WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

An evaluation of

Comprehensive Primary and Community Care Teams (CPCT) in Southern

Part One: Design and Early Implementation

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Acknowledgements

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Karakia

Tutawa mai i runga

Tutawa mai i raro

Tutawa mai i roto

Tutawa mai i waho

Kia tau ai

Te mauri tū

Te mauri ora

Ki te katoa

Haumi e

Hui e

Tāiki e

Come forth from above, below, within, and from the environment
Vitality and wellbeing for all
Strengthened in unity

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EXECUTIVE SUMMARY

Background

In 2022, Te Whatu Ora and Te Aka Whai Ora funded Comprehensive Primary and Community Care Teams (CPCT) across Aotearoa New Zealand. The aim was to expand the capacity and capability of primary and community care by incorporating additional roles, with a focus on populations at greater risk of experiencing inequitable health outcomes. WellSouth is responsible for coordinating the implementation in Otago and Southland (Southern) and the national operating framework affords substantial flexibility in regional design and implementation. This report presents a process evaluation that sought to identify what worked well and areas for improvement in the implementation process, and to understand more about how CPCT is operating across Southern.

Evaluation methodology

The evaluation structure comprises four pillars: capacity, capability, access, and partnerships. These pillars guided the creation of key evaluation questions. A mixed methods approach was taken consisting of: [1] a document review summarising the different models of care, [2] 21 semi-structured interviews, with 32 participants representing 17 organisations (internal staff and external CPCT providers), and [3] a quantitative survey for external CPCT focused on perceptions of partnership working, for which there were 7 responses. Despite the low survey response rate, results were triangulated with interview data to provide a comprehensive and in-depth account of the implementation of CPCT in Southern.

Evaluation findings

Documenting models of care

WellSouth facilitated the formation of eight clusters to deliver CPCT. Clusters consist of a mixture of general practices, Māori Community Providers and Pacific Community Providers. At the time of review, the model of care for most clusters had not yet been finalised. Instead, three employment model categories were identified: [1] community provider(s) manage FTE, [2] general practice(s) manage FTE, and [3] split FTE.

Interview findings

Six themes were identified from the interviews: [1] positivity for collaboration and new ways of working, [2] striking the balance between structure and flexibility, [3] importance of communication and impact on relationships, [4] barriers to collaboration and service delivery, [5] internal process improvement opportunities, and [6] looking to a future beyond CPCT.

Survey results

Survey respondents indicated to what extent a series of items reflected their experience, on a scale of 1 to 6. A score of 1-2.5 indicates a problematic area, 2.6-4.5 indicates room for improvement and 4.6-6 indicates high performance. The average score was 4.1, suggesting some room for improvement. No items had an average score that indicated a problematic area. Results generally aligned with the qualitative interview findings. The highest scoring area was readiness to change. The lowest scoring areas were trust and systems thinking.

Key learnings

Addressing the evaluation pillars

Capacity: Through the additional roles, CPCT providers reported having more capacity to provide patient care. To provide ongoing guidance to CPCT providers, and support timely implementation, additional staff time was provided to the implementation FTE from within existing WellSouth capacity.

Capability: CPCT was reported to have increased the capability of the primary care workforce through the addition of new services, facilitating knowledge sharing (including to enhance the cultural capability of practices), and mobilising the workforce to deliver more care in the community.

Access: Anecdotal evidence suggests CPCT is increasing access to primary care, however, complexities around consent was identified as a barrier to establishing some referral pathways.

Partnerships: Relationships and partnership working were key to the CPCT implementation. The opportunity to build and strengthen relationships with other providers was emphasised by many as one of the most valuable aspects of their involvement in CPCT, and WellSouth's role in facilitating this was greatly appreciated. CPCT providers also had mostly positive experiences working with WellSouth, although some areas for improvement were noted.

Lessons learned, f*uture considerations*

Evaluation learnings and subsequent future considerations can be grouped into four main areas.

- **Relationships and collaboration:** All participants emphasised the value in general practices and community providers being brought together. The opportunity for WellSouth to support the establishment of a regional CPCT network and the value in WellSouth continuing to develop its network coordination role beyond CPCT to facilitate relationships was also discussed.
- **Extent of regional guidance:** CPCT providers appreciated the flexibility afforded by WellSouth's approach. WellSouth may consider the provision of further guidance to support CPCT providers to overcome barriers establishing new referral pathways and making available a suite of resources to support providers when designing future new initiatives.
- **Internal WellSouth processes:** Benefits of robust project management practices were identified, some of which had been initiated. If time allows, staged rollouts for large initiatives, with a prototype to test for and overcome issues on a small scale, could be considered.
- **Future funding and contracts:** Anecdotal evidence of positive outcomes and reported losses associated with ending the service supports the continuation of funding for CPCT. For funding more broadly, longer-term contracts, greater alignment between contracts, discretionary funding, outcomes-based contracts, funding that recognises the value of and adequately resources whakawhanaungatanga, and more funding directed to specialist training and workforce development pathways, should be advocated for.

Conclusion

The implementation of CPCT has generally been well received, being described as worth the effort, valuable and addressing previously unmet needs. The opportunity for organisations to build new and strengthen existing relationships was a key highlight of the implementation process for all involved. Future initiatives will likely follow a similar collaborative approach and so learnings will be valuable.

BACKGROUND

Comprehensive Primary and Community Care Teams

Through Budget 22, Te Whatu Ora and Te Aka Whai Ora partnered to fund the establishment of Comprehensive Primary and Community Care Teams (known herein as CPCT) across Aotearoa New Zealand. CPCT aims to strengthen primary and community care by incorporating additional roles such as physiotherapists, pharmacists, care coordinators and kaiāwhina. This overarching aim is underpinned by a series of objectives, including to: expand the capacity and capability of primary and community care by broadening the range of services available, improve access and equity of access to care, enable early intervention and preventative care, build the sustainability of the primary and community care sector, and develop and strengthen partnerships within the sector.

By focusing on populations at a higher risk of inequitable health outcomes, including Māori, Pacific Peoples, tāngata whaikaha (disabled people), rural communities and people living in areas with high deprivation, it is hoped that CPCT will improve equity of healthcare access and health outcomes. The national operating framework sets out how the principles of Te Tiriti o Waitangi should be applied in the implementation of CPCT. It states that CPCT should "nourish Kaupapa Māori support services" and "ensure auraki/mainstream services are supported" to deliver care that is responsive to the needs of whānau Māori, through partnerships and co-design that support rangatiratanga. It is also stated that CPCT is "underpinned by ensuring there are Tikanga Māori and Pacific models of care".

In the first phase of the national roll out of CPCT, Te Aka Whai Ora directly commissioned kaiāwhina roles for some Hauora Māori and Pacific partners, including organisations in Southern. Resource was also provided directly to the twelve early localities that were established under the Pae Ora legislation. However, following the change of government in 2023, Te Aka Whai Ora was disestablished and the roll out of the remaining planned localities was not progressed. This meant that priorities were realigned, and the pre-existing locality network structure could not be used for phase two of the CPCT implementation in which resource was provided across the rest of the country. Primary Health Organisations (PHOs) were responsible for the coordination of the programme across each of their districts during this second phase.

The national operating framework states CPCT "will be locally led, regionally coordinated and nationally supported", with organisations provided flexibility to operate at a local level to meet the needs of their community. The framework also emphasises collaboration and partnership. In addition to the framework, a small number of other national resources were provided, including a service specification and draft role descriptions. The documents offer high-level guidance, not strict design parameters. This means a range of approaches to CPCT have been adopted nationally and regionally.

The approach to CPCT in Southern

Organisations within the Hokonui locality were commissioned to implement CPCT in their area as part of the roll out with localities. WellSouth were tasked with the remaining implementation across Southern. Following a similar approach to that utilised in Hokonui, WellSouth made the decision to support the original localities-based model to establish collaborative clusters across the district

involving general practices, Māori community providers and Pacific community providers. This approach aligns with the focus on strengthening partnerships, connections, collaboration and the co-ordination of care between providers set out in the contractual service specifications, and WellSouth's strategy. It also differs from some approaches employed by other PHOs, for example those who have used the funding to directly recruit a number of roles to work across several practices.

It was planned to establish nine clusters: Central Otago, Clutha, Dunedin, Fiordland, Invercargill, Queenstown, Southland, Waitaki and Wānaka. Despite taking inspiration from the premise of a locality provider network, many of the clusters were being established in areas with no existing network and without the Locality Network Support Services that supported the creation of localities. At the time of the evaluation, eight of the nine clusters had been established. Unless otherwise specified, these eight clusters –plus Hokonui where relevant– were the focus of this evaluation.

