staff (drawing on a range of skills transfer methods).

11. Embed the role of Senior Health Advisor as a contractual requirement, and require it to continue to be filled by an experienced health executive, with a track record of providing strategic and operational leadership within the New Zealand health system.

Recommendations – Programme implementation

12. Require the Contractor to work with the NHS to complete a multi-year Programme Work Plan at the beginning of the contract period, setting out the priorities, sequencing and interim steps and inputs to achieve the capacity development vision by the end of the Programme.

13. Require the Contractor to work with the NHS to deliver an Annual Work Plan ahead of each fiscal year, identifying the detailed activities for the year ahead, and any re-sequencing or new activities necessary to ensure that capacity building remains relevant and aligned with the strategic vision of the NHS.

14. Require the Contractor to agree a revised Memorandum of Understanding with the NHS, so that it: (a) requires the Contractor to work with the NHS to ensure affected staff are informed of initiatives; and (b) places the onus on the NHS to be sufficiently organised ahead of Programme activities and specialist visits.

15. Define a clearer set of financial management rules for the Contractor, including timing and level of detail for setting component budgets, the thresholds for advising any changes in the mix of outputs being purchased and the rules for managing underspends or overspends among the components and across years.

16. Emphasise the requirement on the Contractor to develop and maintain a central database of all countable service volumes and outputs, so that progress can easily be tracked across years.

17. Set an understanding that Biannual Visits of the Contractor to the NHS will be followed by a direct catch up with the relevant MFAT desk officer.

18. Require the Contractor to undertake a more structured approach to monitoring and reporting on capacity development activities, including by:

    (a) Ensuring participants in training courses are provided with feedback forms at the end of each session, so that views on the design, content, delivery, relevance and effectiveness of the training are captured and used to inform the development of future capacity development activities.

    (b) Considering longitudinal monitoring of individual staff development progress, e.g. by way of regular six-monthly self-assessment forms for selected NHS staff.

(c) Keeping a systematic record of all capacity development outputs (e.g. training sessions), including numbers of staff trained, list of attendees, as well as all feedback from participants and beneficiary staff. These measures would be included in the Programme Annual and Biannual Reports.

Recommendations – Accountability for performance

19. Specify accountability arrangements and reporting requirements for the Contractor (links to recommendation 5).

20. Work with the Contractor to define a clear reporting template that is aligned with strategic objectives and defined work plans, and which contains agreed performance indicators and more of an outcome focus.

21. Require the Programme Annual and Biannual Reports to portray progress in a time series context where possible (e.g. service volumes for training and medical treatments) and to consistently capture and report information on the gender of patients treated and of participants on training courses.

22. Require that all issues or risks raised in Annual Reports are accompanied by an action point and are clearly allocated to an individual for resolution.

23. Emphasise the expectation that the Programme Annual Reports will be accompanied by a meeting between MFAT and the Contractor to discuss progress and cover any questions.

24. Set an expectation that the Programme Annual Reports will be tabled directly with the NHS Board for noting.

25. Explore low-cost ways of keeping the Samoan Ministry of Health and Ministry of Finance (responsible for donor co-ordination) informed about work plans and progress e.g. via greater visibility of the Programme within existing reports or holding update meetings as part of biannual visits.

26. Examine ways in which patient health outcomes under the Medical Treatment Scheme could be reported, in a low-cost, summary format, by the NHS to the Programme office. This reporting could be done on an exceptions basis, (e.g. serious or unexpected clinical events) and be used to support annual reporting on ILP effectiveness, as well as NHS quality improvement efforts. Such reporting would need to be sensitive to the limits of existing health information systems and to any planned or likely future development of that system, and avoid establishing a separate system that may be incompatible with a future NHS health information system.

1. Introduction

1.1 Evaluation objectives

The Samoa Institutional Linkage Programme (ILP) is a programme of support funded by New Zealand and delivered by Counties Manukau District Health Board (CMDHB) to build the capacity and capability of the Samoan National Health Service (NHS). It comprises capacity development (CD) support across governance, management and clinical services in the NHS, as well as the direct provision of clinical services for patients via the Medical Treatment Scheme (MTS). The MTS comprises a Visiting Medical Specialists scheme (VMS) that provides services by specialists from New Zealand to patients in-country, as well as an Overseas Referral Scheme (ORS) whereby patients are brought to New Zealand for surgical treatment.

A distinguishing feature of the ILP model is its *talanoa* or 'peer to peer' element, whereby a 'sister hospital' relationship has been established that fosters networks and collegial relationships between clinical and managerial staff in the NHS and CMDHB.

The purpose of this evaluation was to assess the ILP to determine the effectiveness of support and whether a further phase of New Zealand Aid Programme support is necessary, following the scheduled end of the ILP in June 2014. If continuation of the Programme is recommended, the evaluation was to provide advice on the design, scope, focus, duration and scale of future support.

1.2 Evaluation scope

The timeframe for this evaluation includes the planning and design phase of the ILP over 2008/09, and the operation of the ILP from July 2010 to September 2013. The Programme components within the scope of this evaluation are:

- Governance Strengthening.
- Management Support.
- Clinical Services Support.
- The MTS, comprising the Overseas Referral Scheme (ORS) and the Visiting Medical Specialists Scheme (VMS).
- Programme management, including Biannual Review visits.
- Ministry of Foreign Affairs and Trade (MFAT) management of the Programme.

The evaluation also considered the place of supplementary medical treatment services, both in New Zealand and Samoa, within the Samoan health sector and policy environment.

1.3 Overview of our approach

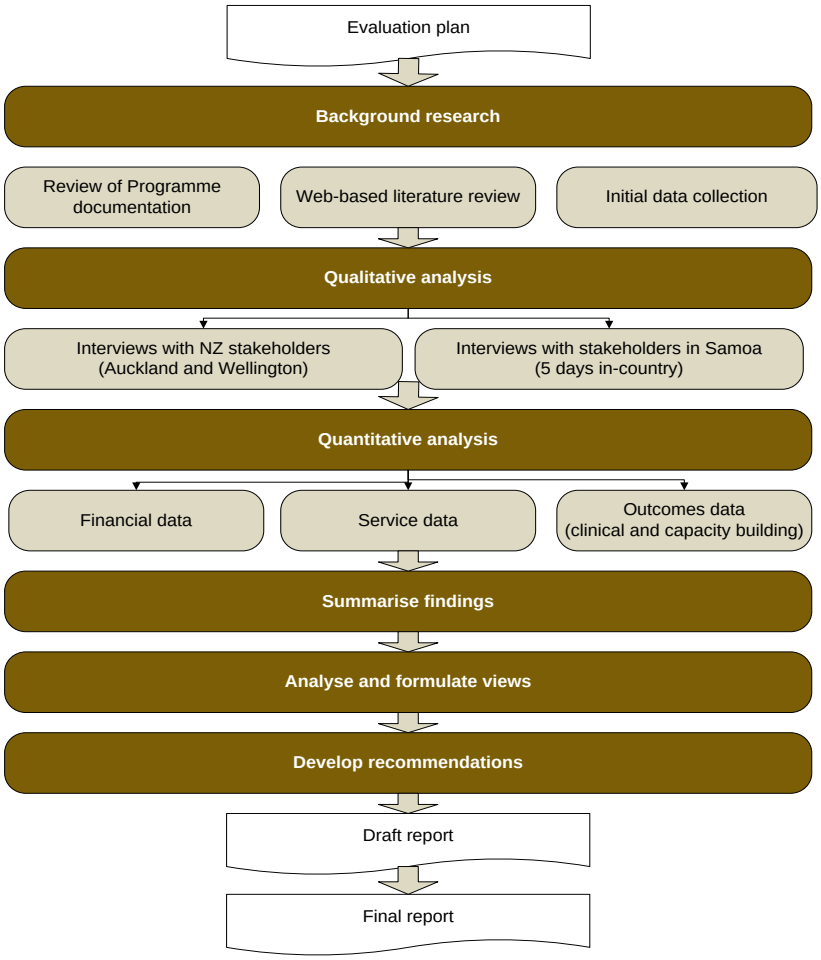
The first step in our approach was to develop an Evaluation Plan, which was approved by the Steering Group for this evaluation. Figure 1 summarises the sequential steps in our evaluation approach.

The background research included a review of Programme documentation, a sample of visit reports from visiting specialists and literature, as well as interviews with New Zealand-based stakeholders in Wellington and Auckland. We also undertook some preliminary financial analysis and issued a request for financial and service volume data to MFAT and CMDHB.

We visited Samoa during the week of 18-22 November 2013. This site visit enabled us to interview stakeholders at the Samoa National Health Service (NHS), the Samoa Ministry of Health, the Samoa Ministry of Finance, NGOs, the Oceania School of Medicine, the Australian Aid Program and other stakeholders in Apia, as recommended by the Steering Group.

A full list of interviewees is set out in Appendix 2.

Figure 1: Evaluation approach



1.4 Core research questions

The evaluation focused on the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD DAC) evaluation criteria of relevance, effectiveness, efficiency and impact.[1] There were four core research questions, specified by MFAT in the Terms of Reference for this work.

- What has been the relevance, effectiveness, efficiency, and impact of the ILP (including key results, value for money, governance, and impacts on gender and human rights issues)?
- How well has the ILP been aligned / integrated with the Samoan Government health services including the MTS?
- How well has the partnership between Counties Manukau DHB and the Samoan National Health Service performed, specifically the *talanoa* (peer-to-peer) element?
- How does this compare with other models used elsewhere in the Pacific and, specifically, an ILP versus a Management Services Contractor (MSC) model?

1.5 Detailed research questions

We developed a series of more detailed questions to guide us during each research stage.

1.5.1 Background research

Our initial research and data gathering sought to address the following questions.

- How was the Programme developed (including the design and procurement of the Programme, a review of Programme documentation, and key informant interviews)?
- How has the Programme been governed?
- What services have been provided, where and to whom (disaggregated by age, gender)?

1.5.2 Qualitative research

We developed a set of interview questions to guide our semi-structured interviews (see Appendix 3) with the aim of obtaining responses that would to help to shed light on the core research questions, as well as to test/validate our quantitative findings.

In terms of staff capacity building, the following research questions included.

- How were participating staff selected?
- How were staff involved in the design, governance and implementation?
- How was support provided (e.g. side-by-side mentoring, training sessions)?
- What have been the benefits to these staff?
- Have there been flow-on benefits to other staff?

[1] The DAC criterion of sustainability was excluded from the Terms of Reference developed by MFAT for this evaluation, as the ILP is relatively young and its impacts were expected to be emergent at this stage.

1.5.3 Quantitative research

As our quantitative research focused on of aspects of the ILP that lend themselves to measurement, we set out the following detailed research questions.

- Has the budget been used efficiently?
- Who is benefitting from the Programme?
- Are services being delivered in the right setting?
- What have been the impacts in terms of patient health gain?
- Is the right mix of services being purchased?
- Which services are at the margin (i.e. what services would be added or dropped if the budget were scaled up or down)?

We also sought to quantify aspects of the Programme that relate to the staff capacity development (including governance strengthening, management support and support for clinical staff). In particular, the number of staff receiving capacity development/support through the Programme, disaggregated, if possible, by gender, qualifications and role.

The way in which the Programme has contributed to new systems and processes being developed and put in place is also of high interest. We sought to determine the number of new policies/protocols/standards/guidelines and their degree of implementation.

1.6 Cross-cutting issues

The qualitative research considered cross-cutting issues of environment, gender and human rights – all of which are required to be considered in New Zealand Aid Programme activities. To address these issues, we included interview prompts that explored:

- How the participation and needs of women have been considered in the Programme design and planning stages.
- The representation of women in Programme governance.
- How the capacity building components of the Programme have addressed the needs of female staff.
- Any unintended/adverse social or environmental effects of the Programme, and how these were anticipated and mitigated.
- The extent to which access to medical services under the Programme has been based on need, and whether priorities have been assessed impartially and against the criteria.

In our quantitative analysis, we also looked to disaggregate data by gender and age wherever possible. We also looked for any lessons from evaluations of similar programmes, such as the Sector-wide Approach to donor health funding in Samoa (Health SWAp).[2]

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[2] See: Davies, P. (2013) *Evaluation of Samoa Health Sector Management Programme (Health SWAp)*; http://aid.dfat.gov.au/Publications/Pages/samoa-health-swap-evaluation-2013.aspx

1.7 Cultural considerations

In our approach to the field visit, we looked to incorporate culturally-appropriate research methods. The concept of *talanoa* was of particular importance. *Talanoa* can be referred to as a conversation or talk, an exchange of ideas or thinking, usually carried out face-to-face. It means creating the space and the conditions to allow participants to engage in social conversation which may lead to more critical discussions.[3]

Our semi-structured approach to the interviews addressed this need. This approach balanced the desire to cover certain topics and maintain a degree of consistency across interviews, while providing space for responses to emerge through conversation, rather than rattling through standardised questions in a pre-set format. This means we sought to build up a rapport with participants, and to engage with their views, rather than just recording and analysing.

We also held two group interview sessions with clinical staff, in addition to one-on-one interviews. This allowed participants to bounce ideas off each other and help generate discussion, as well as gaining some cost efficiencies for the evaluation.

1.8 Ethical considerations

We did not seek or receive any data that identifies individual patients, nor did we interview any patients directly.

Notes from the interviews have been held confidential to the evaluation team. Care has been taken to ensure that quoted comments in this report are not attributed to individuals.

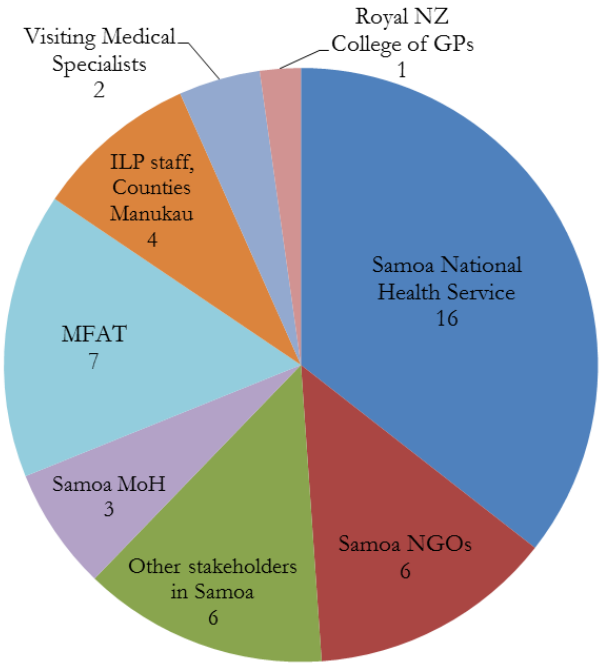
1.9 Overview of interviewees

We interviewed a total of 45 stakeholders – 12 in New Zealand (Wellington and Auckland) and 33 in Samoa (in and around Apia). Figure 2 shows the distribution of interviewees by the category of the most relevant organisational affiliation. The largest number of interviewees was from the NHS, where we spoke with the General Manager (GM), administrative managers, clinical heads of departments, and a group of senior nursing staff. We also interviewed two NHS board members. Our NGO interviews related to three separate organisations. The group of 'Other stakeholders in Samoa' includes representatives from the Samoa Medical Association, the Samoa Dental Association and academics at the Oceania School of Medicine who have been previously involved with the ILP.

In New Zealand, we interviewed Programme management personnel at CMDHB, the Senior Health Advisor, several officials at MFAT, two visiting medical specialists, and the President of the Royal New Zealand College of General Practitioners.

[3] Vaioleti (2006) 'Talanoa research methodology: a developing position...' *Waikato Journal of Education* 12:2006.

Figure 2: Profile of interviewees by organisation



2. Overview of the ILP

2.1 Context

2.1.1 Samoan health need and system focus

The *Strategy for the development of Samoa* identifies four main sets of issues for the health sector:

- Rapidly increasing levels of non-communicable diseases.
- The importance of reproductive, maternal and child health for the long-term health of the community.
- Emerging and re-emerging infectious diseases.
- Injury as a cause of death and disability.[4]

In response to these challenges, Samoa's *Health Sector Plan 2008-2018* sets out six key strategies and objectives, as detailed in the box below. Of note for the work of the ILP, is the focus on strengthening the quality of health care service delivery in Samoa.

Samoa Health Sector Plan 2008-2018 – six strategies and objectives[5]

1. Health Promotion and Primordial Prevention – to strengthen health promotion and primordial prevention.
2. Quality Health Care Service Delivery – to improve access to and strengthen quality health care delivery in Samoa.
3. Governance, Human Resource for Health and Health Systems – to strengthen regulatory, governance, Human Resources for Health and leadership role of the Ministry of Health.
4. Partnership Commitment – to strengthen health systems through processes between the Ministry and health sector partners.
5. Financing Health – to improve health sector financial management and long-term planning of health financing.
6. Donor Assistance – to ensure development of partner participation in the health sector.

2.1.2 The Ministry of Health of Samoa

The Samoan Ministry of Health (MoH) focuses on legislative and regulatory directions for the health sector. Major functions include policy development, and the monitoring and evaluation of all public health services – including those delivered by the Samoan NHS. The Ministry is also responsible for public health movement through health promotion and preventive programmes.[6]

4 Samoa Ministry of Finance (2012) *Strategy for the development of Samoa 2012-2016*, p.10.
5 Samoa Ministry of Health (2008) *Health Sector Plan 2008-2018*, p.11.
6 Ministry of Health (2008) *Health Sector Plan 2008-2018*.

2.1.3 The National Health Service

The NHS is the operational arm of the public health sector. It was split off from the MoH and established as a State-owned Enterprise (SoE) governed by a Board in 2006. The NHS is responsible for delivering health care to the 191,000 people of Samoa. Its main facility is the Tupua Tamasese Meaole Hospital (TTM) at Moto'otua in Apia. There are also several community facilities, including a district hospital on Savai'i. The construction of a new hospital on campus has recently been virtually completed. This construction and subsequent transition of services to the new buildings occurred during the period of the ILP.