The need for evaluation

The addition of new roles into primary care, and doing so by establishing collaborative clusters, builds upon a move from the traditional general practice model to a more allied health approach; a direction which aligns with that of other commonwealth nations[1]. The approach to CPCT in Southern is largely relevant to the priority areas set out in the Government Policy Statement (GPS) on Health 2024-2027, which sets out the current government's priorities and expectations for New Zealand's health system. For instance, the GPS refers to improving access to primary care through increasing options and entry points, developing models of care that are "closer to home", and faster access to general practice. Given the synergy between CPCT and the GPS, it is anticipated that, despite the decision not to progress the establishment of localities, future contracts will likely continue to follow collaborative, community-based and allied health models. Therefore, there was an appetite from WellSouth to learn from the implementation process, in terms of good practice and areas that could be improved for future initiatives. Due to the scope for local variation, there was also interest in understanding more about how the programme is operating across the different clusters.

This evaluation was a process evaluation, meaning the primary focus was on design and implementation processes. Exploring outcomes of CPCT, not only for communities but for primary care and the wider health care system, is also worthwhile. However, the programme was still in its infancy in many areas at the time of evaluation commencement. For this reason, it was agreed that the evaluation would be conducted in two parts: the first part focusing on learnings from the design and implementation process, and the second part having a greater focus on programme delivery and to what extent the programme is making a difference to the staff and communities involved. This report presents part one of the evaluation only; part two and a synthesis will follow separately. Although there was mention of a national formative evaluation of the service, the evaluation team is not aware of any plans to undertake an evaluation at a national level, rather several other PHOs are in the process of conducting regional evaluations. The Southern evaluation findings, particularly the findings relating to outcomes in part two, may be presented in combination with findings from other PHOs to create a more comprehensive picture of the national impact of CPCT.

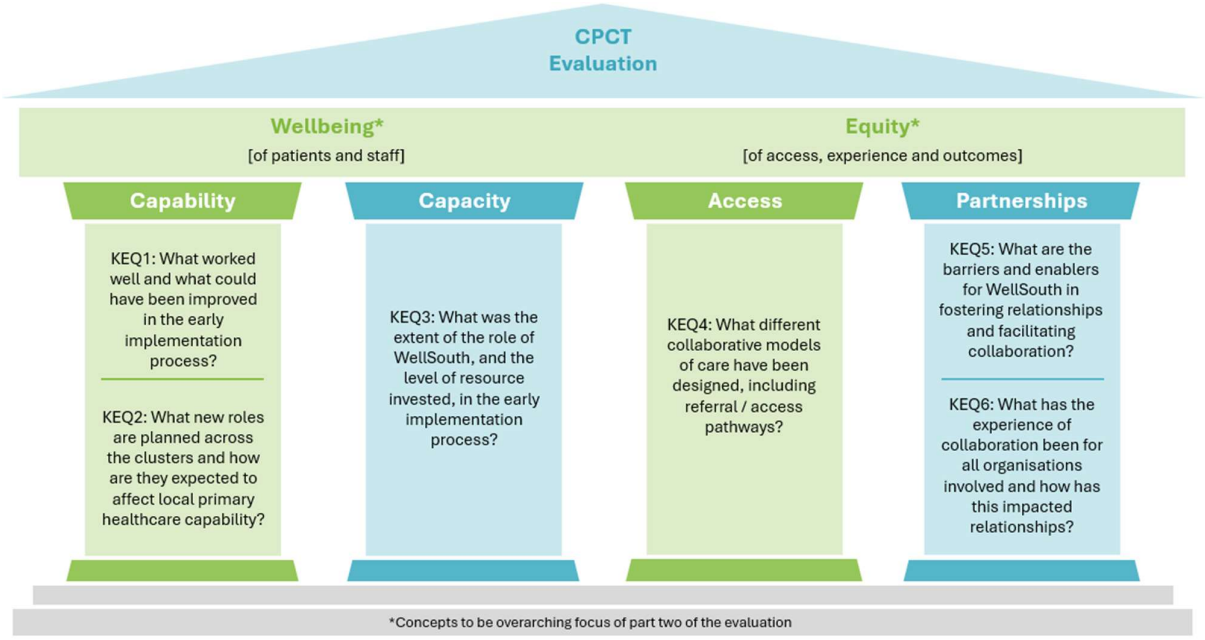
[1] Such as the Primary Care Network Directed Enhanced Service in the UK and implementation of the National PHN Allied Health in Primary Care Engagement Framework across Australia

EVALUATION METHODOLOGY

Key evaluation questions

Developed through the evaluation planning process, and derived from a review of the national CPCT objectives, the evaluation structure comprises four pillars: capacity, capability, access and partnerships. These four concepts are guided by six key evaluation questions (KEQs) that underpin the approach to part one of the evaluation, detailed within the relevant pillars in Figure 1 below. Together, the four pillars support two overarching concepts –wellbeing and equity– that will predominantly be explored within the second part of the evaluation.

Figure 1. Evaluation structure and key evaluation questions for part one of the evaluation



Data collection and analysis

Data collection

A mixed methods approach was employed for the evaluation, consisting of three core components: a document review, qualitative interviews, and a quantitative survey. The document review was undertaken to inform the different models of care being established by each cluster. This approach was supplemented by information gained during some of the interviews and by obtaining clarification from the WellSouth CPCT Project Lead.

Semi-structured interviews were conducted with WellSouth staff who were identified as being involved in the CPCT implementation. General practices and community providers in established CPCT clusters (herein known collectively as 'CPCT providers') were also invited to participate in a semi-structured interview. Invitations were led by WellSouth's Primary Care Relationship Managers,

Māori Clinical Advisor, Pacific Clinical Advisor and Pou Tōkeke team, due to existing relationships and knowledge on preferences for engaging with WellSouth. All interviews were conducted by the lead evaluator and priority was given to conducting interviews in person where possible.

An online survey was distributed to general practices and community providers with some involvement in CPCT (not restricted to established clusters) to explore perceptions of the co-design process and partnership working. The survey also intended to reach anyone who did not feel comfortable speaking directly to the evaluation team. The survey was shared by WellSouth's Primary Care Relationship Team, CPCT Project Team and Evaluation Team over a two-month period. Based on the *He Pikinga Waiora (HPW) Framework Process Evaluation Tool*[2], the survey consisted of 32 items representing three of the four elements that underpin the HPW Framework: community engagement, cultural centredness and systems thinking. The fourth element of integrated knowledge transfer has been incorporated into the plan for part two of the evaluation. Survey respondents advised to what extent each item was an accurate reflection of their experience on a six-point scale.

Participants

In total, 23 interviews were completed, with 34 individuals representing 17 organisations. Participating organisations spanned all nine of the established CPCT clusters[3]. Further detail is provided in Table 1.

Table 1. Total number of interviews, participants, clusters and organisations, by organisation type

Organisation type	Interviews	People	Clusters	Organisations
WellSouth	8	11	N/A	1
Māori Community provider[4]	3	4	6	3
Pacific Community provider[4]	3	6	7	3
General practice	9	13	9	10
Total	**23**	**34**	9	**17**

The online survey was completed anonymously except for the organisation's CPCT cluster. There were seven responses, spanning five clusters: Central Otago (*n*=1), Queenstown (*n*=1), Southland (*n*=3), Waitaki (*n*=1) and Wānaka (*n*=1). This equates to an estimated response rate of 23%[5].

Data analysis

The qualitative interview data was analysed using reflexive thematic analysis[6]. Comparative analysis was then conducted to explore any variations in the experiences or perceptions of: [1] WellSouth staff

[2] https://www.hpwcommunity.com/evaluation

[3] For the purpose of the interview analysis and findings, Hokonui was considered as a ninth cluster, as experiences did not differ substantially from those of the WellSouth established clusters.

[4] Several community providers are working across multiple clusters.

[5] The response rate has been calculated based on the survey dissemination by WellSouth. Invitees were encouraged to share the survey link with relevant colleagues. These occurrences were not captured; therefore the response rate is an estimate.

[6] Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), pp. 589–597

compared to CPCT providers, [2] general practices compared to community providers, [3] WellSouth established clusters compared to Hokonui, and [4] clusters in different employment model categories (determined through the document review). Descriptive statistics were calculated to summarise the quantitative survey data. Further statistical analysis was not conducted due to the low response rate. Relevant findings from each data source were integrated to provide a focused answer to each of the key evaluation questions and findings were shared with participants through a sense-making session.

Strengths and limitations

Generally, the evaluation team experienced a good response rate for the qualitative interviews. There was representation across all clusters, spread across general practices, Māori community providers and Pacific community providers. There were a range of perspectives, including differing cultural worldviews, rurality and contract types. Participation was lowest from general practices, at 40%. Data saturation, the point at which it is believed that additional data will not provide any new insights, was reached prior to completion of the interviews. This means the evaluation team have confidence that the evaluation report is a comprehensive account of the implementation of CPCT in Southern.

Every effort was made to emphasise the evaluation team's independence from CPCT, funding allocations, and WellSouth's management structure, to protect participant identity and foster whanaungatanga. Based on the range of positive and negative experiences each participant shared, the evaluation team believe that the findings are an open and honest reflection of what occurred. Nevertheless, it should be acknowledged that a power imbalance may have been present between a) the evaluation team as WellSouth staff members and participants from the CPCT providers as funding recipients, and b) the evaluation team as internal WellSouth staff members and colleagues as participants. The evaluation team is also cognisant that the pākeha perspective from which data was collected may have restricted the extent to which some participants felt able to discuss cultural values and concepts. Cultural peer reviews were undertaken by WellSouth's Māori and Pacific Clinical Advisors, recognising the influence the perspectives of the evaluation team may have had on the interpretation of findings.

Furthermore, the findings from the qualitative interviews were triangulated with the survey results, to which they were well aligned. Utilising the survey data to enable methodological triangulation adds depth and credibility to the findings.[7] It should be acknowledged that, although the survey was disseminated using multiple communication channels over several months and issuing multiple reminders to maximise engagement, participation remained low. Half of the clusters were not represented in the survey data, and it cannot be assumed that the views of a single organisation reflect the whole cluster. Therefore, interpretations made from the survey data alone are limited but there is value in the complementary insights.

Overall, the evaluation provides a comprehensive account of the implementation of CPCT in the Southern district. The evaluation team are also not aware of any other evaluations of CPCT that have reached completion, making this the first formal evaluation nationally.

[7] Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research, 6*(1), pp. 97-113.

EVALUATION FINDINGS

The evaluation findings are broken down into three parts: an overview of the different models of care, the interview findings, and the survey results. The integrated findings, as they pertain to each evaluation question, are presented in the 'key learnings' section.

Documenting models of care

As expected, at the time of the first stage of the evaluation, clusters were at differing stages in the development and delivery of their CPCT model of care. Statuses ranged from not yet being established (not having signed contracts in place; excluded from this analysis), to undertaking recruitment, to having staff employed in CPCT roles for numerous months. For most clusters, including those with staff in place, discussions were still underway to establish a formal model of care. It was therefore not possible to document individual models of care in detail. Instead, an overview of the structure of CPCT for WellSouth established clusters was documented primarily using contract data, and individual cluster models of care will be explored in more detail in part two of the evaluation.

Cluster compositions

Each cluster consists of a mixture of general practices, Māori community providers and/or Pacific community providers, plus, for the clusters who chose to include a pharmacist role, these roles are based within a general practice but the employment contract is held by WellSouth. Clusters range from a minimum of four (including WellSouth) and a maximum of eight CPCT providers (see Figure 2). The number of general practices ranges from one to six per cluster, with a total of 27 involved in CPCT. In relation to community providers, there is one Māori provider in each cluster, except for one cluster where there are two. Additionally, one Pacific provider is in each cluster, apart from one cluster where there is no representation. In total, six Māori providers and three Pacific providers are involved in CPCT across the region, meaning that four community providers (two Māori and two Pacific) are operating across multiple clusters.

Figure 2. CPCT provider compositions for each WellSouth established cluster

Employment model categories

The funding for each cluster was primarily contracted by WellSouth in one of two ways; the FTE funding allocation was split either across the community provider(s) or the general practices to manage employment. Plus, one cluster split into two subgroups using a mixture of these two FTE options and another split the FTE allocation across all the organisations involved. Therefore, this resulted in three high-level employment model categories that were used in later analyses: [1] community provider(s) manage FTE, [2] general practice(s) manage FTE, and [3] split FTE. The number of clusters in each category is summarised in Table 2.

Table 2. Frequency of employment model categories across CPCT clusters

Employment model category	No. of clusters
General practice(s) manage FTE	3
Community provider(s) manage FTE	3
Split FTE	2

Organisations who were not responsible for the employment of any CPCT roles were provided with staff release funding in recognition of time spent as part of the cluster, for example participation in co-design sessions or attendance at interdisciplinary case meetings. The intention behind the formation of clusters was for all organisations within each cluster, regardless of who employed the FTE, to benefit from the service provided by CPCT. There is flexibility for the organisations to then agree how this will work within their cluster by developing their own cluster model(s) of care.

Early examples of collaborative models of care include several organisations pooling their FTE allocation together into one role that would split their time across locations, bolstering funding to an existing service or programme that can be accessed by multiple CPCT providers, and creating referral pathways for patients from organisations without the FTE contract into the new service. At the time of writing, designs were still in the process of being realised in many areas. A full breakdown of each cluster, by organisational composition, employment model category, recruitment status, and selected CPCT roles can be found in Appendix 1.

Interview findings: Experiences and feedback from participants

There were six overarching themes identified from the qualitative interviews: [1] positivity for collaboration and new ways of working, [2] striking the balance between structure and flexibility, [3] importance of communication and impact on relationships, [4] barriers to collaboration and service delivery, [5] internal process improvement opportunities, and [6] looking to a future beyond CPCT. An overview of the axial codes that constituted each theme is set out in Appendix 2. Each theme will be described in turn, highlighting differences between WellSouth staff and CPCT providers, GP practices and community providers, or model of care categories, where identified. Hokonui's experience did not significantly differ to that of the WellSouth established clusters, therefore distinctions were not made.

Positivity for collaboration and new ways of working

WellSouth's approach to CPCT stimulated the growth of intra-cluster relationships, as it "brought them [CPCT providers] together to talk around a table in an opportunity that they've never really had before". Whakawhanaungatanga is a fundamental principle for collaboration and co-design.[8] Incorporating the facilitation of whakawhanaungatanga into the implementation was heralded by WellSouth staff as "a massive, massive step forward", "invaluable" for collaboration and partnership working, and aligning with WellSouth's strategy. CPCT providers echoed the sentiment of WellSouth staff in the value of being brought together with other organisations in their area. In some cases, organisations were not even aware of each other's existence prior to CPCT but now they are able to contact each other for advice or support, and it was acknowledged that "none of that would have happened before this [CPCT]". In fact, across all participants, new working relationships, especially between general practices and community providers, was the most frequently reported positive outcome from the design and early implementation stages. It was therefore evident that the objective of CPCT to develop and strengthen partnerships is being achieved.

> *The biggest positive of all this is that I actually have got people I can call on at times when I wouldn't necessarily have known where to start looking for information or assistance for some of our patients, so that has been huge*
>
> *General practice*

> *We're starting to see some referrals coming through from the GP practices, so I think the CPCT model is starting to take shape … we see the value in this model, and we hope it's [funding] going to roll over because it's brought us and the Runanga closer together to work together, and now we're looking at other opportunities to collaborate*
>
> *Community provider*

Both CPCT providers and WellSouth staff shared examples which demonstrated that new pathways between services are emerging, within clusters and with the wider health system, and that CPCT is contributing to a shift toward a more allied health approach to primary care. Even in clusters where the FTE has been split rather than shared, there were examples of strengthened relationships and collaboration. In fact, there was an appetite from providers for WellSouth to facilitate more networking, within clusters and at a regional or national level, to share learnings and ideas. It was also suggested that collaboration "might be easier going forward", for future initiatives beyond CPCT, now groundwork has commenced.

Even though collaborative models of care were still being finalised in many areas, CPCT providers anecdotally reported that they "can see the difference in the impact that it's having". Aligning with the programme objectives, they shared good news stories of avoiding hospital

> *There are various programmes that come through WellSouth, but not all of them are probably what I would say worthwhile, but this one I do, for sure*
>
> *General practice*

[8] Wakefield, R. E. (2019). What is co-design in a Māori space? Kotahitanga in action. *Te Kura Nui O Waipareira,* 3, pp. 14-19.

admissions and readmissions, reducing pressure on GPs, increasing access to primary care –by setting up new services and facilitating transportation – and working to reduce health inequities for Māori, Pacific, rural and high needs patients. In addition to patient outcomes, there was also some recognition of positive impacts for practice staff who are "adding value to their scope of practice" and feeling enthusiasm and excitement at the wider potential of these new roles and ways of working.