The *National Health Service Corporate Plan 20011-14* identifies six main challenges for the organisation, namely: human resources development; financial resource; emerging and re-emerging diseases (e.g. viral infections and disease resulting from behavioural/lifestyle changes); an ageing infrastructure, medical equipment; and the external environment. The Plan prioritises 11 Key Result Areas for action.

NHS priorities identified as Key Result Areas, 2011-14

1	Primary Health Care	7	Human Resources
2	Patient Care	8	Finance
3	Governance	9	Infrastructure, Plant and Equipment
4	Service Delivery	10	Disasters and Emergencies
5	Medical Products and Supply	11	Partnerships
6	Information, Communication & Technology		

National Health Service Corporate Plan, 2011-14

2.1.4 Counties Manukau District Health Board

CMDHB is contracted to provide Programme management services (i.e. the Management Services Contractor) and to be the institutional partner to the NHS. The DHB brings experience of planning and delivery health services and of working alongside Pacific peoples. Being responsible for the health care of 521,000 people in South and South-East Auckland, CMDHB has a relatively high number of Pacific people, with 23% of its population identifying as belonging to a Pacific ethnic group. The DHB also operates Middlemore Hospital in Otahuhu and delivers, or contracts for, a range of community-based services for its population.

CMDHB has wider links with the Pacific region, for example the DHB is also contracted by MFAT to support the Government of Niue, by working with the Niue Department of Health. The DHB also has a Memorandum of Understanding (MoU) with the Government of the Cook Islands and a development contract for radiology services with the Marine Training Centre in Kiribati.[7]

[7] Counties Manukau (2013) *Pacific Health Development – Annual Plan 2013/14.*

2.2 New Zealand Aid Programme's support for Samoa

The New Zealand Aid Programme's support for Samoa was $26 million in 2012/13, comprising $16 million in bilateral support and $10m in non-bilateral support (excluding regional initiatives). Within the health sector, New Zealand has committed up to $17.36 million over seven years for a sector-wide approach – the Samoa Health Sector Management Programme (Health SWAp), and an additional $4.16 million over four years to the ILP, to support CMDHB to build capacity in the Samoa NHS.

The long-running Medical Treatment Scheme, comprising the Overseas Referral Scheme (ORS) and Visiting Medical Specialists (VMS), has been rolled into the ILP, with the expectation that capacity development activities under these schemes (e.g. teaching, staff training) will be integrated with capacity development activities within other parts of the ILP.

The ORS has provided specialist medical treatment in New Zealand for over 30 years to patients referred from Samoa. In addition to the treatment not being available in Samoa, the patient must have a life-threatening or seriously debilitating medical condition but with a good prognosis. Since 1999, funds have been available to provide in-country treatment and training under the VMS.

2.3 Programme objectives and approach

The goal of the ILP is that of the Samoan Health Sector Plan (SHSP) 2008-2018: *Improved health and well-being for all Samoans.*

The purpose of the ILP is set out in the Contract for Services with CMDHB.

> *The ILP and the longer term linkages it will foster are intended to assist the health sector in Samoa to increase the capability and capacity of the NHS to provide medical treatment for Samoans according to international standards, taking into account the current operating environment.*

The Contract for Services outlines the four main original components for the ILP:

- Component 1: Governance Strengthening;
- Component 2: Management Support;
- Component 3: Clinical Services Support; and
- Component 4: Medical Treatment Scheme – comprising an Overseas Referral Scheme (ORS) and a Visiting Medical Specialists Scheme (VMS).

Each component has a goal and a series of objectives, as shown in Table 1 below. A fifth component, 'Biannual visits' (six-monthly reviews and planning), was subsequently added.

Table 1: ILP component goals and objectives

Component and goal	Component objectives
Governance Strengthening Goal: To build the capacity of the NHS Board and General Manager to develop, provide and manage quality medical services.	• Strengthened NHS Board capacity. • NHS governance capacity developed. • Improved health service standards and practices. • More effective links between NHS and MoH.
Management Support Goal: To develop NHS knowledge, skills, policies and system for medical services management.	• Improved NHS management policies, systems and procedures. • Strengthened management team and processes. • Improved quality performance measures and standards. • Strengthened financial management systems. • Improved efficiency, accountability, and transparency of medical management.
Clinical Services Support Goal: To strengthen professional development for, and clinical governance of, specialist medical services.	• Strengthened capacity of clinical and allied services. • Skilled and competent health professionals and support staff. • Increased focus on health promotion and prevention. • Improved management of non-communicable diseases and other chronic conditions. • Development of policy and quality framework for quality clinical service delivery that covers credentialing, audit and maintenance of clinical standards developed. • Implementation of professional and service standards.
Medical Treatment Scheme, comprising: • **Overseas Referral Scheme** and • **Visiting Medical Specialists Scheme**. Goal: To facilitate cost-effective visiting medical and overseas medical treatment services which integrate clinical and institutional capacity building elements.	• Provision of selected clinical services for effective treatment in Samoa or New Zealand. • Management of MTS according to agreed criteria. • Organising VMS visits as agreed with NHS and ensuring these are well planned, efficient and effective. • Proven, value for money/cost-effective provision of visiting specialists and medical treatment services. • MTS schemes are managed efficiently and within allocated budgets. • All accepted offshore referrals meet MTS criteria. • Treatment provided in New Zealand is effective and safe and has positive long term outcomes. • VMS visits are timely, planned and meet identified need and are complementary to visits provided by other donors. • VMS visit occur when local systems are ready, patients are available and there is a commitment and plan for follow up treatment.

Source: *Contract for Services*, June 2010

The ILP can be seen as a Programme-Based Approach (PBA) to development because it involves working alongside the NHS to plan and deliver a coordinated set of activities to build service capacity and improve health outcomes. The distinguishing feature of the ILP is its peer-to-peer format, in which CMDHB acts as a collegial partner to the NHS to provide mentoring, training and advice to management and clinical staff. The two organisations have similarities in that they are responsible for planning and delivering a range of health services for their respective populations. This peer support element is not a typical feature offered by a Management Services Contractor arrangement.

This partnership is outlined in a Memorandum of Understanding (MoU), which details how CMDHB and the NHS will work together. Building and maintaining relationships among peers is a key element to this approach.

As such, the ILP appears to represent a more flexible approach than, for example, the sector-wide approach (SWAp) which typically involves coordination among multiple donors and focuses at the level of the entire sector.[8]

2.4 Results framework

As there did not appear to be any clear intervention logic in the Programme documentation, we developed a results framework retrospectively that reflects the stated goals and objectives, and links these to the inputs (i.e. the Programme components) and activities/outputs. The framework, which has been tested with elected stakeholders, is presented in Figure 3, overleaf.

Of note are the two long-term outcomes sought, namely:

- Increase the capability and capacity of the NHS.
- Improved population health outcomes (supported by NHS capability/capacity).

These long-term outcomes are supported by a series of intermediate of medium-term outcomes, such as:

- A more capable workforce (improved skills and knowledge).
- Improved clinical governance.
- Improved quality of care leading to better clinical outcomes.
- Greater strategic alignment and internal planning coherence.
- Improved accountability and transparency.

As we explain below, in section 4, we recommend restructuring the way the Programme is conceptualised and reported on, to strengthen the intervention logic and provide reporting that is more intuitive for a non-specialist audience.

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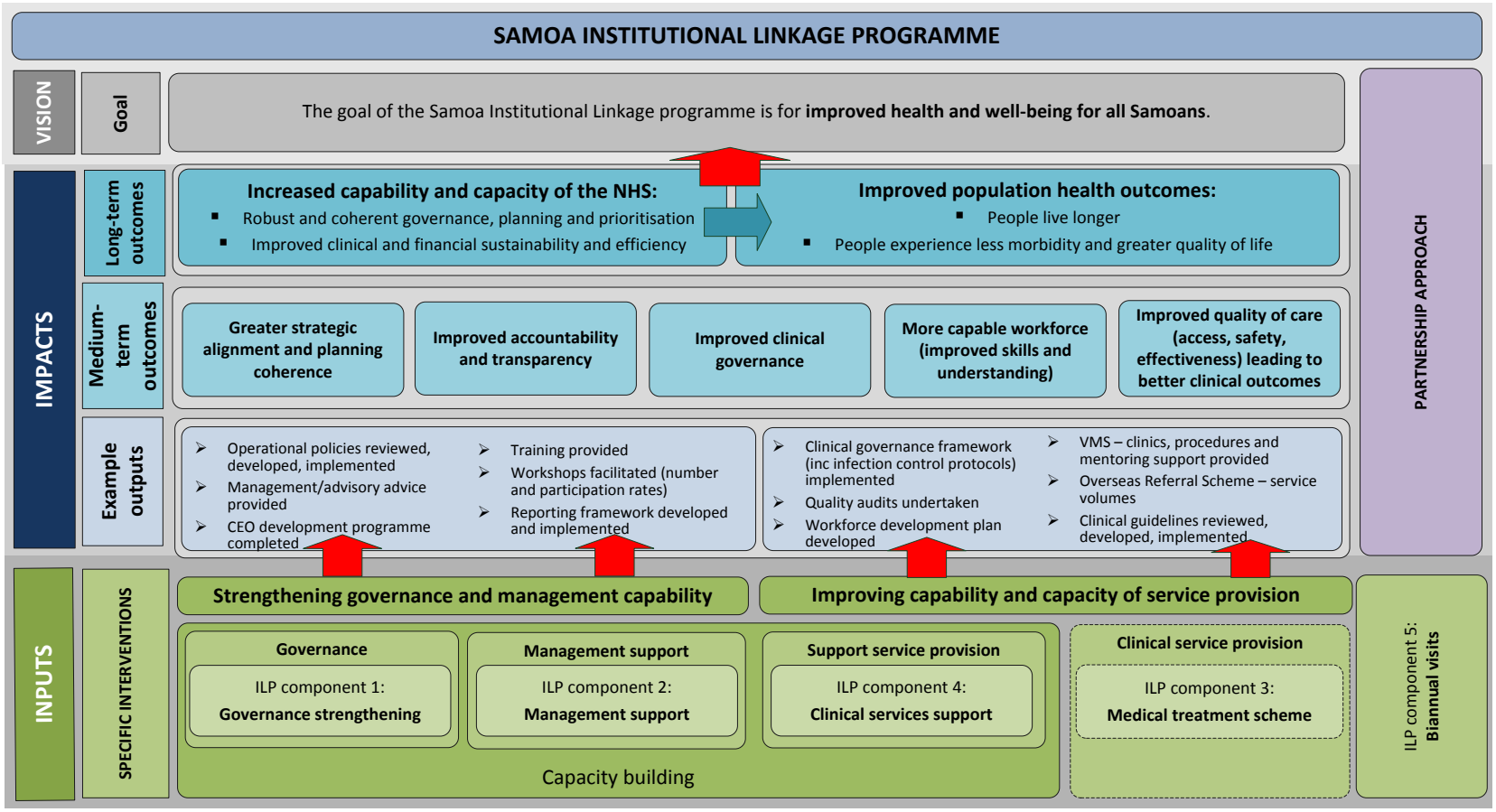
8 Adapted from the European Commission definitions of these delivery modalities http://ec.europa.eu/europeaid/how/delivering-aid/sector-approach/index_en.htm.

Figure 3: A results framework – developed retrospectively



Source: Sapere Research Group

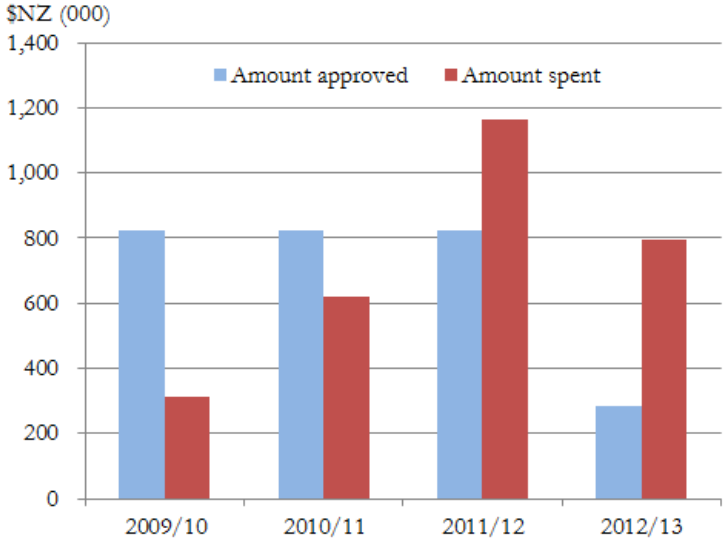
2.5 Funding overview

Funding for ILP activities was sourced from the MFAT Samoa Bilateral Development assistance Programme, as agreed in discussion with the Government of Samoa. The ILP was initially budgeted at NZ$825,000 per year or $2.475 million over three years. Figure 4 shows the amounts approved and the amounts spent for each year, as documented in MFAT's Programme Activity Authorities between 2009/10 and 2012/13. Some points to note are:

- The Contract for Services with CMDHB began in 2010/11, and slower than expected spending in the first year meant that some funds were permitted to be 'rolled over' to subsequent years.
- An additional amount of $285,000 was approved in 2012/13 (primarily for the extension of the Senior Health Advisor's role).
- The ILP was extended one year, into 2013/14, with a further $1.4 million.

Therefore, over the total period 2009/10 to 2013/14, the amount approved for the ILP by MFAT totalled $4.160 million. The amount spent, as at May 2013, was recorded by MFAT as being $2.965 million. The year-by-year amounts shown here reflect MFAT's internal financial control processes and, due to the roll-over of some funding, may not exactly match the in-year budgets and expenditure reported by the ILP office – as outlined in Section 3.10.

Figure 4: Approved funding versus amounts recorded as spent, 2009/10 - 2012/13



Source: MFAT (2013) 'NZAID AMS – Programme Activity Authority – Crown Expenditure'.

The Contract for Services required that the Contractor provide detailed budgets for the ILP components, but noted that the agreed annual allocation for the MTS had been $580,000, comprising $500,000 for the ORS and $80,000 for the VMS. The latter amount is typically used to cover travel and accommodation expenses because, as the Contract notes, these services tend to be provided free-of-charge through goodwill.

Given these historic allocations, the MTS could have been expected to comprise 70% of the notional annual budget of $825,000, with approximately 60% allocated to the ORS and 10% to the VMS. This would leave 30% for the remaining components and the management fee.

3. Findings

3.1 Programme design and initiation

We understand, from our interviews and our review of Programme documentation, that CMDHB suggested the idea of the ILP, following a request for support from the General Manager of the NHS at that time. Interviewees cited various drivers behind this request for assistance, including:

- The need for governance strengthening to support the NHS Board through the transition to the new NHS structure following the reforms.
- The need for institutional strengthening to address weaknesses in patient care.

Although MFAT might have typically grant-funded the services via a not-for-profit MSC, the financial value of the ILP contract required it to go to tender. CMDHB was the only tenderer and was awarded the contract for three years from 2010/11 to 2012/13. Interviewees referred to similarities between the population base of Samoa and CMDHB (the latter has a sizeable Samoan population with similar health needs). There were also references to CMDHB's experience with operating in a similarly devolved structure – operating a large hospital and working alongside community-based health care providers. This meant that CMDHB could be expected to be well-placed to provide ongoing clinical, managerial and governance support to the NHS.

Concerns were raised in interviews about the quality of the initial design. MFAT had to make adjustments to the design in order to put it out to tender, but numerous further changes were subsequently required to aim to build in basic project management principles. These changes were made by way of a series of contract variations and included attempts to improve the results framework, which was (and remains) largely outputs-focused and lacking a clear intervention logic and meaningful performance metrics.

3.2 Programme governance

The contract between MFAT and CMDHB requires a formal Arrangement to be developed between the NHS and CMDHB, to cover how the ILP will be managed. It should also cover how planning will be undertaken, including the role and composition of any project steering or advisory group. MFAT is not a signatory to the Arrangement.

The main governance mechanism for the ILP appears to be the biannual visits to Samoa, which are discussed below. We did not find evidence of a formal structure to these visits or of formal decision making processes as one might expect from such a programme.

There does not appear to be an agreed and standardised reporting format from CMDHB to MFAT, or to other stakeholders such as MoH and we encountered widespread frustration at the depth and quality of reporting.

3.3 Programme planning and management

Planning for the year ahead is undertaken by CMDHB with the NHS General Manager during the biannual visits. There is a clear majority view that the annual programme of activities is jointly determined by CMDHB and the NHS, in response to the priorities indicated by the NHS. Several interviewees within the NHS also commented that CMDHB has been responsive to changing circumstances and emerging issues within the NHS and that the ILP allows for this flexibility

> *Some urgent issues come up – and we've always been grateful for them to look into these urgent areas when we request assistance.*

However there were comments by a few NHS interviewees that there may not be sufficiently widespread visibility of this planning process and the rationale for some activities.

> *Things are dictated by Counties Manukau – it's not bad, it's been helpful. But it would be good to get our view on what we want… I felt like it was 'this is what we're going to do' from their side.*

> *I haven't seen an MoU in place – or anything about the ownership of data.*

There was also acknowledgement from these interviewees that internal NHS processes could better support awareness of ILP activities and the associated rationale and objectives.

> *We don't have a very good administrative process that defines the objectives to be achieved when people come over – what should we expect from them and what do they expect of us?*

In terms of programme management, we heard mutual frustrations on the part of both MFAT and CMDHB. On one hand, MFAT is concerned about the poor quality of reporting, a lack of clear prioritisation in the work planning and a lack of justification for change requests in terms of how funding is to be reallocated. One the other hand, CMDHB may, at times, feel closely managed by MFAT, and feel that the degree of turnover in MFAT desk staff has resulted in multiple changes to approach.

When asked about the alignment of the ILP with other health services and support, including the Health SWAp, a number of interviewees raised the issue of the ILP running in parallel to the SWAp. The SWAp was initiated in 2007 with the intention of coordinating all health development assistance across donors – bringing it all under one umbrella and monitored by MoH. The MoH was seeking to make more cost effective use of funding by mapping it out and eliminating duplication.

Stakeholders' opinions were mixed on whether the ILP has been duplicating activities – with some being of the view that the ILP has been clearly targeted and specifically focused on the NHS; and others of the view that it has duplicated training efforts.

Either way, there was a sense from a number of interviewees from outside of the NHS, that the ILP has lacked connection with broader health sector planning and donor co-ordination – '*the ILP is the one part of the system that we can't really capture.*' More generally, there was a general lack of awareness and visibility of the ILP and its contribution both to NHS and broader sector outcomes, particularly on the part of external stakeholders – '*the ILP is not really visible to us here*'.

3.4 Component 1: Governance Strengthening

3.4.1 Goals and objectives

The goal of the governance strengthening component is: *to build the capacity of the NHS Board and General Manager to develop, provide and manage quality medical services*. The objectives of this component are:

- Strengthened NHS Board capacity.
- NHS governance capacity developed.
- Improved health service standards and practices.
- More effective links between NHS and MoH.

3.4.2 Outputs – starting from the top

As discussed above, the ILP was initiated at a time of significant reform in the Samoa health sector. The concept of a Board, in the new SoE structure, was new to those on the Board, who were feeling their way with the new relationship between the NHS and the MoH. In this context, governance strengthening has been an important focus of the ILPs institutional capacity development work to date.

The NHS Board comprises six members, including the NHS General Manager and the Director General of Health. Two of the Board members are women.

The governance strengthening work commenced with an initial talanoa session with the Board chair, to identify key areas for development. The following areas were identified:

- NHS is in a transitional phase.
- Accountability – reporting part of roles of management.
- Board structure.
- Risks and risk management at a Board level.
- Benchmarking.
- Customer service.[9]

Unfortunately, subsequent ILP reporting does not enable ready monitoring of activities and progress against these areas, so it is not clear how they have driven subsequent governance strengthening support. The annual reports do tell us that CMDHB have:

- Provided one governance workshop for the Board.
- Provided the General Manager with a development programme, which has included one-on-one mentoring, visits to a range of CMDHB sites and support to attend two conferences.
- Helped develop a reporting system (from the NHS to the MoH) and implement a risk register.

[9] *Annual Report 2010/11*, p.13.

The 2011/12 annual report also mentions a week-long leadership visit to Auckland by three Board members, which was funded by SWAp.

The reporting by CMDHB expresses concern that there is no legal representative on the Board, but we found no mention of whether this has been addressed.

3.4.3 Impact – a maturing of the understanding of the role of governance

The 2010/11 annual report states that the governance workshop was evaluated, although the Board's feedback was not directly reported. One interviewee told us that the Board enjoyed the workshop as *'only a few of them had previously received directorship training locally'*. The comment was also made that, at times, the workshop lacked suitable contextualisation for the Samoan operating environment – such as the SoE structure and the legislative requirements set by the Government of Samoa.

A visit to Auckland in 2013 by a small group of NHS board and staff included an opportunity to meet with, and observe, the board of Alliance Health+ – a Primary Health Organisation based in South Auckland. One attendee saw this as *'enlightening'*.

> *The AH+ board was strategic and honest, and it was enlightening… I saw governance-level decision making… [with] an understanding that a decision impacts the whole organisation.*

There was also a view expressed that the support provided by the Senior Health Advisor to the Executive of the NHS has helped improve understanding about the new governance framework – in terms of how the NHS should support the Board and relate to the Ministry of Health as the lead on strategic policy and regulatory matters. But it is unclear whether the reporting system to the NHS is finalised or whether the Board or MoH is satisfied with the reporting. In our interviews, there was a view that the quality of reporting could be improved, in terms of NHS performance and contribution to sector priorities, as well as on the activities of the ILP itself. However, the ILP annual reports do state that financial reporting to the Board is now occurring 'on a regular basis'.[10]

There was a view put forward by a couple of interviewees that the governance strengthening phase is nearing completion, as the Board now knows what's required of them and they have become '*more independent*'. One interviewee also suggested that locally-based and mandated training for public sector directors means that the ILP does not need to focus in this area.

> *We now have an excellent programme to train directors here – it's funded externally and run locally. So that element should not be there [in the ILP] any more. The Government of Samoa is requiring directors to receive qualified training here.*

[10] *ILP Annual Report 2012/13*, p.8.

3.5 Component 2: Management Support

3.5.1 Goals and objectives

The goal of the Management Support component is *to develop NHS knowledge, skills, policies and system for medical services management*. The objectives are:

- Improved NHS management policies, systems and procedures.
- Strengthened management team and processes.
- Improved quality performance measures and standards.
- Strengthened financial management systems.
- Improved efficiency, accountability, and transparency of medical management.

3.5.2 Outputs – activities increased with the appointment of a Senior Health Advisor

Management Support activities have steadily increased over the three years of the ILP due to the new role of Senior Health Advisor, which commenced in February 2012. The focus in Year 1 of the ILP was on identifying priorities and gaps for development and sourcing a Senior Health Advisor to work alongside the General Manager to help progress these priorities. The initiation workshop was led by a former DHB chief executive and the Chief Medical Officer from Counties Manukau DHB. The resulting priorities, along with those of the NHS Chair and General Manager, are shown in Table 2.

From Year 2, many of the activities were driven by the Senior Health Advisor, with a focus on working alongside the General Manager of the NHS and with managers and clinicians to develop and implement policies, systems and procedures that improve patient care. As the Senior Health Advisor role is funded under the Management Support component, activities driven or supported by the Advisor tend to be reported under this component.

However, we found that many of these Management Support activities, where the Senior Health Advisor played an important role, were also directly contributing to improvements in the quality and capacity of clinical services, for example:

- Implementation of a clinical governance framework.
- Development of clinical protocol.
- Preparation of a workforce development plan.
- Preparation of a quality improvement plan.

Progress was also made in working with management and staff to improve processes and standards in teams that provide operational support within the hospital, such as the cleaning, laundry, and sterile supply departments. These areas can be seen as essential building blocks that support the quality and safety of care for patients. We present our findings with respect to the cleaning and sterile supply departments as case studies at the end of this section.

The Senior Health Advisor also worked, at the request of the General Manager, to ensure that the design of the new hospital was fit-for-purpose in a number of areas, for example, having sufficiently large operating theatres suitable for cardiac or orthopaedic surgery.

Table 2: Management Support component - reported activities

Year 1 – 2010/11	Year 2 – 2011/12	Year 3 – 2012/13
Workshop and a talanoa session were held with senior managers, to hear their key issues. Their priorities were: • Risk management – need assistance to be able to identify various risks/potential risks. • Financial management – need assistance/development to be able to understand, interpret financial reports. • Reporting – reporting templates, frequency timeliness and appropriateness of reporting requires development. • Information technology – managers are not comfortable with using MS Excel for budgets. A clear set of priorities for management development were also identified by the NHS Chair and Acting General Manager, and these included: • Accountability reporting. • Quality systems and processes. • Infection control and risk management. • Workforce development. • Key performance measures. • Financial management.	The role of Senior Health Advisor commenced in Feb 2012. Activities drive or supported by the Advisor included: • Implementation of a clinical governance framework. • Development of clinical protocols. • Preparation of workforce development plan. • Advice and planning for the transition to the new hospital. • Support for operational planning at a department level. A review of the radiology department was also commissioned by the General Manager and carried out by a Counties Manukau expert in medical radiography technology and department management. The review identified some fundamental issues regarding procedures, safety of patients and staff, leadership and the need for staff development in specialised areas (e.g. ultrasound). The review also identified a transition process for the radiology department to move to the new hospital	In addition to continuing projects from the previous year, the Senior Health Advisor led or supported a range of capacity-building activities. • Establishing a Clinical Audit and Quality Improvement Division, with an officer responsible for quality who reports directly to the General Manager. • Developing a format for investigating patient deaths and coaching the Principal Officer, Clinical Audit and Quality Improvement, to undertake three death investigations. Each found system and process issues that contributed to the deaths. Of note, 'many significant recommendations have been accepted and actioned'. • Championing a new process for cleaning standards, with the new Managers of Allied Health and Administration. This is important for both achieving a reasonable standard of cleaning and for ensuring that issues are addressed prior to relocation to the new hospital. • A review of laundry services, which include an audit against NZ laundry practice standards. The review identified 5 areas for improvement, including floor layout, process flow, infection controls, and health & safety measures for staff.

Source: ILP Annual Reports

3.5.3 Impact – NHS leadership has been supported

The Senior Health Advisor typically visits Samoa for one week each month. In between visits, there are additional tasks of reviewing documents, plans and providing advice on issues that arise. Many of the people we interviewed within the NHS commented on the impact of the Senior Health Advisor in supporting the General Manager, identifying priorities, driving initiatives and generally playing a connecting role with ideas and people in New Zealand. Several interviewees offered highly positive views.

> *We're very lucky to have him – he's quite open and it means we don't have to send a lot of staff to Middlemore.*

> *He's been remarkable at the level of General Manager – very proactive and effective in assisting the General Manager in terms of decisions.*

> *He kick-started to get people thinking about clinical protocols – he was influential.*

These findings are consistent with the view expressed in the 2012/13 Annual Report., which noted that the Senior Health Advisor has provided support to the General Manager and NHS staff – '*this has been well received*'. The report noted that the Senior Health Advisor had also '*mentored and coached the newly appointed positions'*, such as the Principal Officer for Clinical Audit and Quality Improvement, and has '*become the internal institutional capacity; strengthening systems and processes'*.

A trip by a small group of NHS leaders to Auckland to observe hospital environments and board meetings during 2013 was also cited as being beneficial for their outlook.

> *One idea they have is to make the hospital as homely as possible – in terms of atmosphere, so that patients don't feel scared. To make it a part of life to go there to get treatment … and for patients to have a say in what they need. Also, creating a welcoming environment for staff to learn and improve the quality of care – these are some important things I've learned.*

3.5.4 Impact – a review of information systems resulted in practical recommendations

A review of information systems was also identified by more than one interviewee as an example of the impacts of the ILP, in terms of the Management Support component. The review was undertaken by a visiting person from Counties Manukau in August 2012 and was seen as being driven by the Senior Health Advisor *'who'd identified the gap*'. The review resulted in three practical recommendations.

- Patient medical notes – the need to have doctors and nurses writing on patient notes in chronological order; previously they've always written on separate sections of a file – creating the potential for confusion.
- Patient medication charts – doctors to write prescription for medication directly onto the patient drug chart rather than nurses transcribing from separate prescription forms; an audit found that there can be transcribing errors.
- Structure of medical records section – the room is jammed with manila folders, which hinders record keeping and retrieval. The NHS board has agreed to move to proper files and clips. While there are costs involved, this transition will be funded in stages.

Case study: Cleaning Department, TTM Hospital

Issues

- Cleaning had been an issue in the old hospital building in Apia – the age of the building made it difficult to keep clean.
- The staffing structure also worked against this – the cleaners were being rotated across different wards and there was a lack of responsibility for any particular environment.
- Although there had been a review of cleaning services in 2011, with findings of poor hygiene (e.g. use of same rag for bathroom and kitchen), little progress was being made.

Intervention

- The Senior Health Advisor recommended that the cleaners be re-trained and allocated to certain wards, to instil a sense of ownership and to be part of the ward team.
- The NHS General Manager gave a presentation to the cleaners about why their role is important – e.g. not just a cleaner, but actually here to save lives. The aim was to motivate the cleaning staff and to build a sense of worth and importance.

Outcomes

- Cleaners have been re-trained, issued with new uniforms, and allocated to wards. An operational manager meets with them every two months to discuss performance.
- Cleaning standards have improved greatly – the new hospital building has also helped.

Case study: Central Sterile Supply Department, TTM Hospital

Issues

- The Central Sterile Supply Department (CSSD) sterilises surgical instruments and prepares swabs. The key principle is to keep 'dirty' items separate from 'clean' items.
- The washing of instruments used in surgery and gauze cutting and packing was being conducted in close proximity – with the potential for cross contamination of the gauze.
- Gauze was being cut up and wrapped in brown paper. Within a short time after coming out of the steriliser, the humidity would mean the gauze would no long be sterile.
- There were problems with high rates of infection, e.g. diabetes patients with diabetes sepsis; swabbed with non-sterile swabs and turning into avoidable ulcers.

Intervention

- The Senior Health Advisor suggested to manager that the staff be given permission to rearrange furniture and equipment to support a more sterile environment.
- The Senior Health Advisor adapted CSSD standards from New Zealand and had them translated into Samoan.

Outcomes

- Staff are now focused on CSSD standards and are more motivated to keep improving.
- Got rid of brown paper bags and the gauze strips now being sealed in plastic.
- New hospital now has a high-standard CSSD that is run as well as any in New Zealand.

3.6 Component 3: Clinical Services Support

3.6.1 Goals and objectives

The goal of the Clinical Services Support component is *to strengthen professional development for, and clinical governance of, specialist medical services*. The objectives are:

- Strengthened capacity of clinical and allied services.
- Skilled and competent health professionals and support staff.
- Increased focus on health promotion and prevention.
- Improved management of non-communicable diseases and other chronic conditions.
- Development of policy and quality framework for quality clinical service delivery that covers credentialing, audit and maintenance of clinical standards developed.
- Implementation of professional and service standards.

3.6.2 Outputs – training and service development

The activities reported comprise training provided to clinical staff and service review and development. The training consisted of standalone training courses, as well as tutorials and informal 'on-the-job' training and knowledge sharing under the VMS Scheme. Table 3 summarises reported activities. Planned and targeted training activities increased during Years 2 and 3 of the ILP, with capacity-building activities neonatal training and mental health service development having been identified as priorities in Year 1.

Table 3: Clinical Services Support component – reported activities

Year 1 – 2010/11	Year 2 – 2011/12	Year 3 – 2012/13
The annual report noted the following support: • The ongoing Visiting Medical Specialist scheme. • The Pacific Child Health Indicator Project via the University of Auckland. • Areas identified by the NHS, such as a review of mental health policy and procedures. Recommendations made for work within this component: • Training for clinicians around Neonatal Intensive Care. • Midwife training to support the decrease preventable deaths of babies. • Mental health service development and training.	The annual report noted the focus had been on: • Mental health development continued, with training and service assessment by a visiting team. • Neonatal training – trainers from the Neonatal Nurses College Aotearoa delivered a two-week intensive programme for NICU staff. Six registered nurses from NICU were trained with a further five nurses being trained as trainers. • Visiting specialists transferred skills and knowledge. Quality improvement highlighted as being a priority.	The annual report noted that specialist training was provided in the following areas, with the number of participants recorded: • Palliative Care (80 participants). • Essential Pain Management (60 participants). • Neonatal POINTS of Care (10 participants) – neonatal training continued with training visits in September 2012 and April 2013. • Mental Health (132 participants).

Source: ILP Annual Reports

In addition to these reported activities, several of the activities championed by the Senior Health Advisor and reported under the Management Support Component fit with the objectives of the Clinical Support Services component. These include the development of clinical protocols, and the establishment of new roles and programmes of work in relation to service quality improvement and infection control.

3.6.3 Impact – neonatal training has been well received

The annual reports noted that the blocks of intensive training under the neonatal programme were well received by participating staff. We found a similar message in a group interview with senior nurses, which included neonatal unit representation. The general theme was that the nurses had found the neonatal training programme to be relevant and useful. The training has led to ongoing links with counterparts at Middlemore Hospital, which in turn, has to resources being accessed, such as monitors for babies, which they would not otherwise have.

> *The training has been very good and interesting… well-planned and structured… We have developed a protocol by adapting a manual brought over by the neonatal nurses, and the Counties Manukau nurses offered to review it for us.*

There was a clear view about the retention of the knowledge transferred during the training.

> *Of course it would be retained and used. There are nurses here who have been trained as trainers. The sustainability is there…*

Two NHS board members also remarked positively about the neonatal training programme.

I like the idea of bringing people here to train up, rather than sending a smaller number of staff there. To get training here with our own equipment… this has been very successful.

The training turned out to be money well spent because it had been adapted to suit the Samoan context.

3.6.4 Impact – formal clinical governance accepted as necessary to support service quality

There was widespread acknowledgement among interviewees from clinical, management and governance backgrounds, of the need for standardised protocols to guide all clinical staff. The Senior Health Advisor worked with NHS staff to establish working groups to develop the protocols and a committee structure to oversee their implementation and adherence. Several interviewees commented positively about this process and the representation from among NHS clinical managers, heads of units, nurse manages and the MoH.

It was consultation in the beginning, then assignments to units to work on protocols under the supervision of leaders; then a plenary session and workshops. There is ownership of the protocols by staff and management and senior clinical staff.

This has been the biggest contribution of the programme – it is the help that was needed.

It's an impact as it means everyone is speaking the same language – otherwise the risk is different treatments for the same condition – people sticking to their own ideas. Now it's about evidence-based medicine, although it's bit early to see the outcome of the protocols.

Some interviewees commented that the clinical governance committee structure was less successful due to time constraints on clinical staff and other pressing priorities. There was also a general theme that, although there had been progress on the protocols, further work remains and it may be a bit too early to see the impacts.

The sub-committees are not really working due to the compliance burden and a shortage of staff and time… as the heads of units have been assigned to chair them…There may be an impact, but it's insignificant because we're not resolving the chronic shortage of manpower.

I'm not quite sure yet what impact the protocols will have on practice as it's too soon to tell.

The clinical protocols, these need these to be reviewed. I would like a perspective from overseas, making sure they're evidence-based and best practice.

There's a lot of work to be done on the clinical ones, but there has been some progress. The next step is to contextualise them, for example, referencing the medicines that are available.