Overall, most participants saw a lot of value in CPCT and felt it was working toward "meeting a need in the community that was known but never addressed". There was a trend that the greatest value was perceived by CPCT providers who manage an FTE contract, however one participant noted they needed time for the model of care to be further developed before they felt able to comment on the value of CPCT. Further, the few participants who did not recount positive patient outcomes –in clusters where the collaborative model of care remained in development– still affirmed the benefit of being brought together. These was also an appreciation that the funding model had some cognisance of the importance of, and resource investment involved in, whakawhanaungatanga and nuturing the Vā. Several participants therefore indicated that WellSouth's approach to CPCT resonates with Te Ao Māori and Pacific cultural values in relation to the significance of relationships, something that was praised by community providers and general practices alike.

> *So, the relationship is always key, you know like in Māori and Pacific providers, for us that's quite a critical component for us to be able to establish really good, healthy working relationships... there was some funding allocated for even just having the meetings together, which has been awesome*
>
> *Community provider*

Striking the balance between structure and flexibility

> *It was good to give us consideration ... for us [the care coordinator] was the only one that could work, and it was broad enough that you could slot anything into that really, [so] it did work quite well because our needs will never be the same as an urban setting*
>
> *General practice*

There was a great appreciation for the level of flexibility WellSouth provided. Both internally and externally, there was positive feedback on WellSouth's cluster approach. Several CPCT providers noted that the approach acknowledges that "the needs are different" across the district and the flexibility for clusters to operate in different ways was enabling CPCT to better meet local need. This was especially the case for rural practices and community providers, who suggested that the differing needs of rural communities, including travel to access both patients and services, can often be overlooked. The broad scope and flexibility of the draft role descriptions was also mostly well received as it allowed for adaptation to meet local need.

However, at times some CPCT providers felt this flexibility was applied inconsistently, such as the decision for the FTE to be split in some clusters but not others, creating a point of tension. It was therefore suggested by some participants that an element of structure can support consistency and help to set clear expectations. Overall, participants accepted that being able to "strike the right

balance between being programmatic and being flexible to what local people want" will always be a challenge, although it was suggested by several CPCT providers that greater transparency and accountability in relation to decision-making may support greater consistency and clarity around reasons for decisions.

Another disadvantage of high flexibility and a wide scope identified by some CPCT providers, particularly relating to the national guidance, was the risk of a lack of clarity over direction or parameters. There was general agreement across stakeholders that the national operating framework was confusing and ambiguous. Having WellSouth's support to translate the national guidance into something easier to digest and operationalise locally was considered valuable to many CPCT providers. In fact, one participant acknowledged that, without WellSouth's guidance, they may have given up.

> *[WellSouth] was very good at actually guiding or leading us into, you know, what we could and couldn't do. I think if we didn't have that relationship, we probably wouldn't be doing the programme*
>
> *General practice*

Although opinions on the optimum level of regional guidance varied, the general sentiment from CPCT providers was that more guidance from WellSouth would have been appreciated. WellSouth staff acknowledged that they under-estimated the level of guidance that most clusters wanted to design their own model of care. Ideas from CPCT providers for additional guidance focused on providing examples, ideas and information rather than instructions. Overall, there was a sense that CPCT providers wanted guidance in alignment with the concepts of partnership and rangatiratanga, to support them to make decisions for their community rather than have decisions made for them.

Importance of communication and impact on relationships

> *I liked that it was just one point of contact … I didn't have to talk to three different people, you know how that can be so frustrating and it's like that with a lot of our contracts … you're chucked around all over the place when I'm always thinking I just want one person*
>
> *Community provider*

There was an overall sense of positivity from the CPCT providers regarding their relationship with WellSouth and staff were described as "great", "really good", "very helpful" and "fantastic". Specific aspects participants pinpointed included staff being knowledgeable and approachable, feeling at ease asking questions or for help, and having one point of contact. Clear, concise and distinguishable communication was also noted as helpful due to the mass of correspondence often received.

Trust, which is a central component in WellSouth's strategy and the HPW framework, was also emphasised as a core element of whanaungatanga, especially by community providers, several of whom were mindful that relationship dynamics, including a "power imbalance" stemming from WellSouth holding funding, can make establishing trust more difficult to achieve. A few participants from general practices also noted the importance of organisational trust in partnership working, and that poor experiences from unclear or a lack of communication can pose a risk to organisational trust.

For the most part, the CPCT providers felt like they were kept informed and communication from WellSouth was good. However, at times they faced long waits for updates or, occasionally, received no response at all. There were also several examples recounted by CPCT providers, both general practices and community providers, of WellSouth providing mixed or incorrect information that set false expectations. Whilst acknowledging the uncertainty in which WellSouth staff were operating, it is important to note that these experiences resulted in those CPCT providers feeling "let down", "frustrated", "demoralised" and that some of their time had been wasted, compromising the trust those providers had in WellSouth.

> *I think there has been mixed messages with communication around what's okay or not okay... So, in terms of relationships, I suppose there is some cynicism and there is some lack of trust in some areas, but in other areas we feel really well supported*
>
> *General practice*

There was some acknowledgment from WellSouth staff that, in seeking to build and maintain good relationships by accommodating requests, there were sometimes instances of over-promising something that it was later established could not be delivered upon. Some mixed messages were also attributed to internal breakdowns in communication. Instances of limited information sharing between WellSouth staff was something a small number of CPCT providers pointed out, with one participant questioning: "I know WellSouth is huge, but I do wonder sometimes if anyone actually speaks to anybody ... you sort of have these same conversations". Frustration at repeating the same information to different parties also reinforces the positive feedback from others on the value of having a single point of contact within WellSouth.

Barriers to collaboration and service delivery

The nature of the short-term CPCT contract, given the change in government, led to a time-constrained environment for implementation. This presented for WellSouth staff as feeling pressure to act quickly, therefore limiting time on early planning and not taking a staged approach to the clusters or contracts. For CPCT providers, the short-term contract resulted in struggles to recruit to fixed-term roles, especially in rural areas, and not considering it worthwhile to invest valuable resource in change only for the short-term. Both WellSouth staff and CPCT providers also voiced concern that the time it takes to embed new processes may not be acknowledged when measuring outcomes or determining value over the short term.

> *If we know this is going to be year after year, then you'll invest more in putting some more robust systems in place, but if it's not going to be year after year then you probably wouldn't invest as much energy into creating some systems and processes*
>
> *General practice*

It was also acknowledged that the move toward a multi-agency and allied health approach and away from the concept that patients can only be engaged with one provider is a big shift for some organisations, and change takes time to embed. Several participants noted that change fatigue can exacerbate resistance to change, yet "WellSouth like to change things up" and the flow on effect of those changes should be considered more. Furthermore, there was some recognition of the time it

takes for organisations who work in different ways to learn each other's needs and how they can work together in a way that protects the needs of all. It was also evident that, in places where working relationships already exist, collaboration is easier and quicker to achieve, compared to areas where this is not the case. WellSouth's role in facilitating learning opportunities and discussions was acknowledged by both CPCT providers and WellSouth staff, recognising that "it's challenging when people disagree… but it's a good thing to have those new conversations". This reinforces the value of WellSouth's role as a "network organisation, that networks providers together".

> *It's still quite new, you know, it's a new concept to them so I think they're just kind of learning how to work with us, and likewise vice versa*
>
> *Community provider*

Both WellSouth staff and CPCT providers highlighted the complexity of coordinating "many moving parts", such as keeping track of multiple contracts, associated administration and logistical challenges arising from aligning schedules. Several participants from both general practices and community providers discussed that, whilst acknowledging the benefits of whakawhanaungatanga, "where there's no purpose it can just become another nice cup of tea to have" and "it's good to have some action points to follow up on as well". This suggests that, especially with the constraints of being time poor, there is a balance to be struck between surface-level networking and building meaningful relationships with organisations where there is likely to be value in doing so. Despite the additional complexity and administration associated with the approach taken, it is important to acknowledge that WellSouth staff and CPCT providers generally considered the experience as worth the effort.

> *We're a little bit stuck with the referral pathway… We've got heaps of patients that are due for a whole lot of proactive care, but they never come, they might engage more with [community provider] … but it's really hard to get consent from them to send a referral*
>
> *General practice*

Where collaborative models of care were being designed, particularly for clusters that have adopted a 'community provider(s) manage FTE' employment model approach, blockages in referral pathways were the main barrier to service delivery. In particular, the more collaborative clusters were struggling to send referrals without a secure IT platform to share data between organisations. Aside from IT security, data protection and privacy issues were also a barrier to setting up formal referral pathways, especially between general practices and community providers. Whilst data sharing is an issue that spans beyond the confines of CPCT, it was suggested by several participants that if staff with clinical experience were more involved in the planning and design, these concerns may have been identified earlier on.

Internal process improvement opportunities

A challenge consistently highlighted by CPCT providers was experiencing protracted processes and long delays, particularly in the early introduction and contracting stages. Descriptions of the experience included "disjointed", "drawn out", "dragging on" and "lots of delays". There was also

some uncertainty, especially in the introductory stages, regarding the finer detail of how CPCT was expected to work, with some of the information provided described as “an awful lot of preamble" that was “like wading through treacle”. Additionally, for some CPCT providers, a high level of administration was highlighted and there was a small amount of confusion over the wording of contracts, especially for those organisations not directly employing any FTE. Knock-on effects for CPCT providers of long and potentially laborious processes included time away from clinical work, loss of motivation, doubt over whether it was worth persevering, and concerns about the impression of the provider’s organisation to potential new staff.

> *I got very disillusioned with the whole thing because it took so long, and it was lots of messages. I was just- I just got sick of listening about it and I thought I am not even sure where it’s going to go and so why [bother]?*
>
> *General practice*

WellSouth staff were cognisant of the fact that protracted processes negatively impacted on the experiences of the CPCT providers and perceived that some internal processes were less efficient than they could have been. Primarily, these centred around more robust documentation, role parameters and decision-making processes. Once these areas were identified, additional staff time was also given alongside the FTE allocated to the implementation to support progress, including the introduction of a project oversight group that met at regular intervals.

It was also acknowledged that the decision to take an iterative approach, influenced by time pressure, meant the design and implementation of CPCT happened simultaneously. Whilst this approach supports flexibility to adapt to local needs and to pivot when unexpected challenges arise, it also meant solving problems on the go and making repeated alterations, which impacted on the experience for the CPCT providers, particularly through increased administration. Some participants, both WellSouth staff and CPCT providers, suggested that, more internal planning prior to involving the providers may have removed some of the uncertainty they experienced during the early stages.

> *It was overwhelming that they all got rolled out practically at the same time, so it was just constant emails and calls … it was a little bit too much*
>
> *Community provider*

An alternative approach proposed by several participants, which resonated with some WellSouth staff and community providers working across multiple clusters, was “expanding slowly” by implementing one cluster at a time. By taking a staged approach starting with a prototype cluster, some key learnings may have been identified and rectified earlier and on a smaller scale, which, in hindsight, may have saved time in the long run. It is likely the approach would also have diluted the administration burden, making the experience less overwhelming for community providers involved in multiple clusters.

Looking to a future beyond CPCT

Aware that the CPCT funding was due to end approximately 8-9 months after the interviews took place, CPCT providers stressed the “huge, huge loss” this would be, because without being adequately resourced “a huge amount of what is quality work would fall over”. As well as job losses

and the potential loss of positive health outcomes attributed to CPCT, flow on effects of stopping the funding included concerns of letting the community down, damaging relationships with patients and putting pressure on other areas of the health system. Patients may require a referral to an alternative service, or health concerns may escalate without CPCT care. In acknowledging the large impact that ending a service can have, the CPCT providers requested that they are afforded as much notice, certainty and clarity as possible if funding will not be continuing, so they have time to withdraw safely from patients and staff can be prepared to look for employment elsewhere.

> *Losing those resources alone, the cost of those would be amplified on what would be spent on the people not getting the care that they receive from [CPCT], it would cost you money to cancel those contracts … the early intervention, the support, the education that people are getting is stopping them going into hospital*
>
> *Community provider*

Despite the impending contract end, WellSouth staff were hopeful the networking between general practices and community providers that underpinned the early stages would "create working relationships way past CPCT" and new referral pathways may endure. However, CPCT providers voiced concerns that "there's a risk if there's no sustainable plan, you know like with the CPCT to rollover, then nobody has the incentive to work together" and therefore if the maintenance of relationships is not well resourced going forward then connections may break down.

Thinking beyond CPCT, several CPCT providers suggested alternative funding approaches including funding outcomes rather than activities to enable organisations to decide the best way to achieve those outcomes in their community, allowing organisations to submit proposals for how they would like to use their allocation of funds, and providing an accompanying pot of discretionary funding to cover the vast range of patient needs. It was also proposed that some of the role specifications are too limiting for the available workforce and, for community providers particularly, they felt there was an over-emphasis on registration and lack of recognition for the value of lived experience.

> *We run about X different contracts and the reporting and how to collect that data is different for most of them and it's really time consuming…it could be a full-time job for one person, [but] we don't have the, you know, the admin, and we don't have the contract managers and all that backup kind of staff*
>
> *Community provider*

Additional considerations for future contracts were also discussed, with some variation between general practices and community providers. CPCT providers generally noted that there needs to be more consideration given to how different contracts fit within existing services and more recognition for the additional resource requirements surrounding a new contract or service. For community providers the focus was on administration time for managing and reporting on multiple contracts, for which bulk funding was a proposed solution, whereas for general practices there was more emphasis on physical assets to support mobilisation such as laptops and vehicles.

Survey results: He Pikinga Waiora Framework process evaluation tool

Overview of survey results

The 32-item survey required respondents to indicate to what extent each item reflected their experience, using a six-point Likert scale, ranging from 1 (not at all) to 6 (completely). Items can be grouped into 10 sub-categories: readiness to change, commitment to community engagement, trust, influence, partnership synergy, shared control of resources, community involvement, reflexivity, capacity to create change, and systems thinking. These subcategories can be further grouped to form three broad categories that reflect core aspects of the HPW Implementation Framework: community engagement, cultural centredness and systems thinking. Definitions for each category and subcategory, as per the HPW guidelines, are set out in Appendix 3.

Due to the low response rate, the survey results and findings are predominantly discussed at the broad category and subcategory levels (see Table 3). A breakdown of the average response scores for each item is provided in Appendix 4. Building on the HPW guidelines, an average score of 1-2.5 indicates a problematic area, 2.6-4.5 indicates room for improvement and 4.6-6 indicates high performance. Overall, the average score was 4.1, falling at the upper end of the room for improvement score banding. The average score for all three broad categories were also within the room for improvement score banding. No average scores at any level indicated a problematic area. Overall, the survey results are consistent with what was found in the qualitative interviews.

Table 3. Average scores for the He Pikinga Waiora Framework process evaluation survey tool, at broad and subcategory levels

Framework category ○ Subcategory	**Average item score** (1 – 6)
Community engagement	**4.2**
○ Readiness to change ○ Commitment to community engagement ○ Trust ○ Influence ○ Partnership synergy ○ Shared control of resources	○ 5.6 ○ 4.7 ○ 3.6 ○ 3.8 ○ 3.6 ○ 4.0
Cultural centredness	**4.0**
○ Community involvement ○ Reflexivity ○ Partnership capacity to create change	○ 3.8 ○ 3.7 ○ 4.3
Systems thinking	**3.6**
○ Systems thinking	○ 3.6
Total	**4.1**

High performance areas

The highest scoring category was 'community engagement', likely influenced by 'readiness to change' and 'commitment to community engagement' being the two highest scoring subcategories by quite a large margin. In fact, they were the only two subcategories to achieve scores indicative of high performance. The only other subcategory to score higher than the overall average, was 'partnership capacity to create change'. It is positive that these areas have scored well given the aim of the cluster approach is to enable flexibility to meet local community need and the acknowledgement by some interview participants that the CPCT approach is a change from traditional ways of working.

Areas indicating room for improvement

On the other hand, 'systems thinking' was the lowest scoring category, which suggests that CPCT may be seen as narrow in its scope to enable change. The HPW Framework suggests that involving stakeholders with a wider range of perspectives and influence may help when scores are low in this area. This supports the findings from the qualitative interviews relating to bringing a wider range of stakeholders together early on in planning stages, including people with clinical expertise.

The lowest scoring item in the entirety of the survey was within the 'systems thinking' subcategory*: participation in CPCT has enabled me to express my own cultural viewpoint* (see Appendix 4). Without further context, it is difficult to determine whether this refers to being able to express cultural views with WellSouth, with others in the cluster or in relation to the services CPCT can provide. This finding can be explored further in part two of the evaluation.