3.6.5 Impact – an infection control programme with clear priorities has been put in place

A specialist in clinical audit and infection control from New Zealand was contracted in the second half of 2013 to visit Samoa on a recurring basis. This was a response to a request from the NHS General Manger, following analysis of patient mortality data, which revealed a series of deaths attributable to incorrect or inadequate diagnostics and medications, and

avoidable sepsis.[11] Needing to address the issue quickly, the General Manager made the decision to bring in specialist help.

The visiting specialist, on his second visit, also brought an experienced infection control nurse to support the newly established position of infection nurse within the NHS. One interviewee commented that the flexibility of the ILP allowed for this timely intervention, and drew a comparison with seeking support under the SWAp.

> *For his next visit, he brought an infection control nurse. With the SWAp you'd have to wait a year. We have a new nurse starting in an infection control role, so he saw the value of finding someone with 20 years of experience to come, and he was able to achieve that too.*

The visiting infection control nurse was seen as having added a lot of value within a week, for example, helping to develop an infection control programme through to 2015 – which will be assessed by an infection control committee. Two immediate priorities are proposed: (1) hand washing education campaign; (2) isolation of patients with MRSA or TB[12], which involve training staff with procedures and equipment for isolation.

While this flexibility and ability to make things happen quickly is viewed as positive, it may also have been a contributing factor towards a sense of confusion about this new role. Several interviewees commented that the sudden appearance of this new and ongoing role was not communicated well internally within the NHS.

3.6.6 Impact – mental health service development still a work in progress in a challenging environment

The 2012/13 Annual Report references some of the activities to build capacity within mental health services, in terms of assessing the current landscape of services provided in the community and also conducting some training to build capacity, for example:

- Mental health policies and procedures have been reviewed by a visiting team, with a report with several recommendations submitted to the NHS Board.
- Participants (132) attended mental health training workshops.
- A mental health nurse exchange programme will identify and support three Samoan nurses for mental health training (details yet to be agreed).

Mental health was mentioned infrequently by the interviewees we talked with during our site visit, but the comments that were made point to a challenging environment, where capacity development is not straightforward.

> *The visiting specialists from New Zealand are all of Samoan heritage, except one, and when they came three weeks ago – they were so passionate about moving things forward. It's a challenge for us is to absorb new concepts in a limited timeframe.*

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[11] Sepsis – a potentially fatal whole-body inflammation caused by severe bacterial infection.

[12] MRSA – methicillin-resistant staphylococcus aureus, a bacterium that has developed antibiotic resistance that makes infection more difficult to treat. TB – tuberculosis is an infectious disease that can be lethal.

The community services here have been manned by nurses for years because of the shortage of doctors. So nurses take ownership – mental health has been their territory for so long; so if you're saying we're going to introduce a doctor then it can cause anxiety.

There were some differences of opinion among NHS staff with respect to the priorities for developing mental health service capacity. References were made to an apparent lack of progress on a protocol to assist non-specialist nurses in dealing with patients with mental health issues.

We understand that they were here to review – but we already reviewed things and most of the issues were about reinventing the wheel.

The visiting mental health team presented last year and they wanted to create a protocol for staff to use in outpatient settings, for when the mental health staff are not available. They were going to come back in November to do training for us, but nothing was followed up. We heard they came back, but the promise to develop the training did not happen. I was interested and the nurses wanted it.

3.7 Component 4: Medical Treatment Scheme

3.7.1 Goals and objectives

The goal of the MTS is *to facilitate cost-effective visiting medical and overseas medical treatment services which integrate clinical and institutional capacity building elements*. The objectives are:

- Provision of selected clinical services for effective treatment in Samoa or New Zealand.
- Management of MTS according to agreed criteria.
- Organising VMS visits as agreed with NHS and ensuring these are well planned, efficient and effective.
- Proven, value for money/cost-effective provision of visiting specialists and medical treatment services.
- MTS schemes are managed efficiently and within allocated budgets.
- All accepted offshore referrals meet MTS criteria.
- Treatment provided in New Zealand is effective and safe and has positive long term outcomes.
- VMS visits are timely, planned and meet identified need and are complementary to visits provided by other donors.
- VMS visit occur when local systems are ready, patients are available and there is a commitment and plan for follow up treatment.

The MTS provides medical treatment where the expertise or facilities are not available in Samoa and comprises: the ORS for the referral and treatment of Samoan citizens in New Zealand; and the VMS, involving clinical teams visiting Samoa to treat patients. These activities are expected to contribute to ILP capacity building, including training.

3.7.2 Background to the Scheme

A 2004 review of the Medical Treatment Scheme to Pacific Island countries, of which the Samoa MTS was a part, outlined the following rationale for continuing with the Scheme:

- On humanitarian grounds, as some people would die without treatment.
- New Zealand's historical, social and cultural relationships with the region.
- Consistency with NZAID's goal of poverty elimination in so far as it responds to 'poverty of opportunity', given that Pacific Island countries lack capacity.
- It would be unrealistic, in terms of being neither cost-effective nor clinically feasible, for Pacific Island countries to provide a full range of medical services for their peoples.

In the early 2000s, efforts were made to increase in-country treatments, via visiting medical specialists, to enable more patients to be treated and to improve overall cost-effectiveness [13]

3.7.3 Outputs – Overseas Referral Scheme

Fifty patients were treated under ORS during the three years of the ILP. There were 17 patients treated in 2010/11 and 20 patients 2011/12 – although a lower number of 13 patients were treated in 2012/13. This lower amount may have partly been a timing issue – as the annual report notes, operations for two patients were rescheduled from near the end of the financial year to the start of the subsequent year.

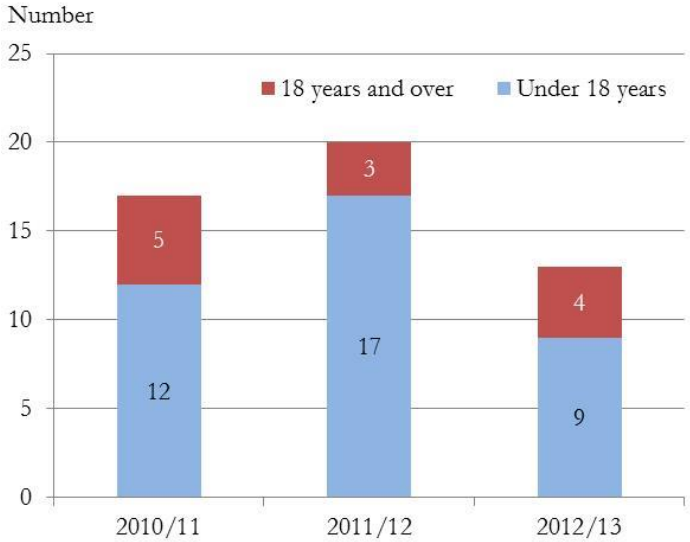
The focus of the treatments during this period has been on children and young people with slightly over three-quarters (76%) being aged under 18 years – as Figure 5 shows. In terms of gender, 64% of patients treated during this period were female and 36% were male.

The most frequent surgical procedures relate to cardiac surgery, particularly to treat rheumatic heart damage in children. The fact that the majority of ORS patients are young means that there is a life-long payoff from these relatively early interventions.

In 2010/11, of the 26 referred to the ORS, 17 (65%) were accepted for treatment; while in 2011/12, 20 of the 27 patients referred, or 74%, were accepted. Patients were declined for treatment because of poor prognostic outcomes or because they did not sufficiently meet the clinical criteria (e.g. ability to benefit). In 2012/13, all 13 patients who were referred were accepted for treatment.

[13] *Report on a Review of NZAID's Medical treatment Scheme to Pacific Island Countries*, February 2004.

Figure 5: Patients treated under the Overseas Referral Scheme, by age group



Source: ILP Annual Reports

3.7.4 Impacts – Overseas Referral Scheme

Overall, we found support within the NHS for the ORS. Several interviewees acknowledging that the patients referred for treatment in New Zealand tend to have high ability to benefit, since most are children or young people who have serious health conditions. However, we did not find any systematic recording of patient health outcomes and the quality and safety of the treatment and the follow-up care.

The 2011/12 Annual Report notes that the follow-up of patients following their treatment in New Zealand *'is still a challenge'* with some NHS doctors and administrative staff noting that although a patient will generally visit the hospital for an initial follow-up, as recommended by the physician in New Zealand *'any subsequent follow-up is generally not adhered to'* and that staff *'find it difficult to track these patients'* It is also unclear that there is a mandate for patient outcomes to be tracked once they have returned to Samoa and the care of the NHS.

We did not find expressions of dissatisfaction with the referrals and prioritisation of patients to the ORS. A couple of interviewees commented on the referral process, however the referral criteria and final decision making process remain somewhat unclear. Furthermore, we did not get a clear sense of how the ORS fits with the Government of Samoa's Medical Treatment Scheme. We have not sighted any written documentation around the ORS criteria and decision making process, or the Government of Samoa's Medical Treatment Scheme.

> *The heads of units recommend patients for overseas treatment. We have an overseas treatment committee here to review clinical reports, chaired by the [NHS] General Manager. There's also an overseas referral office that focuses on the Samoan scheme as well as the ILP. We then give patients to Dr [ ] and if he doesn't approve, then the New Zealand scheme takes over.*

> *I like the clear criteria for [ORS] referrals; it's fixed, compared to the loose criteria here, where we don't always have the final say on who goes.*

One interviewee commented that the pricing and value for money of the ORS could be looked at. We understand that the ILP office has tried to compared cost estimates between public and private hospitals, and that the estimates tend to be similar. A report from a visiting medical specialist from [ ] Hospital in Auckland also comments this issue.

> *Dr [ ]raised concerns about costs of heart surgery and I explained how [ ] management our [specialty] department have addressed this in recent years, reducing costs and only accepting those for whom there was likely a high chance of survival.*

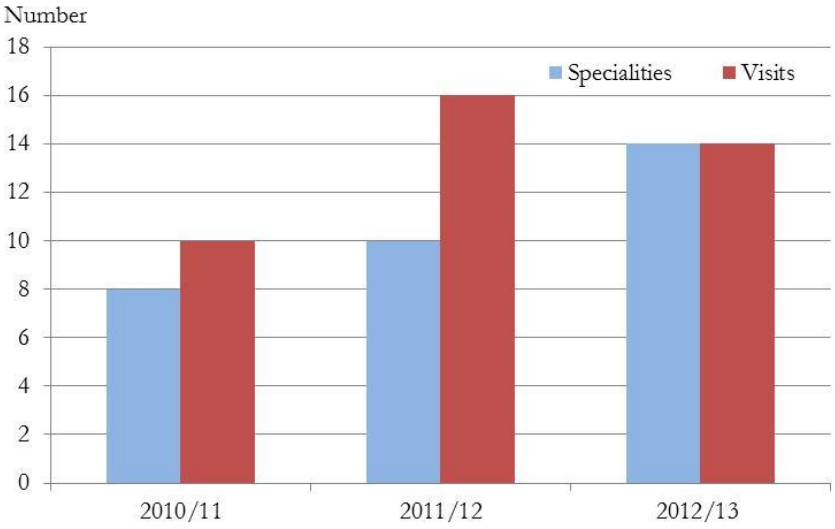
One interviewee, with extensive experience, argued for a shift in resources, away from the ORS, citing the New Zealand contribution as being less than 10% of the Government of Samoa's own MTS – '*MTS is NZ aid – its NZ$500k per year. Samoan Government MTS is NZ$5m per year*'. The suggestion was this funding could be reallocated and targeted at activities that focus on effectively to build NHS capacity and independence.

> *I always query why the New Zealand scheme, with $500k, doing the same thing… In 30 years of this scheme, what have we achieved? What can we do [instead] to help self-sufficiency in Samoa? That's how I see our role.*

3.7.5 Outputs – Visiting Medical Specialists Scheme

The number of visiting medical specialists has increased during the three years of the ILP. In 2010/11, there were 10 visits by specialists. In 2011/12 and 2012/13 there were 16 and 14 visits, respectively – as Figure 6 shows. In addition, the number of specialties has increased from 8 in 2010/11 to 14 in 2012/13.

Figure 6: Visiting Medical Specialists – number of specialty areas and visits



Source: ILP Annual Reports

In addition to the number of visits, the main performance measures reported are outputs, such as the number of patients seen by the visiting specialist teams, the number of patients receiving treatment (surgical operations or medical procedures), and the number of health professionals trained by the visiting teams. Table 4 shows that:

- The total number of patients seen by visiting medical specialists more than doubled from 244 in 2010/11 to 789 in 2011/12. (These figures are for outpatient clinics and exclude ward rounds. No figures were reported for 2012/13.).
- The number of patients receiving treatment increased from 106 in 2010/11, to 173 in 2011/12, and followed by a much larger increase to 929 in 2012/13. Much of this latter rise is due to eye treatments delivered by the Pacific Eye Institute, as Figure 8 shows.
- An increase in health professionals being trained by the visiting specialists, from 446 in 2011/12 to 518 in 2012/13. No figures were reported for 2010/11.

This overall picture of an increase in outputs is consistent with the higher number of specialist visits each year. Accordingly, expenditure, rose from $94,000 in 2010/11 to $149,000 in 2012/13 – a rise of 48%, although this is partly due to a move to visiting team for surgical visits. These figures may be approximate, as they are reliant on the numbers recorded by the visiting medical specialists in their trip reports to the Programme Office at Counties Manukau. As the Biannual Report for July-December 2012 notes, as not all specialists submitted a report and not all VMS reports provide details.

Table 4: Visiting Medical Specialists – reported service volumes

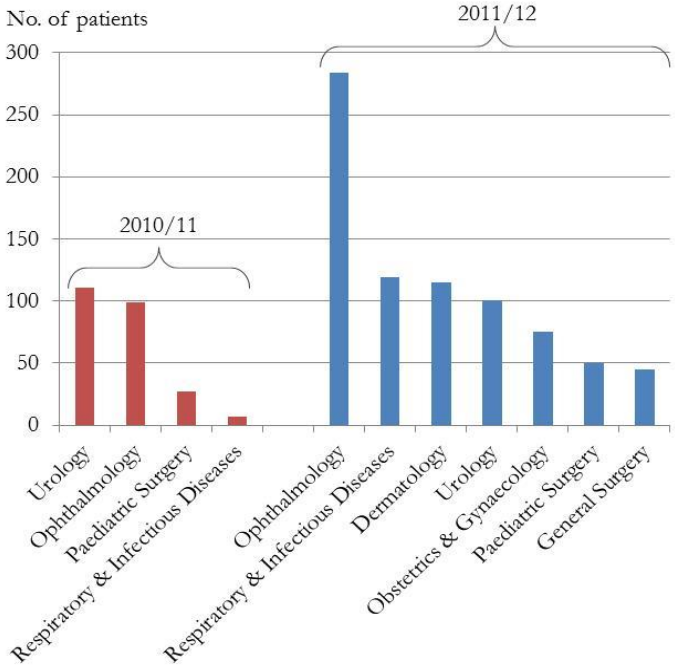
Year	Number of patients seen by a specialist	Number of patients receiving treatment	Number of health professionals trained
2010/11	244	106	Not reported
2011/12	789	173	446
2012/13	Approx. 500 as at December 2012	929[1]	518

Source: ILP Annual Reports;

1. Includes 357 treatments undertaken by the Pacific Eye Institute

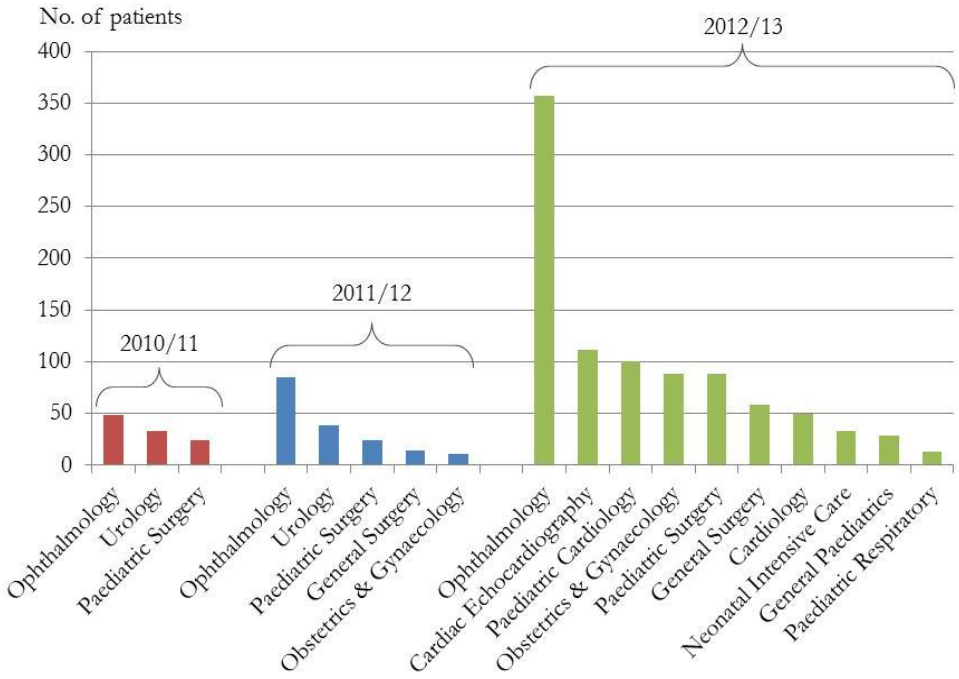
The number of specialties being reported against the VMS has increased over the three years of the ILP – in terms of patients seen and patients treated. Figure 7 and Figure 8 show that ophthalmology has handled the largest number of patients in 2011/12 and 2012/13. We understand that this is partly due to the Programme Office organising visits from specialists at the Pacific Eye Institute in Fiji. A full list of specialties covered is provided in Appendix 4.

Figure 7: Patients seen by Visiting Medical Specialists in clinics, by specialty



Source: ILP Annual Reports; Note: data for 2012/13 was not reported.