The subcategories of 'trust' and 'partnership synergy' also had relatively low scores, indicating room for improvement in the strength of some relationships, something the HPW Framework highlights the importance of improved communication to achieve. This may reflect the fact that many relationships were new and that building whanaungatanga takes time. It also reinforces the interview findings related to the value of investing time in whakawhanaungatanga to build strong relationships, and the value of WellSouth's role in facilitating these opportunities.

KEY LEARNINGS

Addressing the evaluation questions

What new roles are planned across the clusters and how are they expected to affect local primary healthcare capability?

The most frequent role contracted by WellSouth's CPCT funding was a care coordinator. Of the eight WellSouth clusters with a contract in place, all have at least one care coordinator role, regardless of whether the contracts are managed by general practices or community providers. Care coordinators therefore represent almost two thirds of the WellSouth funded CPCT roles and FTE. The next most common role was a kaiāwhina, representing over a quarter of the WellSouth funded FTE (1 in 5 roles). In addition, it should be noted that, prior to the disestablishment, Te Aka Whai Ora directly funded a small number of kaiāwhina roles within community providers as part of CPCT. Overall, it is understood that there is a kaiāwhina (whether funded via WellSouth or directly from Te Aka Whai Ora) present in six out of the eight clusters. The small number of FTE remaining incorporates two pharmacy and two physiotherapy services (all four in different clusters). For Hokonui, who were funded directly by Te Whatu Ora, flexibility was afforded to include a dental service, which was one key point of difference between Hokonui and the clusters established by WellSouth.

Anecdotally, through the addition of both the care coordination and kaiāwhina roles, CPCT providers reported having the capacity and capability to provide a wider host of services, particularly in the prevention space. Stories were shared which provide evidence that the roles have increased the mobilisation of the workforce, with enhanced capability to deliver a wider scope of health care in the community or in people's home. For example, the addition of a podiatrist or a registered nurse as a care coordinator means some medical procedures or assessments can be provided at a patient's home alongside other supports, rather than requiring attendance at a future appointment. It is possible that enhancing the capability of primary care may in turn reduce pressure on secondary care, however this assumption will be considered further in part two of the evaluation.

Furthermore, for the clusters that funded pharmacy or physiotherapy, this addition primarily enabled a new service to be added to the organisation. This has the potential to not only enhance the scope of care delivered to patients through the availability of the service, but also increase skills and knowledge of the workforce. There is also evidence that new relationships have the potential to increase cultural capability, due to the new connections between general practices and community providers, and it is anticipated that the additional workforce development funding will have further impacts. These potential outcomes will be explored in part two of the evaluation.

What was the extent of the role of WellSouth, and the level of resource invested, in the early implementation process?

The role of WellSouth in the design and implementation of CPCT across Southern has been wide ranging and, at times, differed from, what was initially expected. For instance, the depth of existing relationships and partnerships between organisations within clusters were more variable than anticipated, meaning that more time was spent bringing organisations together, facilitating

introductions, and stimulating ideas for collaboration. Resource requirements varied by cluster. Clusters where strong relationships between organisations already existed and organisations that added resource to an existing staff member with connections in place required less support from WellSouth to launch CPCT than places where the programme was a larger change.

It is difficult to quantify the specific level of resource invested into CPCT, particularly as further support was provided to the implementation staff FTE from within existing WellSouth staff capacity. This meant, at times, staff were juggling competing priorities across multiple projects. It was suggested that FTE solely dedicated to the project may have reduced some of this pressure by removing the risk of managing competing responsibilities. Consistent with the principles of project management, clear documentation may help to capture a more accurate picture of WellSouth's investment in relation to staff time costs for large projects where dedicated FTE are not in place.

What worked well and what could have been improved in the early implementation process?

WellSouth's role in the implementation of CPCT was generally well received by the CPCT providers. Despite the complexity and administration associated with bringing organisations together, establishing clusters and negotiating collaborative contracts, the underlying message from participants was that it was worth the effort. CPCT providers appreciated WellSouth's support translating national guidance into something that could be applied locally, being afforded flexibility and choice in the CPCT roles and having the opportunity to build relationships with other organisations. CPCT providers also reported having one point of contact for WellSouth worked well.

In the areas where a service had been established, CPCT was predominantly perceived as working well to meet a need in the community and CPCT providers said they valued the funding. Several CPCT providers chose to use the funding to increase the hours of an existing member of staff. This approach had the benefit of being much faster to implement, as a recruitment process was not required, and the person was able to utilise their existing connections. For others, particularly those who needed to recruit new staff, more guidance around the scope of the role and examples of how to get started, especially for developing referral pathways, would have helped to speed up the implementation. For all, more networking to share best practice and learnings would have been welcomed.

There was room for improvement identified in the efficiency of some internal WellSouth processes that resulted in long delays being experienced by internal and external stakeholders and in relation to communication, where, at times, mixed messages caused some frustration for providers. These findings demonstrate scope within WellSouth for stronger project management practices, such as clearer documentation of agreed processes, and a more robust and transparent decision-making process. This is evidenced through the value attributed by some WellSouth staff to the introduction of regular project oversight meetings with the wider project team, to support decision-making.

What has the experience of collaboration been for all organisations involved and how has this impacted relationships?

Strong relationships are a critical component of effective partnership working and collaboration, especially in Te Ao Māori and Pacific cultures. There are two key relationship types that have been impacted through the implementation of CPCT: the relationship between WellSouth and the CPCT providers, and intra-cluster relationships. WellSouth has a duty to uphold the revised hauora

principles from Wai2575, derived from Te Tiriti o Waitangi, including supporting partnership and tino rangatiratanga for Māori. For WellSouth staff, having the opportunity to work with and build relationships with different internal teams, general practices, Māori community providers and Pacific community providers was a highlight of working on the CPCT project team.

For the majority of CPCT providers, the process of being brought together for the purpose of collaboration helped to build new and strengthen existing relationships, regardless of whether a collaborative service had yet been established. Whanaungatanga was emphasised by many as one of the most valuable aspects of their involvement in the design stages, and CPCT providers appreciated the opportunity as well as the way in which it was resourced. Where new connections were formed, it was hoped they would have benefits beyond CPCT and, in some cases, examples of this were already being shared.

Both general practices and community providers had mostly positive experiences working with WellSouth and relationships between CPCT providers and WellSouth were generally described as good. There were, however, a small number of examples in which inconsistent messaging from WellSouth risked damaging organisational trust. This finding is important to note when considering the significance of relationships for strong partnership working and the likelihood of more collaborative initiatives and approaches in the future.

What are the barriers and enablers for WellSouth in fostering relationships and facilitating collaboration?

In most areas, organisations were keen to be brought together with others in their area, and beyond, to learn more about what services were available and to share ideas. Organisations were also eager to collaborate where there was benefit to all stakeholders, although in rural areas geographical spread and travel requirements made engagement more difficult. Having support from WellSouth to coordinate all parties, manage logistics, and provide a central point of contact enabled valuable conversations to take place that fostered whanaungatanga. Additionally, having WellSouth offer ideas, stimulate and facilitate discussions, and provide some guidance or direction helped to encourage collaboration.

Key barriers to collaboration between CPCT providers that WellSouth had to navigate were around capacity and logistics. Aligning the schedules and priorities of multiple parties to attend meetings, a lack of action points arising from meetings, and an absence of ownership over the delivery of agreed actions were identified as barriers to progress. The complexity of establishing new referral pathways, including IT systems, privacy concerns and data sharing, was another issue that was discussed multiple times, and one where further guidance from WellSouth might be of value. Where existing working relationships were limited, time was also needed for organisations to build connections and establish trust before collaboration could be forthcoming. The short-term nature of funding can often place pressure on organisations to act, without recognising the importance of having time to lay these relationship foundations. Time constraints can also influence decisions as to the value of entering a new partnership and the changes that come with it, if only for a short period.

What collaborative models of care have been designed, including referral/access pathways?

At the time of the evaluation, clusters were at different stages of the design and implementation of CPCT. For most clusters, work to establish or finalise the CPCT model of care was still in progress. Some early examples of collaboration that were highlighted, or ideas that were voiced which are yet to come to fruition, include:

- Pooling the several FTE allocations together into one role split across multiple locations,
- Bolstering funding to an existing service or programme, and implementing a new referral pathway, so that the increased capacity can be accessed by patients from across the cluster,
- Creating referral pathways for patients across the cluster to access a new service established through the CPCT funding,
- Having new avenues to contact other organisations for advice on patient care or needs, especially between general practices and Māori community providers, and general practices and Pacific community providers, to enhance care for Māori and Pacific patients,
- Hosting joint community events to extend the skills, resources and reach of events, and
- Working with other agencies and services outside of the cluster to establish pathways into the service from elsewhere in the health sector.

As discussed in more detail elsewhere in this report, complications surrounding referral pathways was identified as a barrier to collaborative models of care that had not yet been fully resolved. Finalised CPCT referral and access pathways could not be documented here, however this will be explored more in part two of the evaluation.

Lessons learned

For WellSouth, the experience of coordinating the design and implementation of CPCT generated learnings that can be utilised across a range of future contexts. Although documented throughout this report, key learnings have been consolidated here:

- The ability to adapt to local community need, enabled through the flexibility and choice given to CPCT providers, was well received and considered worth the effort.
- General practices and community providers were grateful for the opportunity to be brought together to learn more about the services available in their area and build connections.
- The advantages of facilitating new relationships and collaboration were evident but, without incentives and ownership over coordination and actions, they may not be sustainable.
- The level of support and guidance needed from WellSouth to coordinate multiple parties, establish clusters and design new models of care, was greater than anticipated. To support delivery within the short timeframe of the contract, additional staff time was given alongside the FTE that was allocated to implementation through the contracted funding.

- The CPCT providers appreciated being kept informed and having one point of contact for WellSouth, but emphasised the need for concise communication that makes the relevance and actions required clear and stands out from the vast amount of information being received.
- Whilst acknowledging timeframe constraints as motivation behind the speed of launching into implementation, in hindsight, investing more time into the initial planning and bringing in relevant stakeholders earlier, prior to launching the programme with providers, may have ultimately saved time and improved the experience of all.

Future considerations

Based on the evaluation findings, three sets of future considerations have been identified: those applicable to CPCT, those relevant to WellSouth more broadly, and those applicable to the wider system.

CPCT considerations

- Although outcomes were not the focus of this part of the evaluation, anecdotal examples of positive patient outcomes including increased access and avoided hospital admissions were shared. These initial positive indications, alongside the resource that has been invested and the time it takes to embed a new model of care, support advocating for the continuation of CPCT funding. A more detailed exploration of the outcomes of CPCT will be presented in part two of the evaluation.
- CPCT providers expressed a strong interest in being able to share ideas and learnings with other organisations beyond their cluster. WellSouth may consider coordinating a regional network, or working with other PHOs to coordinate a national network, for organisations involved in CPCT to facilitate greater knowledge transfer.
- For many clusters, especially those working as a collective, CPCT is a large shift from traditional ways of working and change takes time to embed. WellSouth may consider providing ongoing guidance and support, including a particular focus on overcoming barriers to establishing effective referral pathways, for those CPCT providers who would like it.
- The loss of a service has a range of effects for patients, staff and the wider health system. If funding cannot be provided for the continuation of CPCT, CPCT providers requested that they are given as much notice and clarity as possible to safely withdraw the service from patients where necessary and minimise further impacts.

WellSouth considerations beyond CPCT

- The non-staged approach to implementation meant, at times, WellSouth staff and community providers working across multiple clusters felt overwhelmed by administration and changes to processes derived from the iterative approach taken. When implementing a new initiative, WellSouth may consider conducting a staged rollout that starts with a prototype to test ideas, generate learnings on a smaller scale, and spread the intensity of the workload.

- Many CPCT providers wished for more guidance from WellSouth to achieve their vision but did not want that guidance to be prescriptive. In striking the balance between providing support and protecting autonomy, continuing to utilise approaches that are flexible to local need may be valuable. Making more resources available to support providers when launching a new service could also be considered. For instance, examples of different models of care including referral pathways, or a list of ideas and tips on how to get started, could be provided.
- CPCT providers emphasised the high levels of administrative work associated with meeting reporting requirements and some uncertainty over expectations. To consolidate understanding and enhance data quality, WellSouth may consider advocating for appropriate levels of funding that adequately compensate providers for their administration time, enables adequate infrastructure for data collection expectations to be met, and allows for resource to support providers in understanding reporting requirements.
- The findings indicated that collaboration may be more readily achieved when there are strong pre-existing relationships, organisational trust, clear ownership over actions and a lead organisation to orchestrate. WellSouth should continue to develop its network coordination role for general practices and community providers beyond CPCT, to facilitate on-going relationships.
- Room for improvement was identified in some internal WellSouth processes to reduce delays and mixed messaging. For large projects of this nature, WellSouth may consider utilising more robust project management practices, such as using documentation to monitor progress and increase transparency, and establishing a project oversight group –similar to that which was introduced during the implementation– from the outset, to routinely bring all internal stakeholders together and enable a more agile decision-making process. Consideration may need to be given to what skills and roles will be required throughout the project to ensure representation within the oversight group (e.g. clinical expertise).

Wider system considerations

- In recognising the difficulty for healthcare providers recruiting to fixed-term positions, change fatigue and the benefits of strategic planning, consideration should be given for WellSouth to advocate for longer-term contracts that provide an assurance of funding and make investment in change more worthwhile.
- Workforce shortages are limiting the ability to recruit to across the healthcare sector, including within CPCT. For community providers, parameters such as the requirement for a professional registration for care coordination were a barrier to recruitment. WellSouth's role in advocating for more funding to be directed to training, contracts with professional development pathways, and wider parameters for funded roles is something for consideration.
- When involved in creating or advocating for new contracts, WellSouth may consider a wider suite of appropriate options such as the provision of discretionary funds, outcomes-based contracts, and funding allocations based on successful proposal submissions, as well as clear distinctions and linkages between the multitude of contracts.

- Considering the value placed on building cross-agency relationships and the resource required to support this, which was evident throughout this evaluation, WellSouth may have a role in advocating for funding that recognises and adequately resources whakawhanaungatanga to support collaboration.

Conclusion

The implementation of CPCT in Southern has generally been well received. In particular, the flexibility of the approach taken enabling adaptation to local community needs and the facilitation of cross-agency networking, relationship building and collaboration were highlighted as key successes. Anecdotal evidence provides initial indications that CPCT is having positive health outcomes, particularly in proactive and preventative care, avoiding hospital admissions, and increasing access and ease of access to primary care. Examples were also shared of new connections between general practices and community providers increasing cultural capability and co-ordinated care, increased capacity for community providers, greater mobilisation of community care, and the introduction of new services in rural areas. These stories indicate that CPCT may be contributing to reducing health inequities. This evaluation therefore provides early evidence that CPCT in Southern appears to be meeting the national objectives, including strengthened partnerships and collaboration, increased capacity and capability, meeting local community need, improved access, and improved equity of access for Māori, Pacific Peoples, Tāngata Whaikaha and people living in rural communities.

The evaluation also identified learnings for WellSouth in relation to working with or coordinating the collaboration of primary care providers, and designing and establishing collaborative models of care. Given the synergy with the GPS, it is expected that, even if the CPCT funding is not extended, future contracts may follow similar collaborative models. Therefore, in addition to the importance of listening and acting on feedback from stakeholders for upholding relationships, it is likely there is considerable value to be gained from ensuring these evaluation learnings and considerations are instilled across WellSouth in preparation for future collaborative approaches.

APPENDICES

Appendix 1: Overview of CPCT clusters, including employment models, organisational composition, CPCT roles and recruitment statuses (at time of writing)

Cluster	CPCT roles	CPCT providers	Status	Employment model category
Central Otago	Kaiāwhina (TAWO)*	-	No contract	-
Clutha	Care Coordinator; Physiotherapist; Kaiāwhina (TAWO)*	5 GP Practices 1 Māori Provider 1 Pacific Provider	Roles in place	Split FTE
Dunedin	Care Coordinator; Physiotherapist; Kaiāwhina (TAWO)*	2 GP Practices 1 Māori Provider 1 Pacific Provider	Partially recruited	Two sub-clusters: Community Provider(s) manage FTE and GP Practice(s) manage FTE
Fiordland	Care Coordinator; Pharmacist	1 GP Practice (+ WellSouth) 1 Māori Provider 1 Pacific Provider	Roles in place	GP Practice(s) manage FTE
Invercargill	Care Coordinator; Kaiāwhina; Kaiāwhina (TAWO)*	2 GP Practices 2 Māori Providers 1 Pacific Provider	Roles in place	Community Provider(s) manage FTE
Queenstown	Care Coordinator; Kaiāwhina; Kaiāwhina (TAWO)*	4 GP Practices 1 Māori Provider 1 Pacific Provider	Partially recruited	Community Provider(s) manage FTE
Southland	Care Coordinator; Kaiāwhina	5 GP Practices 1 Māori Provider 1 Pacific Provider	Roles in place	GP Practice(s) manage FTE
Waitaki	Care Coordinator; Kaiāwhina (TAWO)*	6 GP Practices 1 Māori Provider 1 Pacific Provider	Roles in place	Community Provider(s) manage FTE
Wānaka	Care Coordinator; Pharmacist	2 GP Practices (+ WellSouth) 1 Māori Provider	Roles in place	GP Practice(s) manage FTE
Hokonui[#]	Care Coordinator (TWO); Dentist (TWO)		Roles in place	One GP Practice manages FTE

*A number of kaiāwhina roles were contracted directly to kaupapa Māori hauora services by Te Aka Whai Ora prior to the disestablishment. These roles were not a focus of the evaluation but provide context and comparison to the experience with WellSouth. One role is shared between Central Otago and Queenstown.