Figure 8: Patients receiving treatment by Visiting Medical Specialists, by specialty



Source: ILP Annual Reports

3.7.6 Impact – a high degree satisfaction with the Visiting Medical Scheme within the NHS

Several interviewees within the NHS, including managers and clinicians, commented positively on the process for determining the mix of visiting specialists under this scheme. The schedule of visits is determined in consultation between the partners, with the mix largely determined by clinical need – on the basis of any backlog of assessments and procedures that cannot currently be handled in the NHS being viewed as most urgent.

There also appeared to be sufficient opportunity for the NHS to determine the timing of the visits, to match specialists with identified health need, and to coordinate the visits with those provided by other donors – consistent with the goals for this component.

> *They go out of their way to find the right people to send to us – even specialists outside of Counties Manukau. When they come over … having them talk with the operating theatre team transfers skills and knowledge.*

> *The VMS is well organised. Counties email us about what teams we need. Once the scheduled programme is in place… then we prepare for their arrival. We liaise through email, that's the routine.*

> *The specialist gives us a date and we organise our patients. We also network via emails to give us direction to treat patients that we'd otherwise have difficulties with.*

> *The response from our teams has been positive for most, if not all, visiting specialists. We cannot ask for any more of their time, as we realise this is what they've made available.*

3.7.7 Impact – a mix of views on pre-visit preparedness

A couple of interviewees within the NHS noted that there is still room to improve the coordination, communication and general preparedness ahead of visiting teams.

> *The reception of VMS could be better organised in terms of getting the outpatient list together. There are system problems and there's the potential to organise it better.*

> *There's always been an issue of knowing when the teams will come – lapses in our system. A team comes over, but are there patients to see? How far in advance are the VMS schedules sorted and publicised? Some coordination is missing.*

Visiting specialists were mainly positive about the preparations undertaken ahead of their visits, although there were recurring comments about NHS information management and patient recall systems. This is issue was also raised by NHS staff as an ongoing challenge – although there have been recent efforts to improve medical record management, following a review by a specialist from CMDHB (as discussed above).

> *There was sufficient preparation in country prior to visit… Most patients were referred to me via the Head of Department who screened the patients before he went on leave.*

> *Pre-screening by local staff – good, on the whole. The medical record system and patient recall system is not ideal, so some children who were seen last time were not contacted.*

> *Very well selected patients; Dr [ ] or registrars were always in attendance to help with the consultation and translation.*

The clinics were superbly organised by Dr [ ] who put a lot of work into having previous records/clinics sheets etc. available. I believe we had a 100% turnout this week, this has not happened previously on my visits.

Unfortunately the staff at TTM had been very busy in the weeks prior to us visiting and hadn't remembered that we were due that week so they were unable to arrange any custom outpatient clinics for us, so our time was utilised with inpatients.

3.7.8 Impact – visiting specialists are transferring skills and knowledge but a sense that more could be done

There was also reference to visiting specialists using a varied approach to transferring skills and knowledge as part of their visits, but there is little in the way of specific examples cited, and a generally impression that that capacity building under the VMS is largely opportunistic.

I presented a teaching session based on recognition of simple congenital [ ] defects. It was well attended by hospital staff. I also conducted ongoing teaching with registrars who sat in on clinics.

No opportunity for formal teaching, but opportunities for discussion.

I did a teaching session for final year medical students at Oceania University on physiology and pharmacology for children from an anaesthetic perspective. I did no teaching in the anaesthetic department this time but did do two talks last time…

Some interviewees suggested there could be more of a structured focus to planning and recording the transfer of skills and knowledge during the visits from the New Zealand specialists. However, it was also acknowledged that the delivery of care to patients tended to drive the schedule for specialists. There are some specialist visits are of a technical nature, (e.g. radiology, biomedical technicians), and tend to focus on developing service capacity.

There should be more skills and knowledge transfer… It needs to be more coordinated so that people with any connection to the service are notified and plans are in place, so that people are warned and it's expected who'll be there and what training they will receive… At the moment the emphasis is on doing the [clinic] numbers.

Skills transfer – this needs to be documented so that it's reported back to Counties Manukau. It should articulate the numbers of people trained, what they've been trained on and the potential further training. This is what has been happening elsewhere, under other programmes. There's a lot the visiting specialists could do – teaching, ward rounds, lectures.

The VMS must have clear idea of what is necessary to transfer their expertise; it means they must find champions within the NHS and be sure what equipment is available.

However, one interviewee offered a cautionary view about the limits to capacity building.

Samoa won't be able to do it all in, say, 5-10 years… The operations [ ] are sometimes complex and uncommon even for us in a major centre. You're never going to have specialist paediatric surgeons, it's two-three general surgeons doing everything with some orthopaedics. For a population of 190,000, you'll never [be able to] support the surgical specialties.

3.7.9 Impact – value for money is based on goodwill of the visiting specialists

The time provided by visiting specialists is voluntarily offered, typically at low or no cost, with a per diem payment being made available while in-country. Visiting specialists who are employed by a DHB are typically required to take annual leave by their employer. We heard a view, offered by a small number of interviewees, that the VMS Scheme provides good value for money because of this goodwill from the specialists. One viewpoint was that DHBs, as government-owned entities, could be encouraged to better support the provision of New Zealand Government aid to Samoa.

3.7.10 Impact – anecdotal evidence suggests the MTS provides valuable benefits to patients and NHS staff

In terms of how the MTS impacts on treated patients, we did not find evidence of outcomes being systematically tracked – for either the ORS or VMS components. We understand that some visiting specialists, who return to Samoa each year, retain their own record of patients seen, in lieu of a central system. This assists with their tracking down patients for follow-up visits.

We did find some anecdotal evidence that patients are benefiting from the assessments and procedures conducted – largely from our examination of the sample of VMS reports, along with interviewee responses.

> *A very worthwhile trip, especially because of the number of blind operated on.*

> *This trip was of tremendous help to the people of Samoa with cataracts as of course they have no ophthalmologist in the hospital at present.*

> *Most patients benefitted from the advice given. The local staff got to present to patients and listened/contributed to the discussion and management plans.*

> *The record system is pretty old… so there are cases of patient notes not being located. I keep a database myself of patients, to give the registrars a list for follow-up visits.*

Some of the visiting specialists also commented on examples of the transfer of knowledge and skills to NHS clinical staff – typically referencing the benefits of ongoing peer-to-peer connections.

> *The most important thing is the relationship with the person over there… the clinicians can now deal with a partial colectomy for blocked bowels and will liaise with us before we visit.*

> *On previous visits I have provided the medical doctors with a practical session with regard to the set-up of this machine. I have since developed a 'how-to-set-up' guide with pictures and instructions, which was supplied to them by the visiting respiratory team last year. This time we did a practical session… and this was beneficial as they reported having had some technical difficulties.*

> *Our programme is a regular service and we've been strong on trying to build a sustainable service and relationships. We know all the registrars – and you can only do that when you go regularly. Some common things they do deal with – hernias – they'll operate for children.*

If I do a couple alongside them, then I'm probably transferring skills, such as surgical techniques – the tips of the trade.

3.8 Component 5: Bi-annual visits

The 'Bi-annual visits' component was not in the original contract, and the first Annual Report reported on just the four original components. However it did include a section entitled 'Component 5 – Annual Reviews', which documents three formal visits to Samoa between July 2010 and March 2011.

In the second Annual Report (2011/12), component 5 is reported as 'Biannual visits', and documents two visits over the period. The first visit in August 2011 involved:

- Meeting with the new General Manager of the NHS and providing a 'detail outline' of the ILP work plan for the year.
- Progressing mental health workforce development and attaining endorsement from MoH, NHS and National University of Samoa Nursing Faculty.
- Identifying key individuals for linkage around the VMS visits, to support a joint collaborated and coordinated approach to the specialist visits.
- Discussing other related projects that impact on health in Samoa (it is not clear who these discussions occurred with, or what the outcomes or decisions were).

The report notes that the key element of support role – the Senior Health Advisor – was identified as an activity to be delayed until the new General Manager settled into his role.

The second bi-annual visit in March 2012 involved review of the ILP to date and identifying areas for assistance. In this visit, the General Manager identified that the SHA role needed to be extended to at least two years, to support the transition of the NHS to the new hospital and advise on issues relating to the hospital's construction. The visit also included:

- A meeting with the Minister of Health.
- Briefing and debriefing meetings with Post.

The Annual Report states that updates to the Minister of Health are provided through the Ole Manu monthly communications. Only one interviewee made mention of this communication device in our interview, but our discussions with other government agencies, professional bodies and NGOs revealed very mixed awareness and visibility of the ILP and its activities, with a number of interviewees commenting on the lack of transparency around the Programme.

The 2011/12 Annual Report also notes that the ILP team 'continue to engage with Samoa's Ministry of Health through the Director General, providing update of the work of the ILP and to coordinate and plan placements of their staff within CMDHB and other hospitals/organisations in Auckland as part of work-placements and attachments funded by the Sector Wide Approach Programme (SWAP)'.

The 2012/13 Annual Report sets out the purpose of this component. It states that the goal is *'to manage and facilitate the programme development'*, with the listed activities being:

- The ILP is well coordinated and strong relationships with NHS and other sectors in Samoa are developed and maintained.
- Biannual monitoring and support visits to meet with NHS and key stakeholders to review progress and recommend changes to the ILP is required.
- Overseas referral training (in-country and attachment).
- The monitoring and evaluation framework is managed and reported on.

The report states that two visits were carried out, but does not specify when, who was met with, how the agendas were set, or what the outcomes of discussion were.

Interviewee responses noted that the biannual visits are used to review progress and map out a work plan for the year ahead. The visits are also a chance for the NHS and CMDHB to discuss emerging priorities or unexpected problems that arise, and whether the ILP can assist – if appropriate. During a recent biannual visit, for example there were four suggested priorities from the NHS for visiting specialists to support capacity building: biomedical technicians, operating theatre nursing, anaesthetist support, and the intensive care unit. A planned visit by biomedical technicians was cited as an example of ILP responsiveness to an issue that had arisen with new medical equipment.

> *The NHS asked for biomedical technicians to assist with the dentistry service, for setting up new dental chairs that had been purchased… The NHS can set up the chairs as much as can, but for the finer technical detail, Counties Manukau will send a specialist technician for a few days to make sure it's certified. The idea is to also to train the NHS biomedical team and to keep those links with the Middlemore team – to seek advice on looking after the chairs and other queries.*

Figure 9: Tupua Tamasese Mealoe Hospital, Apia

Source: Sapere Research Group

3.9 The peer-to-peer model

A core element, and particular benefit, of the ILP are the collegial relationships and networks that are built up over time – between clinical and managerial staff in the NHS and CMDHB. A number of interviewees described how these relationships can be drawn on to help solve unexpected issues and longstanding problems. One interviewee noted that these sorts of benefits would be unlikely to occur under other approaches – such as the Health SWAp or a budget support approach.

> *The ILP encourages relationships which can be drawn on to help solve problems – this wouldn't occur at the SWAp strategic level and certainly not under a general budget support approach.*

Much of the support from CMDHB is provided 'on demand', and a number of interviewees remarked on the very rapid response from their ILP contacts, and in particular the Senior Health Advisor's response – even to emailed queries. Several interviewees commented positively about the institutional relationship with CMDHB and with Middlemore Hospital. Common themes include the responsiveness to changing needs and the flexibility to try new things or to things differently in a short space of time.

> *We have an MoU – it's a partnership – it's a very pleasant arrangement; they are very responsive to our needs.*

> *Counties Manukau are colleagues and peers, but not locals. This is a plus.*

> *The visiting specialists – probably half come from Counties Manukau and half from a variety of sources elsewhere. There were more from Auckland DHB before and now it's more Counties. Awareness of the ILP has grown since we took over… we've promoted the VMS more at Middlemore Hospital.*

> *The executive support at Counties Manukau for the ILP means there is a trickle-down effect through the organisation; e.g. charge nurses are more likely to release a nurse to be involved, as a way to support the ILP.*

Interviewees also compared the ILP approach with that of the SWAp, describing the ILP as much more responsive and flexible:

> *Peer-to-peer is good for us… as we engage directly with them as opposed to the SWAP which is tied down, and the activities are rigid…. The ILP has worked better for us than SWAp overall... Project-based aid goes via the Ministry of Finance which complicates things. With the ILP sitting outside of Samoa, we don't have as much bureaucracy.*

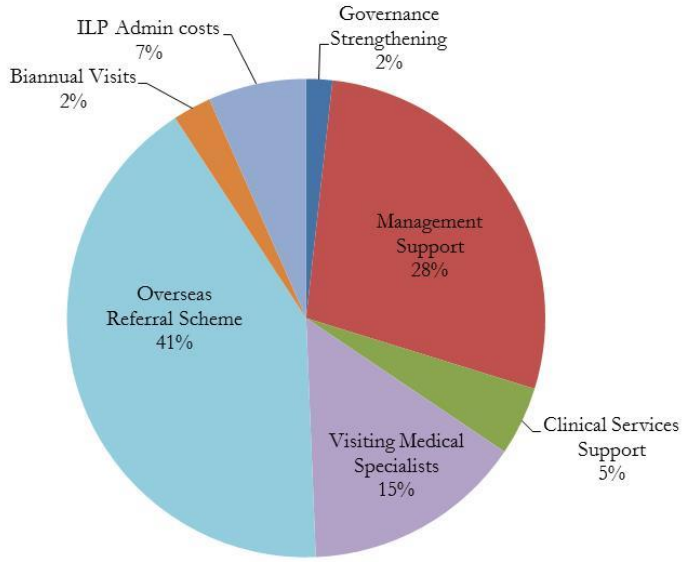
> *There's a lot to gain from having a relationship between one institution and another – we can bypass the bureaucratic arrangements that the SWAp adheres to.*

3.10 Financial performance

The Contract for Services requires that the Contractor, provide 'detailed budgets with respect to the managing and service delivery of the various ILP components'. We found that the work plans provided a breakdown of the planned budget by component. The Annual Reports stated actual expenditure by component, with the exception of the 2010/11 report (Year 1). This first year report did not appear to present figures on total ILP expenditure, although expenditure figures the MTS component were presented.

Planned ILP budgets were presented clearly in the reports for 2011/12 and 2012/13. Figure 10 shows that the MTS dominated the ILP budget for 2012/13; its sub-components of the ORS (41% or NZ$500,000) and the VMS (15% or NZ 180,000) comprised over half of the budget of $1.21 million. Management Support was the next largest component at 28% ($338,000) of the budget. The other components were smaller, comprising Clinical Services Support at 5% ($56,000), Biannual Visits at 2% ($39,000) and Governance Strengthening also at 2% ($21,000). The Programme administration fee for CMDHB accounted for 7% ($80,000) of the budget.

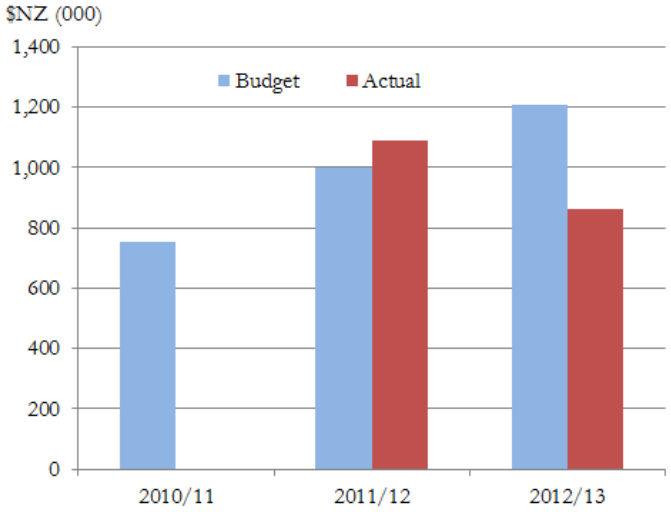
Figure 10: ILP planned budget by component, 2012/13



Source: ILP Annual Report, 2012/13, CMDHB

Figure 11 shows that CMDHB reported an overspend in 2011/12, equating to 9% ($92,500). This was reported as being due to allowing for more visiting specialists and for a team approach for surgically-focused visits. The report noted the figure remains within the three-year budget allocation. In contrast, actual expenditure in 2012/13 was lower than the budget of $1.21 million by $345,000 or 29%. Although there were underspends in most of the five components of the ILP, the largest underspends occurred in Management Support ($201,000 or -59%) and the ORS ($76,000 or -15%) – as shown overleaf in Figure 12.

Figure 11: Reported ILP budgets versus actual expenditure, Years 1-3

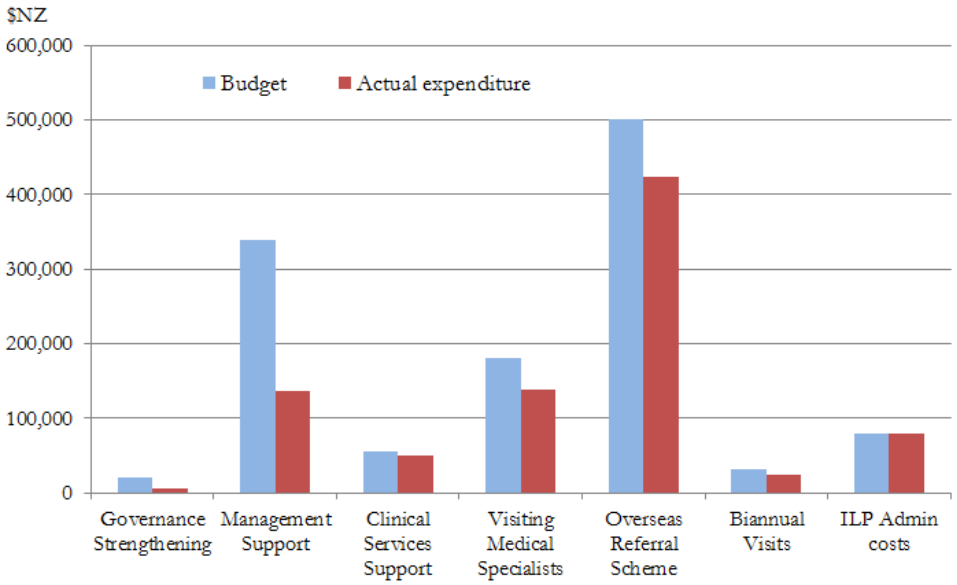


Source: ILP Annual Reports, 2010/11, 2011/12, 2012/13

Note: Total expenditure does not appear to be reported in the Annual Report for 2010/11

A contributing factor to the underspend in Management Support was the limited availability of the Senior Health Advisor, with travel to Samoa for one week per month being less frequent than budgeted for. The underspend within the ORS was noted in the 2012/13 Annual Report as relating mainly to two young patients whose operations were rescheduled by Starship Hospital in Auckland from May 2013 to August 2013. Discussion with staff at CMDHB also noted that the actual cost of treating of one patient ended up being substantially less than had been advised and budgeted for. As this occurred in May 2013, there was no time to schedule an additional patient before the end of the financial year.

Figure 12: ILP budgeted versus actual expenditure, 2012/13



Source: ILP Annual Report, 2012/13

3.11 Monitoring and reporting

CMDHB, as the Contractor, is required to produce annual and biannual reports on the activities carried out under the Programme, along with an assessment of the progress made in each activity. In terms of recording information, the Contractor is also required to:

- 'Maintain a database that will enable them to report on progress towards Programme objectives'.
- Work with the NHS to 'develop and maintain a mechanism with the NHS health information system that enables monitoring of the long-term outcomes of patients treated under the scheme [i.e. the MTS]; and in partnership with the NHS establish a system to show the extent and outcomes of all capacity building activities'.

As well as requesting service and financial data, we reviewed the annual and biannual reports, along with other internal reporting, such as a sample of the reports provided by visiting medical specialists to CMDHB at the end of each visit and a sample of the progress reports provided by the Senior Health Advisor to the Programme Director every six months. We found that an annual report had been prepared for each of the three years of the ILP.

In terms of management of the information to support ongoing monitoring, we did not receive any methodical database, for example in the form of spreadsheets showing service volumes in time series (i.e. assessments, procedures carried out, training attendances).

We did not find any systematic monitoring of the quality of care delivered to patients under the VMS or ORS or of patient health outcomes – either at the CMDHB or within the NHS. Within the reports submitted by the visiting specialists, we found the specialists who perform surgery in Samoa tended to note that the procedure had gone well, and in some cases, would reference the steps taken to reduce the risk of complications. Examples include: the specialist being clear about which procedures were safe in the environment, taking steps to ensure that any relatively more complex procedures were scheduled at the beginning of a VMS trip; and continued follow-up with the NHS physician following their return to New Zealand.

We found that while the annual reports monitor progress towards the objectives of each component, the reports tend to focus on the twelve-month period in question. There does not appear to be a broader picture of ongoing performance, in terms of aggregate service volumes and financial performance. In particular, the ORS and VMS metrics are not consistently presented in the reports, which hinders times series analysis or the formation of a wider view of performance.

We also found that some issues or problems were referenced, but a corresponding response was not clearly identified (i.e. an action within a timeframe or responsibility for one party). Interviews with MFAT stakeholders also raised a lack of clarity, at times, about what they needed to do to respond to issues that appeared to be left hanging.

In terms of the dissemination of annual reports, we found that although the NHS management receives a copy of all report, there did not appear to be regular wider sharing of these ILP performance assessments to other stakeholders in Samoa – such as the NHS Board or the MoH. The responsibility for this lies with NHS management rather than CMDHB.

4. Analysis

This chapter analyses themes in the findings of our research. It offers a framework for considering capacity development activities and then considers the main findings against the DAC evaluation criteria and examining cross-cutting issues of gender and human rights. It then considers the partnership approach of the ILP against other approaches.

4.1 A framework for considering capacity development activities

Figure 13, overleaf, sets out a framework developed to aid our assessment of how the ILP has supported the NHS to date, and where the efforts could focus in the future – if funding were to be continued. It presents the health services as being composed of several layers.

- **Infrastructure and processes** – these are the foundations of front-line services received by patients. They include the corporate and clinical support services within the NHS that should support the provision of high quality and safe patient care. These 'building blocks' can be grouped into those that directly support patients and clinical services (e.g. clinical governance, sterile supply, biomedical equipment maintenance) and those that support the organisation and staff as a whole (e.g. corporate services).
- **Clinical support services** – these support services assist with the clinical diagnosis and treatment and include the radiology, pathology laboratory and pharmacy departments.
- **Patient treatment services** – these include 'front-line' services such as outpatient clinics (hospital and community-based), inpatient services (i.e. admitted to hospital for medical or surgical treatment), allied health services (e.g. physiotherapy, dental), and community-based services including primary care (e.g. general practice, district nursing).

To date, we see the ILP as having worked across each of these layers. Within patient treatment services, the VMS and ORS provide direct assessment and/or treatment in hospital settings (the VMS includes training and knowledge sharing). Approximately 60% of ILP funds are allocated to the Schemes.

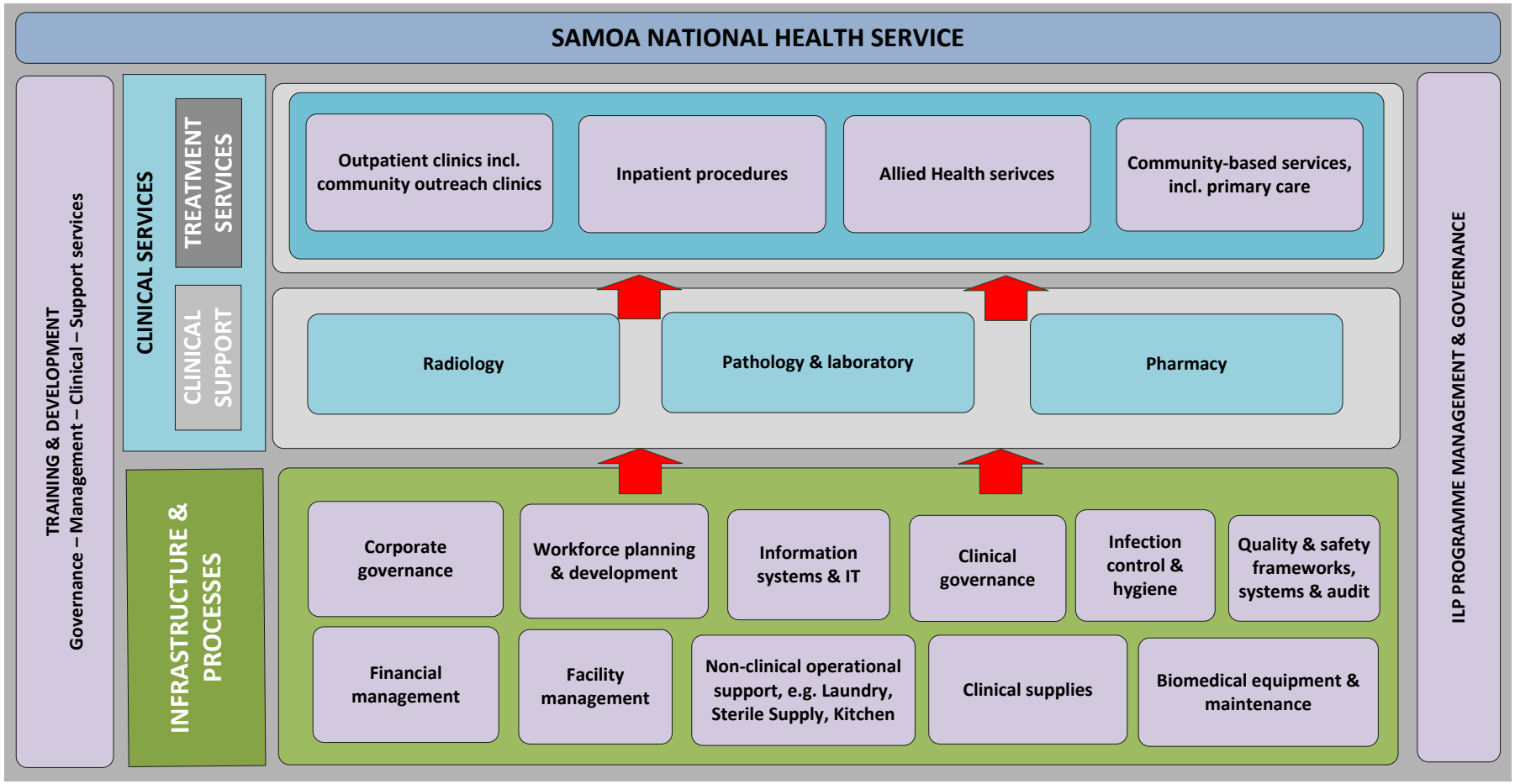
Within the next layer, clinical support services, a review of the radiology department was carried out in 2011/12 by a technical expert provided by CMDHB (this was provided under the ILP's Management Support component).

Arguably, the focus of capacity development efforts has been on the bottom layer – the platform that supports clinical services. It appears that the ILP, through the Governance Strengthening, Management Support and Clinical Service Support components, has touched most of these areas, to varying degrees. Our findings covered some of the highlights including: mentoring support for the General Manager, creation of an infection control role and work plan, lifting quality standards in the cleaning and sterile supply departments, and the acceptance of the need for clinical governance and the drafting of clinical protocols.

We would conclude that, if the ILP were to continue, it remains a sensible strategy to focus the capacity development activities on these building blocks – both clinical and non-clinical. There is also scope to provide training and capacity development support to community-

based services, including primary care. This would be consistent with the NHS Corporate Plan, which identifies the development of primary care services as a priority.

Figure 13: Analytical framework



4.2 Considering the ILP's relevance, effectiveness, efficiency and impact

We focus our analysis through the lens of the core DAC evaluation criteria of relevance, effectiveness, efficiency and impact.

4.2.1 Relevance

Alignment with NHS priorities

The activities undertaken by the ILP have largely been aligned with NHS needs – given the regular input of the NHS General Manager and clinical leadership executives into the work plans. The capacity building support – particularly that provided to the General Manager – has been flexible and responsive to requests and the changing needs in the NHS. In terms of patient treatments, the MTS has helped address significant unmet patient need. The VMS element is served by a mix of specialists who return regularly (e.g. paediatric surgery, cardiology) and those who involved in one-off visits to deal with specific issues (e.g. biomedical technicians to deal with setting up new dental equipment).

It is less clear that the needs that have been responded to are actually the highest priorities for the NHS. A number of factors are at play here.

- While the initial talanoa sessions resulted in lists of priorities from the Board and NHS managers, it is not clear how the subsequent design and implementation of the ILP supported these priorities, as reporting has not been well aligned against them.
- There seems to be some internal confusion within the NHS as to how priorities are identified and who is consulted. As a result, there does not appear to be broad buy-in or awareness of the detailed work Programme.
- More broadly, it is not clear how the Programme is aligning with the strategic vision of the NHS. This may possibly be due to the absence of a clearly articulated 'end state' for the NHS – in terms of the model illustrated above (i.e. which specialties and clinical services the NHS is aiming to be able to deliver in a clinically and financially sustainable way, by a certain point in time). The desired end state needs to be feasible, taking into account the health needs of the population, as well as the constraints imposed by the operating environment, including resources, workforce and scale. With a clear strategic vision, the ILP could then prioritise areas for attention where capability development is required and work in a structured way to ensure the necessary building blocks are in place.

There appears to be scope to focus more on community-based services, including primary care. Primary care services are listed as a priority in the NHS Corporate Plan 2011-14. This move to develop primary care services has been something that the NHS leadership and the ILP office mentioned during interviews. Should the ILP continue, it could look at offering support to the newly formed Division of Primary Health Care, for example, with VMS outreach clinics alongside community-based NHS staff, including nurses and other health care workers and ensuring that training opportunities and strategies to support quality improvement within the NHS are accessible to community-based staff.

Alignment with wider Samoan health system

There seems to be opportunity for better connections with the wider health sector. The ILP does not appear to be well aligned with the timeframe for Health Sector Plan 2008-2018 – so there is a risk that capacity building support is pulled out or changed halfway along this pathway. A Programme commitment to 2018 would require a more strategic work plan to 2018 with clearer articulation of desired outcomes by 2018 and interim steps each year along a pathway towards delivery of the articulated end-state. Capacity building should be seen as ongoing and incremental game with impacts becoming more visible after several years – particularly in an environment where there tends to be a high degree of nervousness around change.

This more strategic approach would support greater transparency around the planning, activities and achievements of the ILP, and understanding of how these are contributing to the broader sector goals and priorities. This could be achieved through standardised reporting to stakeholders (in particular the Ministry of Health and the Ministry of Finance) that aligns and is integrated with sector reporting, along with formalised and structured engagement with key programme partners.

The Senior Health Advisor has supported the development of an NHS workforce development plan. The capacity building activities of the ILP, particularly those in clinical services, should be explicitly aligned with these broader workforce needs and priorities.

Documenting how the MTS of the ILP fits with the similar but larger Medical Treatment Scheme of the Government of Samoa is a gap that should be addressed, e.g. to determine if the criteria are similar or if the ILP MTS is supplements or substitutes for treatments under the Samoan scheme.

4.2.2 Effectiveness

The patient treatment services of the ILP, provided under the Medical Treatment Scheme, are likely to have been effective for the following reasons:

- The VMS reports sampled generally show that surgical treatments have been delivered as being conducted successfully. The focus could be on exceptions, in terms of serious or unexpected events.
- There is evidence that visiting surgeons monitor for post-operative complications, ensure patient follow-ups during subsequent visits, and being available to connect with NHS clinicians.
- There is evidence that the treatments in the ORS are targeted at those patients have are likely to benefit the most – i.e. younger people with life-threatening conditions who have more potential for successful health outcomes over the long term.

There is scope to improve understanding of the effectiveness of the MTS by instituting more centralised tracking and reporting of patient outcomes. Although the NHS may be sensitive to perceptions of external audits or clinical governance, it is not unreasonable to expect a report back, by writing a follow-up report to visiting specialists to close the loop. For example, if the NHS and visiting specialists had to provide a summary report for each visit – e.g. at 90 days – it could be a useful exercise for NHS clinicians to report on the outcomes of a sample of patients treated.

This would not be a full clinical audit, but would aid in the understanding of clinical outcomes and would reveal outliers, for example, if a patient died of infection a month after the visiting specialist left. A sample of patient outcome reports could be shared with the relevant visiting specialist, possibly on an exceptions basis (e.g. serious or unexpected clinical events), and then anonymised and shared with the ILP office at CMDHB for summary and inclusion in the Annual Report.

This approach would need to be sensitive to the limits of existing health information system and to any planned or likely future development of that system. As a principle, any reporting on outcomes should be done in a way that avoids establishing a separate system or process that may be likely to be an incompatible with a future NHS health information system.

In terms of capacity development, the ILP can be said to be particularly effective in a number of specific instances:

- The neonatal training courses were viewed by participants as effective and the impacts as being sustainable, with trainers being trained.
- An infection control programme with clear priorities has been put in place and the position of infection control nurse has been established.
- There is an acceptance of the need for a clinical governance framework and committees to work towards improving the quality and safety of care received by patients.

There were also plenty of examples where the consensus is that it is too soon to tell if efforts have been effective, for example in the development of clinical protocols, which need to be finalised and implemented.

There were also cases where efforts on the part of the Programme were assessed to be less effective than they might otherwise have been. Examples include preparation ahead of visiting medical specialist visits and the arrival of the specialist in infection control and clinical audits This suggests there has, at times, been a lack of internal processes or communication. The onus is on both partners to ensure that affected clinical and management staff are informed in advance.

In section 4.1 we are implying a more structured approach to capacity development. In terms of the individual capacity development activities, we recommend that these draw on the best practice guidance (such as that promulgated via the World Bank Institute's website), applying the following principles.

- Capacity development activities are contextualized for the local environment, to ensure that teaching is relevant and suitably contextualized – being cognisant of the constraints in the working environment and cultural considerations.
- A variety of skills transfer methods are employed, tailored to staff capacity development needs, learning styles and the nature of the skills/learning to be imparted.
- Capacity development efforts are systematically monitored and evaluated, drawing on best practice methods and indicators (discussed further in section 4.2.4, below).

4.2.3 Efficiency

Consideration of efficiency and relative value for money appears more straightforward for the MTS component of the ILP, given the existence of inputs and output measures. MTS expenditure tends to account for more than half of the ILP budget – and was as high as 65% in 2012/13 (with the ORS accounting for 49% and VMS for 16%).

The focus of the ORS has been on children and young people, with 76% of patients being aged under 18 years. This allows for a relatively long timeframe for benefits to accrue from major surgery undertaken, such as heart surgery for post-rheumatic fever complications in children. This allocation of resources to younger patients can therefore be seen as providing good value for money, relative to sending an older mix of patients who may benefit less.

Logic suggests that it might be more cost-effective to send specialist teams to treat more patients in Samoa, compared with sending fewer patients to New Zealand for the same treatment. A simple examination of the average cost per person assessed and/or treated under these components during the three-year period of the ILP would seem to be consistent with this view, for example:

- The ILP cost-per-person treated under the ORS equates to $29,000, whereas
- The ILP cost-per-person treated under the VMS equates to $260.

However, we offer some caution about this type of comparison. One issue is that these costs are from an ILP budget perspective and so they do not take into account the full costs of the VMS and ORS. Other costs incurred, for example, include the expenses borne by patients who travel to New Zealand (in the case of the ORS), and the costs borne by the NHS in hosting visiting specialists, such as clinical time, consumables, or bed days. Furthermore, the value for money of the VMS is supported by visiting specialists effectively offering their time at a heavily discounted rate. In addition, the nature of the services being provided under each component is different, with the ORS providing major surgery, often life-saving, to a small number of patients who are typically children and young people. This is surgery that would not be clinically feasible to perform within the NHS. In contrast, the VMS teams tend to provide outpatient clinic assessments within the NHS to a larger number of patients of various ages, along with some procedures and operations deemed to be clinically feasible in that setting. Table 6, below, compares some of these key features of the VMS and the ORS.