[#]CPCT in Hokonui was contracted directly with Te Whatu Ora, not WellSouth.

Appendix 2: List of axial codes constituting each theme identified through the thematic analysis of the qualitative interview data

Internal process improvement opportunities	**Striking the balance between structure and flexibility**
Protracted processes	Pros and cons of structure versus flexibility
Benefits of early planning stage	National and regional guidance or support
Staged approach	Adapting to local context
Level of resource	Reporting outcome measures
Decision-making processes	Assumptions of current state
Process documentation	Inconsistency
Administrative burden	Transparency and accountability
Importance of WellSouth communication and impacts on relationships	**Positivity for collaboration and new ways of working**
Limited internal communication	Emergence of new ways of working
Impact of mixed messages	Facilitating relationships and partnership working
Maintaining relationships	Sharing perspectives, ideas and learnings
Quality of WellSouth communication	Positive outcomes
Trust	Value of service in meeting community need
Barriers to collaboration and service delivery	**Looking to a future beyond CPCT**
Impact of short-term funding	Learning opportunities
Recruitment complexity and limitations	Impacts of losing funding
State of pre-existing relationships	Alternative funding approaches and considerations
Blockages with referral pathways and data sharing	Sustainability of change
Lack of ownership or clarity over actions	Additional resource considerations
Additional complexity of collaborative approach	
Mindset and change fatigue	

Appendix 3: Glossary of He Pikinga Waiora (HPW) Framework process evaluation tool key concepts, derived from HPW data analysis guidance

Term	Definition
Community engagement	Collectively, these items relate to the strength of community engagement as a shared endeavour. Community engagement is highest when all partners share responsibility and control of all the phases of the project.
- Readiness to change	These items reflect the degree to which the community or community organisations are ready to change. If these items are low, especially as rated by the community, it is very important for the partnership to identify why there isn't readiness to change. Perhaps there are constraints that can be resolved. Not being ready to change will likely leads to challenges in later stages.
- Commitment to community engagement	These items reflect the degree to which partners are committed to the principles of strong community engagement. Such commitment reflects a willingness to work as equal partners. If these items are low, it would be worth revisiting the nature of the partnership and whether this commitment can be changed. Low commitment to engagement will likely lead to an unequal relationship and resentment later in the partnership.
- Trust	These items reflect the level of trust in the partnership. If these items are low, it is worth having a dialogue about why trust isn't present. Sometimes having a good intense discussion or conflict about trust can be enough to demonstrate commitment to work together and help to establish trust. Low trust that isn't addressed usually ends up hurting the effectiveness of the partnership.
- Influence	These items reflect the degree of influence that all partners have. All partners should have the ability to influence the partnership. If these items are low, consider changing the agreements or the way that meetings are run to make sure all partners have a say in the workings of the partnership. If low influence continues, partners often withdraw and limit their effort to the partnership because they don't think their work really matters.
- Partnership synergy	These items reflect the level of connectedness and ability to work effectively together. An effective partnership achieves synergy. If these items are low, it is worth discussing what is inhibiting the achievement of synergy. Usually, the quality of relationships and dialogue is low in these situations so it might be worth thinking about improving communication in the partnership.
- Shared control of resources	These items reflect whether there is shared control of resources. If these are low, consider developing MOUs or subcontracts that enable partners to have some control over resources.

Cultural centredness	Collectively, these items relate to the degree to which the community has agency and power to create change in the community and whether that change is reflective of the cultural perspectives of the community.
- Community involvement	These items reflect the degree of community involvement in the phases of the research and intervention. When there is high level of community involvement, we can assume there is agency to define the problem and identify solutions that fit the culture of the community. If these items are low, identify ways that the community members can be more involved in the work of the project.
- Reflexivity	These items relate to the level of collective reflection about the nature of the partnership and the relationships among the partners. This reflection can be about the quality of the relationships and communication and also about whether positions of privilege are addressed and discussed. If these items are low, consider ways to integrate reflection into regular work meetings. Such reflection can improve the quality of the working relationships among members.
- Partnership capacity to create change	These items reflect the level of skills and resources the partnership has to carry out the work of the partnership. If these items are low, consider adding additional stakeholders to the partnership either as members or as part of advisory boards.
Systems thinking	Collectively, these items reflect the level of “big picture” thinking about the context and problem being addressed.
- Systems thinking	Systems thinking involves the complexity of the larger structures in society and how those affect the work of the partnership. It also involves integrated multiple perspectives and multiple level of analysis. In short, systems thinking involves addressing complex relationships and realising that health problems do not get resolved with simple fixes. If these items are low, it might be worth involving additional stakeholders who can help you think about the problem from a different perspective.

Appendix 4: Average scores for the He Pikinga Waiora Framework process evaluation survey tool, broken down to item-level

Framework category ***Subcategory*** ○ Item	**Average item score** (1 – 6)
Community engagement	**4.2**
Readiness to change	***5.6***
○ My organisation is committed to implement CPCT	○ 5.6
○ My organisation is determined to implement CPCT	○ 5.6
○ My organisation is motivated to implement CPCT	○ 5.6
Commitment to community engagement	***4.7***
○ CPCT builds on resources and strengths in the community	○ 4.4
○ CPCT emphasises what is important to the community (that affect wellbeing)	○ 4.7
○ CPCT views community engagement as a long-term process and commitment	○ 4.9
Trust	***3.6***
○ I trust the decisions others make about issues important to our local implementation	○ 3.1
○ I can rely on the people I work with for implementing CPCT	○ 4.0
○ People in this partnership have confidence in each other	○ 3.7
Influence	***3.8***
○ Suggestions I make within this partnership are taken seriously	○ 4.1
○ I have influence over the decisions this partnership makes	
○ I am able to influence the design of CPCT at a local level	○ 3.7
○ My involvement influences the partnership to be more responsive to the community	○ 3.7 ○ 3.6
Partnership synergy	***3.6***
○ Goals are widely understood and supported in this partnership	○ 3.4
○ The partnership recognises challenges and comes up with good solutions	○ 3.7
○ The partnership responds to the needs and problems of your stakeholders and community as a whole	○ 3.7
Shared control of resources	***4.0***
○ All parties hire personnel	○ 4.1
○ All parties decide how to share financial resources	○ 4.0
○ All parties decide how to share in-kind resources	○ 3.7
Cultural centredness	**4.0**
Community involvement	***3.8***
○ Community partners are involved in the identification of local needs	○ 4.0
○ Community partners are involved in the design of CPCT at a local level	○ 3.6

Reflexivity ○ Our partnership had discussions about our partnership's role in promoting strategies to address health inequity ○ Our partnership evaluates together what we have done well and how we can improve our collaboration ○ Our partnership reflects on issues of power and privilege within the partnership	***3.7*** ○ 4.0 ○ 3.4 ○ 3.6
Partnership capacity to create change ○ The partnership has diverse membership to work effectively towards its aims ○ The partnership has legitimacy and credibility to work effectively towards its aims ○ The partnership has the ability to bring people together for meetings and activities ○ The partnership has connections to other relevant stakeholders to work effectively towards it aims	***4.3*** ○ 4.1 ○ 4.6 ○ 4.1 ○ 4.4
Systems thinking	**3.6**
Systems thinking ○ Participation in CPCT has helped me to recognise there are many different points of view on the optimal model of care ○ Participation in CPCT has helped me to think more clearly about positive and possible changes ○ Participation in CPCT has enabled me to express my own cultural viewpoint ○ CPCT will be developed to target changes at multiple levels	***3.6*** ○ 3.6 ○ 3.9 ○ 3.0 ○ 4.0
Total	**4.1**