These issues are worth bearing in mind when considering whether the amount of funding is efficiently allocated across the two components of the MTS. Allocating more of the MTS funding to the VMS would mean some trade-offs, for example, the major surgery undertaken under the ORS could not delivered under the VMS, and so a different group of patients would likely be treated instead. We do not have patient outcome data to know if the overall health gains would be greater under this approach. It is also unclear whether the patients treated under the ORS would otherwise be treated under the Government of Samoa's Medical Treatment Scheme, as we have not sighted any documentation on the criteria or pathways for referral under the Samoan Scheme.

Therefore we are unable to conclude whether the ORS is a vital supplement to the Samoan Medical Treatment Scheme (i.e. treating patients that would not be treated otherwise) or something of a substitute (i.e. treating patients that may well be treated under the Samoan Scheme in the absence of the ORS). This is an issue that could be considered more closely, if both the New Zealand Samoan Medical Treatment Schemes were looked at jointly under a single review that looked at respective purposes, scope and edibility criteria.

Other models for delivering clinical services could be worth exploring, in terms of their efficiency, for example, the use of telepresence technology as a way to obtain the input of New Zealand-based specialists into complex diagnoses. Such an arrangement could reduce the need for travel and enable specialist input to be available throughout the year.

Table 5: VMS and ORS – some key features

	Visiting Medical Specialist Scheme	Overseas Referral Scheme
Main focus	Outpatient assessment clinics and some treatments from specialist teams visiting Samoa.	Major surgical treatment in Auckland.
Scope	A wide range of specialties, including cardiology, urology, obstetrics & gynaecology, ophthalmology, paediatric surgery, respiratory & infectious diseases.	Tends to be paediatric cardiac surgery; often life-saving in nature.
Annual volume	Several hundred (200-800) patients seen in Years 1 & 2, with 100-200 operations/ procedures each year.	Between 13 and 20 patients treated during each year of the ILP.
Patient age range	Various ages.	Tend to be children and young adults.
ILP cost per patient (average)	Approx. $260 (Costs largely relate to travel costs and per diems for visiting specialists).	Approx. $29,000 (Costs largely relates to prices charged by the hospital providing the treatment).
Other costs incurred	NHS incurs costs, e.g. staff time, consumable, bed days. VMS volunteer their clinical time and low/no cost.	Patients/families fund their travel to New Zealand.

We note that MFAT reports identified a risk in CMDHB being the management office and provider of services, in that there may have been an incentive to place patients into their own hospital – regardless of the cost. We saw no evidence for this. The ILP office stated that they had compared prices among providers in Auckland. Furthermore, most of the ORS volumes seem to be undertaken at Auckland and Mercy Hospitals (i.e. non CMDHB hospitals).

In terms of other services, there are signs that in-country training has been efficient in that it has been tailored to procedures that are within scope of the NHS's current service mix. The neonatal nurse training, for example, was seen as being good value for money because it was adapted for a Samoan context and focused on raising the quality of the care routines of the nurses. In addition, some nurses were trained as trainers, thereby ensuring the skills and knowledge were transferred in a sustainable way. A counterfactual scenario, such as neonatal nurses being sent to New Zealand may have been less efficient if the equivalent travel costs allowed for only a small number of NHS nurses to be directly exposed to the training.

4.2.4 Impact

The key impacts of the ILP, in the relatively short time frame of three years, are as follows.

- **Patients have been able to continue to access services that offer clear benefit**. In the case of the ORS, these are typically younger patients who may have life-threatening conditions, and are likely now to have a good chance of positive health outcomes. In the case of VMS, using the NHS in Samoa as the setting for care is enabling a greater volume of patients to be assessed in outpatient clinics and, in some cases, offered medical procedures and surgical treatments.
- **Trusted relationships have been established** – between the ILP office and the NHS leadership, between the General Manager and the Senior Health Advisor, and among visiting clinicians and the clinical staff of the NHS. These relationships take time but their value is high in terms of the potential to influence individuals and systems and to help achieve changes that support improved capacity. This matters, given that the cultural context places a premium on known and trusted relationships.
- **Building blocks for quality and safety of patient care** – capacity building and systems development work to date has focused on establishing foundational building blocks. Although the impacts of this investment are just beginning to be felt and will take time to fully accrue. It is generally too soon to tell what the overall capacity building impacts of the Programme have been, and whether they will endure. The Programme took a long time to really get started, with key activities occurring over the last couple of years with the appointment of the Senior Health Advisor.

We do not see a clear need to increase resources for capacity development activities. Instead it is a case of targeting current resource to where capacity development is required and is likely to be most achievable and enduring. Further, there would be benefit in development better performance measurement to support communication of the performance story.

Monitoring and evaluation of capacity development efforts could usefully draw on the best practice guidance on metrics/indicators. For example, standard feedback forms could be developed for participants of training workshops/seminars to complete, covering aspects such as design/content (relevant, understandable), mode of delivery, presenter, pace, and results (whether they will apply the learning). Feedback should be systematically recorded by CMDHB in a central repository, reported on as part of standard programme reporting, and inform the development and roll-out of further capacity development activities.

More broadly, longitudinal monitoring of individual staff capacity development progress could be undertaken, covering the following aspects.

- Knowledge and skills to perform their role.
- Confidence to perform their role.
- Provision of necessary support to perform their role.
- Usefulness and timeliness of feedback received on their work.
- Availability of equipment and materials necessary to perform their role.
- Skills and knowledge acquired via ILP activities/support.
- Opportunities to apply skills and learnings acquired through the ILP.

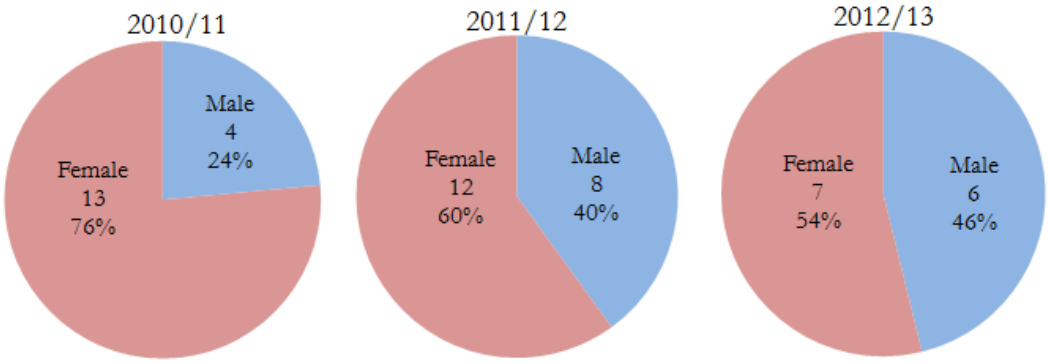
One way of monitoring this could be via a simple self-assessment form completed every six months by selected NHS staff members.

4.3 Cross-cutting issues

4.3.1 Gender

In terms of patients receiving treatment, the MTS appears to have a sufficient focus on female health, although reporting is more consistent for the Overseas Referral Scheme than the Visiting Medical Specialist Scheme. The gender of patients treated under the Scheme has been reported each year, with the data suggesting that female patients are well-represented in terms of access. Between 54% and 76% of patients were female over the three years of the ILP, as Figure 14 shows. Overall, 64% of the 50 patients treated in this period were female.

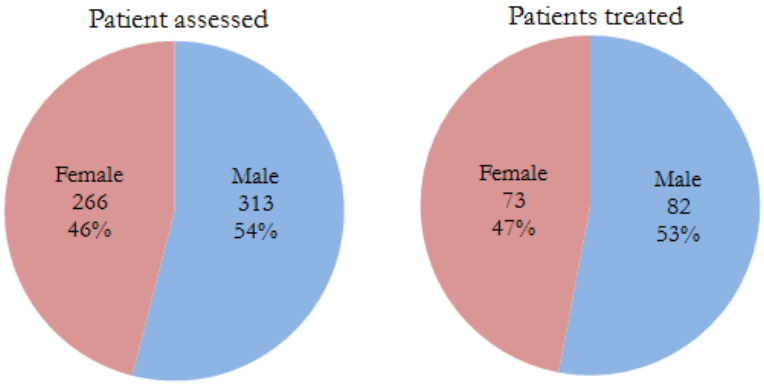
Figure 14: Gender breakdown of ORS patients, 2010/11 - 2012/13



Source: ILP annual reports

Reported data on patients assessed and treated under the VMS is disaggregated by gender for 2011/12 only – the second year of the ILP. Our sample of VMS reports for other years suggests that patient gender forms part of the report template supplied to the specialists by CMDHB, and that this data is captured – if not uniformly so. Figure 15 shows that during 2011/12, females comprised 46% of patients who were assessed and 47% of those who were treated.

Figure 15: Gender breakdown of VMS patients, 2011/12



Source: 2011/12 Annual Report

Reporting on the specialty areas of the VMS also suggests a growing focus on women's health. Clinics on obstetrics/gynaecology were reported during 2011/12 and 2012/13, with a sizeable increase in related procedures between those years, for example:

- 75 women were assessed in obstetrics/gynaecology outpatient clinics in 2011/12.
- The number of women receiving treatment by obstetrics/gynaecology specialists increased from 11 in 2011/12 to 88 in 2012/13.

The 2010/11 Annual Report presented a breakdown of visiting medical specialists by gender – with the balance being 9 specialists of each gender. In addition, 80% of the visiting teams have members of each gender, with and CMDHB tries to arrange for the obstetrics/ gynaecology visits to have a female specialist present, where this is possible.

In terms of capacity building activities, the gender of participants in training activities has not been reported – although this appears to be a requirement of the contract. This is an area where reporting could be more detailed. If all training courses collect this information, along with numbers of participants, and it could be collated and reflected in the annual reports.

Anecdotally, it appears that women are well represented for training opportunities, such as visits to Auckland for attachments, conferences and observations – recent examples include the Clinical Director, the Principal Officer for Quality Improvement, and the Manager of Information Systems. The Senior Health Advisor conducts an assessment and considers the requirements of a department, before making a recommendation for an appropriate person. This process suggests that selections tend to be based on merit and organisational need.

4.3.2 Human rights

Health and access to basic health care, at least, is typically understood to be a human right. It is therefore worth considering the extent to which the ILP supports access for those that are often among the most disadvantaged groups – people with disabilities, people in lower socio-economic groups and those that live in rural or remote locations.

In the absence of data on the domicile of patients attending the VMS or ORS, it is not obvious if there are major inequalities in access by area. Intuitively, the population in areas outside Apia and on Savaii may find it more difficult to access services in Apia. Therefore consideration could be given to semi-regular VMS clinics being held outside Apia – where the population and the burden of disease support this. The district hospital in Savaii may be a candidate for some specialties. This approach would be consistent with the NHS intention to strengthen community-based services, particularly if it involves working with the range of nurses in outlying areas (e.g. mental health, maternity and public health are some candidates).

As the ORS only covers treatment costs, access can be a challenge for patients who have been approved for treatment but who are unable to raise the airfare to New Zealand. The 2011/12 Annual Report refers to two patients who were not treated due to cost barriers, while the 2012/13 Annual Report cites a case where time taken to raise the funds meant that the outcome was not optimal – the patient's leg could have been saved with earlier intervention. If these cases are few in number, then it may be worth considering whether there are ways to provide financial assistance to enable the poorest people to access the service. This issue was also raised in the 2004 Review of NZAIDS's Medical Treatment Scheme to Pacific Island Countries. Funds for those in genuine need of support could come from within the ORS or by linking up with government, NGOs or charities in Samoa.

4.4 The Samoa ILP partnership approach and other aid modalities

Clearly, there are different approaches, or modalities, for delivering development aid – as outlined in Table 6. The ILP can be said to be a Programme-Based Approach (PBA) in that involves a programme of activities focused on the NHS with a clear role for the NHS to set priorities, contribute to implementation, and provide an assessment of performance. However we would frame the ILP as a 'PBA with a twist' – as the use of CMDHB as the Management Services Contractor and ILP partner enables a level of partnership that is not typically found in this type of arrangement.

Table 6: Some broad approaches to delivering aid

Approach or modality	Description
Project Support Approach	A series of activities aimed at bringing about clearly specified objectives within a defined time period and with a defined budget.
Programme-Based Approach (PBA)	Based on the principle of coordinated support for a locally-owned programme of development. Aims to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation. Involves leadership from the host country, a single programme and budget framework, and donor coordination and harmonisation of reporting, budgeting, financial management and procurement.
Sector Wide Approach (SWAp)	A sector approach is like a PBA but at the level of an entire sector. Aims to acts to minimise transaction costs incurred by partner governments to ensure greater ownership of development policy, strategy and spending – than compared with the Project Approach. Requires a strong coordination process among donors, an agreed strategic framework and measurable outcomes, and a medium-term financing framework sourced from all funds. An approach promoted by the European Commission.
Budget Support	Involves policy dialogue, financial transfers to the national treasury of the partner country, and performance assessment and capacity-building, based on partnership. The European Commission sets the following eligibility conditions: • A well-defined national or sectoral development or reform policy and strategy is in place. • A stability-oriented macroeconomic framework is in place. • A credible and relevant programme to improve public financial management is in place.

Source: Adapted from European Commission - EuropeAid website

In terms of alternative options, it appears that a Project Support approach, which focuses on predefined and discrete projects, may not offer the same flexibility and inclusive partnership as the ILP. As noted in the recent Health SWAp evaluation, a move to a Project Support approach may be viewed as a backward step given that the Government of Samoa is a strong supporter of harmonised and collaborative approaches. It may also mean reduced scope for a wider dialogue on performance and reform within the sector.[14]

The European Commission sets out some tight preconditions before proceeding with the relatively advanced and mature Budget Support approach. However, some of the problems identified in the Samoa Health SWAp evaluation suggest that this approach is more of a medium-term goal for the health sector as its institutions and capability matures. Some of those identified issues, for example, included a lack of effective monitoring and evaluation mechanisms and health information systems – features necessary to underpin a Budget Support approach.

This suggests the alternative options are the SWAp and the PBA. These two modalities that that the New Zealand Aid Programme has recently pursued in the health care sector in Samoa. More specifically, the high-level choices appear be to:

- Roll the ILP into a SWAp arrangement – there are uncertainties associated with this option, as we understand that the SWAp is unlikely to continue in its present form, given some of the findings of the evaluation and the frustrations experienced by all partners.
- Continue with the ILP under a more typical PBA approach – e.g. a different management arrangement as a MSC (e.g. an NGO or company).

  or

- Continue with the ILP under the current partnership / peer-to-peer mode.

The strengths of the ILP have been its ability to build relationships among clinical, technical and management peers, the ability of CMDHB to tap into its human resources and knowledge of processes and standards etc. These features may be less likely in an arrangement where the MSC did not share the similar mandate and structures as the NHS (i.e. being responsible for the health outcomes of a population and owning and operating a hospital).

Furthermore, the context and culture of the NHS matters; it is a system within a limited workforce that is under time and resource pressures to manage the demand for health care. It also operates in a culture where relationships are paramount and need to be nurtured. If capacity building is seen as a medium-term project in the health sector in Samoa, these contextual issues are more likely to be addressed under a peer-to-peer model that offers centralised skills and knowledge within a 'sister organisation'.

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[14] Davies, P. (2013) *Evaluation of Samoa Health Sector Management Programme (Health SWAp)* (AusAID Health Research Facility: Canberra, Australia). Commissioned by SWAp Development Partners. http://aid.dfat.gov.au/Publications/Pages/samoa-health-swap-evaluation-2013.aspx

Our conclusion is that should the ILP continue to be funded, then the current partnership model is most appropriate and worth persevering with – subject to some strengthened performance accountabilities, which we discuss below.

4.5 Conclusions – addressing the core research questions

4.5.1 Relevance, effectiveness, efficiency, and impact

The Programme provides clearest benefit in treatments (i.e. VMS and ORS) where there is a return in addressing urgent need that may not otherwise be met. Although ORS services are provided to a relatively small number of individuals, many of these are children who will experience lifelong benefits as a result of treatment. The recent increase in resources to the VMS is likely to represent value for money, relative to the ORS, given the more efficient mode of service delivery and the larger service volumes.

We would conclude that it makes sense to look closely at the role of the ORS alongside the Government of Samoa's Medical Treatment Scheme. Comparing the purpose, processes and eligibility criteria of each scheme would help determine whether the ORS is supplementing the Samoan Scheme (i.e. treating patients who may not otherwise be treated) or substitute for expenditure that may occur anyway. This may be best done as part of a formal review, jointly agreed by the governments of Samoa and New Zealand, with the aim of determining how the ORS can best support the Samoan Scheme. Such a review could also look at other models for delivering clinical services, for example, the use of telepresence technology to obtain specialist input into complex diagnoses.

4.5.2 Alignment and integration with the Samoan Government health services

We conclude that there appears to be opportunity for improved connections between the ILP and the Government's vision for development of the Samoan NHS.

From a practical perspective, the ILP is not aligned with timeframes for Health Sector Plan 2008-2018, so there is a risk that crucial capacity building support is pulled out or changed significantly halfway along this pathway.

One of our key findings relates to the lack of linkage between the ILP and the strategic vision for the NHS. The ILP work plans and reports could better describe the Programme's activities contribute to the realisation of NHS desired outcomes and the sustainable models of service delivery that support their achievement. The ILP could then provide inputs, if required, to help the NHS determine what specialties and clinical services the NHS can deliver within country in future (with and without visiting specialist support). The role of the Senior Health Advisor in supporting the production of a NHS workforce development plan is an example of this type of support.

The ILP could then prioritise areas for attention where capability development is required and work in a structured way to ensure the necessary building blocks are in place. Capacity building should be seen as ongoing and incremental game with impacts becoming more

visible after several years – particularly in an environment where there tends to be a high degree of nervousness around change.

4.5.3 Partnership between Counties Manukau DHB and the Samoan National Health Service

There have been clear benefits from the Programme, and particularly from the partnership approach, above and beyond those derived from the pre-existing MTS. Examples are

- Increased clinical networking with CMDHB as an institution.
- The emergence of a 'sister institution' that is responsive and flexible in meeting emerging or unexpected needs within the NHS.

4.5.4 Comparison with other models

The ILP operates under a 'PBA with a twist' model, whereby the use of CMDHB as the Management Services Contractor and ILP partner enables a deeper and more engaged level of partnership that is not typically found in this type of arrangement.

Our conclusion is that should the ILP continue to be funded, then the current partnership model, subject to some strengthened performance accountabilities, is appropriate and should be continued. In comparison with other approaches (project support, SWAp and budget support approaches) we believe that this approach is ideally suited to the context and to the culture of the NHS, where relationships are paramount and need to be nurtured. If capacity building is seen as vital for realising delivery of a more clinically and financially sustainable end-state, there are clear benefits of operating a peer-to-peer model that offers centralised skills and knowledge within a 'sister organisation'.

4.5.5 Other conclusions

Centralised record keeping of Programme service volumes seems piecemeal and does not enable time series picture of performance. High-level reporting on patient outcomes would also allow for judgments to be made about the quality and the effectiveness of treatments.

We would conclude there is scope to improve the annual reporting to MFAT as the funder. This will involve being clearer about the indicators that matter (e.g. measures of gender participation, counts of training courses) and to place the performance story in the context of (a) what was expected and planned and (b) a time series for ILP – so that the funder can see annual progress at the margin.

In terms of information sharing and catch-ups, the expectation should be that MFAT as the funder is debriefed after biannual visits. Face-to-face catch-ups are probably necessary once or twice a year to share information, answer queries, and build confidence.

Reporting to the Samoan Ministries of Health and Finance on the activities of the ILP should be incorporated into sector reporting by the NHS, so this does not introduce an additional or duplicate reporting stream. This reporting should show how activities of ILP have contributed to sector priorities and outcomes.

This increased focus on transparency and appropriate checks and balances needs to be handled without impeding one of the Programme's real strengths – the flexibility to respond quickly to urgent need or changing needs within the NHS.

5. Recommendations

5.1 Overview of approach

This section presents a set of recommendations, based on our conclusions reported in the previous chapter.

As an opening statement, we provide our view on continuation of the Programme and then present our specific recommendations across four key themes: Programme vision; Programme design; Programme implementation; and accountability for performance.

We have framed the recommendations as practical steps in the form of a 26 point plan; if implemented, we believe this would improve the efficiency, effectiveness and ultimately the impact, of the Programme.

5.2 Continuation of the Programme

In comparison with the pre-existing MTS, we believe that there have been clear benefits from the Programme, particularly from the partnership or peer-to-peer approach.

It is easiest to illustrate the benefits derived from patient treatments (i.e. VMS and ORS) where there is a return in addressing urgent need that would not otherwise be met. Although the ORS services, in particular, are provided to a relatively small number of individuals, many of these are children who will experience lifelong benefits as a result of treatment.

In terms of capacity and systems development, work to date has focused on establishing foundational building blocks. This type of work takes time, as do the development of working relationships between the peer-to-peer partners. The impacts of this investment are just beginning to be felt and will take time to fully accrue.

On balance, with some changes to the way that the Programme is designed, implemented and governed (as outlined below), we believe there is value in continuation of the Programme. Halting the Programme now, or making significant changes in approach or direction, would risk a loss of momentum and may mean that the emerging benefits that are beginning to accrue may not materialise.

5.3 Specific recommendations

5.3.1 Programme vision

1. Require the Contractor (by the end of the contract period) to articulate how a future plan for the ILP should link to the strategic vision for the NHS (drawing on the most recent version of the NHS Corporate Plan, the NHS Workforce Development Plan and the Samoa Health Sector Plan). This vision should explain how the ILP could best prioritise its resources and sequence its activities to support the patient health outcomes and capacity development outcomes that the NHS seeks to achieve over the medium term (for example, the next five-to-ten years).

2. Refocus the Programme on the delivery of a more structured, prioritised and sequenced set of interventions that will support the achievement of the NHS strategic vision, with input from the Contractor. The focus should be on capacity development actions that will support the NHS in the change programme required, in addition to provision of services to address the needs identified currently.

3. Retain the peer-to-peer relationship approach as the key element for enabling the activities of the Programme to remain responsive and flexible to NHS needs.

4. Consider a medium-term funding commitment to the Programme, of five-to-ten years, that is aligned with a strategic planning milestone within the Samoan Health Sector (for example, the Samoa Health Sector Plan 2008-2018). This should be subject to a clearer set of Programme outcomes being mapped out for the period of that commitment.

5.3.2 Programme design

5. Require a Programme Governance Committee to be established, with oversight for approving Programme Work Plans and Annual Report. (This action links to the requirement to improve accountability for performance below.)

   (a) The committee should comprise managerial and clinical representation from the Contractor and the NHS, as well as a standing invitation for the MFAT desk officer.

   (b) Ensure that there are clear decision-making processes for the committee.

   (c) Align the meeting schedule for the committee with reporting requirements.

6. Retain the ORS and VMS as discrete components with fixed budgets and consider setting measurable performance benchmarks for the service outputs, subject to the outcome from recommendation 7, below).

7. Consider a joint review of the ORS and the Government of Samoa's Medical Treatment Scheme, to be agreed by the Governments of Samoa and New Zealand, and which examines the purpose, processes and eligibility criteria of each Scheme with the aim of determining how the ORS can best support the Samoan Scheme.

8. Consider other models for delivering clinical services, for example, the use of telepresence technology to obtain specialist input into patient diagnoses.

9. Retain the capacity development components of the Programme, and require the Contractor to ensure that planned activities align with the NHS strategic direction.

10. Ensure that capacity development components of the Programme address the three areas of governance, management and clinical leadership, and that the design of individual capacity development activities draws on best practice principles to ensure that activities are tailored to the environment and to the learning needs of staff (drawing on a range of skills transfer methods).

11. Embed the role of Senior Health Advisor as a contractual requirement, and require it to continue to be filled by an experienced health executive, with a track record of providing strategic and operational leadership within the New Zealand health system.

5.3.3 Programme implementation

12. Require the Contractor to work with the NHS to complete a multi-year Programme Work Plan at the beginning of the contract period, setting out the priorities, sequencing and interim steps and inputs to achieve the capacity development vision by the end of the Programme.

13. Require the Contractor to work with the NHS to deliver an Annual Work Plan ahead of each fiscal year, identifying the detailed activities for the year ahead, and any re-sequencing or new activities necessary to ensure that capacity building remains relevant and aligned with the strategic vision of the NHS.

14. Require the Contractor to agree a revised Memorandum of Understanding with the NHS, so that it: (a) requires the Contractor to work with the NHS to ensure affected staff are informed of initiatives; and (b) places the onus on the NHS to be sufficiently organised ahead of Programme activities and specialist visits.

15. Define a clearer set of financial management rules for the Contractor, including timing and level of detail for setting component budgets, the thresholds for advising any changes in the mix of outputs being purchased and the rules for managing underspends or overspends among the components and across years.

16. Emphasise the requirement on the Contractor to develop and maintain a central database of all countable service volumes and outputs, so that progress can easily be tracked across years.

17. Set an understanding that Biannual Visits of the Contractor to the NHS will be followed by a direct catch up with the relevant MFAT desk officer.

18. Require the Contractor to undertake a more structured approach to monitoring and reporting on capacity development activities, including by:

    (a) Ensuring participants in training courses are provided with feedback forms at the end of each session, so that views on the design, content, delivery, relevance and effectiveness of the training are captured and used to inform the development of future capacity development activities.

    (b) Considering longitudinal monitoring of individual staff development progress, e.g. by way of regular six-monthly self-assessment forms for selected NHS staff.

    (c) Keeping a systematic record of all capacity development outputs (e.g. training sessions), including numbers of staff trained, list of attendees, as well as all feedback from participants and beneficiary staff. These measures would be included in the Programme Annual and Biannual Reports.

5.3.4 Accountability for performance

19. Specify accountability arrangements and reporting requirements for the Contractor (links to recommendation 5, above).

20. Work with the Contractor to define a clear reporting template that is aligned with strategic objectives and defined work plans, and which contains agreed performance indicators and more of an outcome focus.

21. Require the Programme Annual and Biannual Reports to portray progress in a time series context where possible (e.g. service volumes for training and medical treatments) and to consistently capture and report information on the gender of patients treated and of participants on training courses.

22. Require that all issues or risks raised in Annual Reports are accompanied by an action point and are clearly allocated to an individual for resolution.

23. Emphasise the expectation that the Programme Annual Reports will be accompanied by a meeting between MFAT and the Contractor to discuss progress and cover any questions.

24. Set an expectation that the Programme Annual Reports will be tabled directly with the NHS Board for noting.

25. Explore low-cost ways of keeping the Samoan Ministry of Health and Ministry of Finance (responsible for donor co-ordination) informed about work plans and progress e.g. via greater visibility of the Programme within existing reports or holding update meetings as part of biannual visits.

26. Examine ways in which patient health outcomes under the Medical Treatment Scheme could be reported, in a low-cost, summary format, by the NHS to the Programme office. This reporting could be done on an exceptions basis, (e.g. serious or unexpected clinical events) and be used to support annual reporting on ILP effectiveness, as well as NHS quality improvement efforts. Such reporting would need to be sensitive to the limits of existing health information systems and to any planned or likely future development of that system, and avoid establishing a separate system that may be incompatible with a future NHS information system.

Appendix 1: References

Counties Manukau District Health Board (2013) *Pacific Health Development – Annual Plan 2013/14*. Implementing Fanau Ola to realise better health and wellbeing for Pacific families.

Davies, P. (2013) *Evaluation of Samoa Health Sector Management Programme (Health SWAp)*, 21 May 2013. Commissioned by SWAp Development Partners. http://aid.dfat.gov.au/Publications/Pages/samoa-health-swap-evaluation-2013.aspx

Easterbrook-Smith, S. (2009) *The 2009 Synthesis Report on Development Practice Learning.* Prepared for the New Zealand Ministry of Foreign Affairs and Trade.

Easterbrook-Smith, S. and V. Wichman (2011) *Report of the Evaluation of the Cook Islands Medical / Health Specialist Visits Schemes,* February 2011. Commissioned by the New Zealand Aid Programme, New Zealand Ministry of Foreign Affairs and Trade.

Irava, Dr W. (2012) *Comparing costs of cardiac treatment between Government, Private Insurance, and visiting cardiac teams*. Report prepared for the Strengthening Specialized Clinical Services in the Pacific (SSCSIP) project, College of Medicine, Nursing and Health Sciences, Suva.

Ministry of Foreign Affairs & Trade (2010) "Contract for Services – Institutional Linkage Programme for Samoa between Ministry of Foreign Affairs and Trade and Counties Manukau District Health Board", June 2010; CT file: CON/407/3; Koru record ID: 19552.

Ministry of Foreign Affairs & Trade (2012) "NZAID AMS – Programme Activity Authority – Crown Expenditure"; Prepared 19/07/2012; Approved 19/07/2012

Ministry of Foreign Affairs & Trade (2013) "NZAID AMS – Programme Activity Authority – Crown Expenditure"; Prepared 09/05/2013; Approved 11/06/2013

National Health Service (2011) *National Health Service Corporate Plan, 2011-14*.

National Health Service (2012) "NHS Workforce Development Plan" version 15 April 2013.

National Health Service (2012) "NHS Quality Plan, 2013-2015" version 7 June 2013.

Samoa Ministry of Health (2008) *Health Sector Plan 2008-2018* http://www.health.gov.ws

Unknown (no citation on file) (2004) *Report on a Review of NZAID's Medical treatment Scheme to Pacific Island Countries*, February 2004. Commissioned by NZAID.

Appendix 2: List of interviewees

Organisation	Interviewees
Samoa National Health Service	Leota Laki Lamositele Sio, General Manager Uituilagi Dr Tia Vaai, Manager, Clinical Services Leilani Galuvao, Manager, Health Information Dr Ailao Imo, Head of General Medicine Lepaitai Hansell, Principal Officer, Quality Improvement Dr Mau Imo, Consultant/Head of Ophthalmology/Head of Eye Department Dr Farah Fatupaito , Consultant Paediatrics/Head of Paediatrics Unit Dr Pesamino Une, Head of Anaesthesia June Scanlan Lui, Acting Manager: Nursing TTM Hospital Natasha Mamea, CNC, surgery Matilda Nofoaiga, SNS, after hours Asomaliu Tupuola, SNS, medical ward Asenati Tuilaepa, CNC, maternity and neonatal Pisaina Tago, CNC, mental health Matalena Seuseu, CNC, paediatric and oncology
Samoa Ministry of Health	Palanitina Tupuimatagi Toelupe, Director-General Professor Pelenatete Stowers, Manager, Midwifery and Nursing Gaualofa Matalavea Saaga, SWAp Coordinator
Other stakeholders in Samoa	Dr Megan Counahan, Donor Coordinator, Australian Aid Program Latoya Lee, Cancer Society Meaalofa Leota, Cancer Society Peseta Noumea Simi, Aid Coordination Centre, Ministry of Finance Le Mamea Dr Limbo Fiu, NHS Board; School of Medicine Dr Stanley Dean, Oceania University of Medicine Fuimaono Dr Peniamina Leavai, Member, Samoa Dental Association Leausa Toleafoa Dr. Take Naseri, President, Samoa Medical Association Peter Amosa, Samoa Red Cross Tasi Young, Samoa Red Cross Toelau Ese, Samoa Red Cross Donna Lene, Senese Inclusive Education
MFAT	Pete Zwart, Deputy Director - Samoa, Vanuatu, Kiribati Sumi Subramanium, Principal Development Manager Health Laveai Ioane, Regional MTS Activity Manager Maria Reynen-Clayton, Cook Islands Activity Manager Michael Upton, First Secretary Development Karen Punivalu, Senior Development Programme Coordinator Tom Wilson, Development Manager
Counties Manukau DHB	Doleen Raj, Regional Pacific Coordinator Elizabeth Powell, General Manager, Pacific Health Development Alan Wilson, Senior Health Advisor Tania Wolfgramm, Programme Manager
Other stakeholders in New Zealand	Dr C. S. Benjamin, Samoa MTS Coordinator; Mercy Ascot Dr James Hamill, Visiting Medical Specialist, Starship Hospital Tim Malloy, Royal NZ College of GPs

Appendix 3: Interview questions

General questions for all stakeholders

1. What parts of the Programme have gone well? (and why)
2. What parts of the Programme have not gone well? (and why)
3. Have there been any unintended impacts from the Programme? Could they have been foreseen? How have they been addressed?
4. What is the outlook for securing the desired benefits in future?
5. How could the programme be improved? What would you add to the Programme? If you had to drop something from the Programme to enable your preferred addition, what would you drop?

High-level outcomes

6. To what extent has the medical /nursing/allied health capability of the Samoan National Service been strengthened by the Programme? What evidence is there?
7. How does the governance and/or management of health services work? Have there been any improvements in governance as a result of the Programme? What evidence is there?
8. Have there been improvements in the access to care for patients?
9. Have health outcomes improved as a result of the Programme?
10. Have there been improvements in the quality of care experienced by patients?

Planning and processes – questions mainly for administrators

11. What do you think was the Programme was set up to achieve? Where is this documented?
12. Were the issues that the Programme was expected to address clearly defined? Where are they documented?
13. Were the objectives for implementing the Programme clear and measurable? Where are they documented?
14. What benefits did you hope to get from the Programme?
15. What sort of reporting or performance review processes have been put in place?
16. What indicators do you have in place to measure the impact of the Programme?
17. To what extent do the clinical, management and governance staff show confidence in, and commitment to, the Programme?

Operational perspectives – questions mainly for clinical staff

18. Do you think the goals of the Programme are clear? Is the way the Programme is set up likely to deliver on these goals?
19. How is it decided which services are delivered under the VMS versus the MTS?
20. Have you seen any benefits for patients in terms of the quality of their care?
21. What lessons have been learned that you would recommend? Have changes been made as a result of the lesson learned to date?
22. Do you expect further benefits can be secured from the Programme?

Capacity building – questions for Samoan clinical and administrative staff

23. Have you had input into how the Programme is implemented in your work place?
24. How has the Programme impacted on your ability to perform your role?
25. Have you seen any benefits for other staff?
26. What operational policies have been developed as a result of this Programme (e.g. clinical protocols, guidelines)?
27. Have these policies been implemented? If so, how has the implementation process gone? Was the necessary support provided?
28. Have these policies been monitored? If so, have any changes been made as a result?

Appendix 4: Visiting Medical Specialists – visiting teams

Specialty	2010/11	2011/12	2012/13	Count
Obstetrics & Gynaecology	Y	Y	Y	3
Ophthalmology	Y	Y	Y	3
Paediatric Surgery	Y	Y	Y	3
Cardiology		Y	Y	2
General surgery		Y	Y	2
Neonatal		Y	Y	2
Paediatric	Y		Y	2
Paediatric Cardiology	Y		Y	2
Respiratory & Infectious Diseases	Y	Y		2
Urology	Y	Y		2
Bio-medical engineering		Y		1
Cardiac Echocardiography			Y	1
Dermatology		Y		1
Mental Health			Y	1
Paediatric Respiratory			Y	1
Pain Management			Y	1
Palliative Care			Y	1
Physiotherapy	Y			1
Respiratory	Y			1

Source: ILP Annual Reports