WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

An evaluation of

Comprehensive Primary and Community Care Teams (CPCT) in Southern

Part Two: Delivery and Outcomes

July 2025

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Acknowledgements

The evaluation team at WellSouth would like to thank everyone who contributed to this evaluation, through participating in an interview, enabling observations, connecting us to consumers, or reviewing and sense-checking findings. We acknowledge that this evaluation would not have been possible without your involvement and support. We especially extend our thanks to the community, who welcomed us into their space and shared their personal experiences with us. Your insights were invaluable to this evaluation.

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

CONTENTS

EXECUTIVE SUMMARY

Background

Through Budget-22, Te Whatu Ora and Te Aka Whai Ora partnered to fund the establishment of Comprehensive Primary and Community Care Teams (CPCT) across Aotearoa New Zealand. CPCT aims to strengthen primary and community care by incorporating additional roles into the health sector. WellSouth were contracted to implement CPCT across Otago and Southland, with the exception of one team operating through the Hokonui Locality. This was achieved by establishing location-based clusters consisting of general practices, Māori community providers, and Pacific community providers.

Evaluation methodology

The evaluation has been conducted in two parts. This report presents the second part of the evaluation, which aimed to understand how the service is being delivered and to whom, and the difference it is making to consumers and clinicians. Part one, which focused on the design and implementation process, has been published separately. A mixed methods approach was employed, consisting of five key components: [1] collation of contract reporting data, [2] review of workforce development applications, [3] quantitative analysis of primary care data, [4] qualitative interviews with staff at CPCT providers, and [5] qualitative interviews with consumers of CPCT.

Evaluation findings

Access

It is estimated that CPCT in Southern has engaged with 6,672 individuals in the 12 months since inception, over a fifth of whom were Māori and a similar proportion were Pacific Peoples. This equates to a rate per 1000 enrolled population approximately 11 times higher for Pacific Peoples and 3 times higher for Māori compared to non- Māori/non- Pacific. This finding suggests CPCT is aligning with the aim to reduce inequities of access.

Capability

The additional roles have increased capability by expanding available skillsets and areas of expertise, as well as promoting the sharing of knowledge between clinicians, within organisations and across CPCT clusters, both in terms of clinical skills and cultural safety. The CPCT workforce development funding has also been utilised to expand workforce capability beyond CPCT in a range of areas, including prevention, advanced clinical skills training and emergency response in rural areas.

Outcomes

The services being delivered by CPCT are wide-ranging, encompassing delivering clinical care for physical and mental health concerns, increasing the provision of preventative care, supporting patients to access social support as well as to navigate the health system to access medical care, and delivering health education. Case study analysis found a wealth of positive outcomes that contribute to improved physical and mental health, including: reducing barriers to primary care access (especially for our Māori, Pacific, rural and disabled communities), increasing health literacy, maintaining independent living, reducing hospital readmissions, reducing social isolation, increasing

safe and optimum medication regimes, and improving long-term condition management. The new collaborative ways of working were also reported to have strengthened intra-cluster relationships, making smoother referral pathways between services and a greater continuity of care.

Despite limited data due to the programme only being established for 12 months, data analysis also found evidence to support the clinician and consumer insights. CPCT practices were found to have small but statistically significant increases in rates of immunisations, diabetes annual reviews and cardiovascular risk assessments. Early indications also point towards a downward trend for hospital readmissions and HbA1C, although more data is required to confirm this finding.

Additionally, it was anecdotally reported that CPCT is reducing pressure on primary and secondary care, thereby enabling more work at the top of scope and potentially contributing to increasing job satisfaction and sector sustainability. Some data analysis also suggested that CPCT may have had a small effect on reducing GP utilisation rates, potentially through the additional capacity and multi-disciplinary approach reducing pressure on GPs.

Key learnings

- Given the positive outcomes illustrated in this evaluation, evidence supports the continuation of funding for CPCT as a long-term investment into primary care.
- Repeating the analysis of primary care data to incorporate an additional 9-12 months of data would be valuable to potentially strengthen findings.
- The ability to provide support beyond immediate clinical healthcare was highly regarded for improving health outcomes. Therefore, there appears to be value in funding work to address social determinants of health as well as the direct provision of healthcare, such as social and practical support, education, navigation and advocacy.
- If not included through CPCT going forward, there appears to be value in advocating for the provision of funding to resource work to address the wider social determinants of health.
- Incentivising collaboration, allowing flexibility of scope, and mobilising the workforce to deliver care within the community were key enabling factors that apply beyond CPCT.
- The need for funding to backfill roles whilst staff attend training, as well as covering training costs, should continue to be incorporated into workforce development budgets.
- The role of PHOs in facilitating networking between organisations and providing guidance for setting up new initiatives continues to be valued.

Conclusion

Overall, it was found that CPCT is highly valued by consumers and clinicians in Southern. The programme appears to be achieving the national objectives, improving the physical and mental wellbeing of people and communities by supporting people to better access and understand health care, plugging gaps in current provision, and reducing the burden on other areas of the system. This evaluation not only provides evidence that CPCT in Southern is delivering a valuable service but also contributes to a pool of national evidence that indicates CPCT is making a meaningful difference not only to our communities but to the health system more broadly.

BACKGROUND

Comprehensive Primary and Community Care Teams (CPCT)

Through Budget-22, Te Whatu Ora and Te Aka Whai Ora partnered to fund the establishment of Comprehensive Primary and Community Care Teams (CPCT) across Aotearoa New Zealand. CPCT aims to strengthen primary and community care by incorporating additional roles into the health sector. This overarching aim is underpinned by a series of objectives, including to: expand the capacity and capability of primary and community care, improve access and equity of access to care, enable early intervention and preventative care to support hospital avoidance, improve continuity and coordination of care, and strengthen partnerships and collaborative working to meet local needs.

By focusing on high-risk groups, it is also hoped that CPCT will contribute to improved health outcomes and equity of health outcomes, especially for Māori, Pacific Peoples, tāngata whaikaha (disabled peoples), rural communities and people living in areas of high deprivation. The national CPCT operating framework sets out how the principles of Te Tiriti o Waitangi should be applied in the implementation of CPCT. 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".

There were two key phases in the national roll out of CPCT. In the first phase, Te Aka Whai Ora directly commissioned kaiāwhina roles for some Hauora Māori and Pacific partners, including organisations in Southern. In partnership with Te Whatu Ora, they also directly contracted the twelve early localities established under the Pae Ora legislation to establish CPCT in their areas. Following the change of government in 2023, Te Aka Whai Ora was disestablished and the remaining roll out of planned localities was not progressed. Subsequently, in the second phase, Primary Health Organisations (PHOs) were contracted to deliver the remaining implementation of the programme across their respective districts. As CPCT was a relatively short-term contract, there was interest in determining the value of continuing the programme. After a recent extension of some roles, CPCT contracts are due end on 30 June 2026.

CPCT in Southern

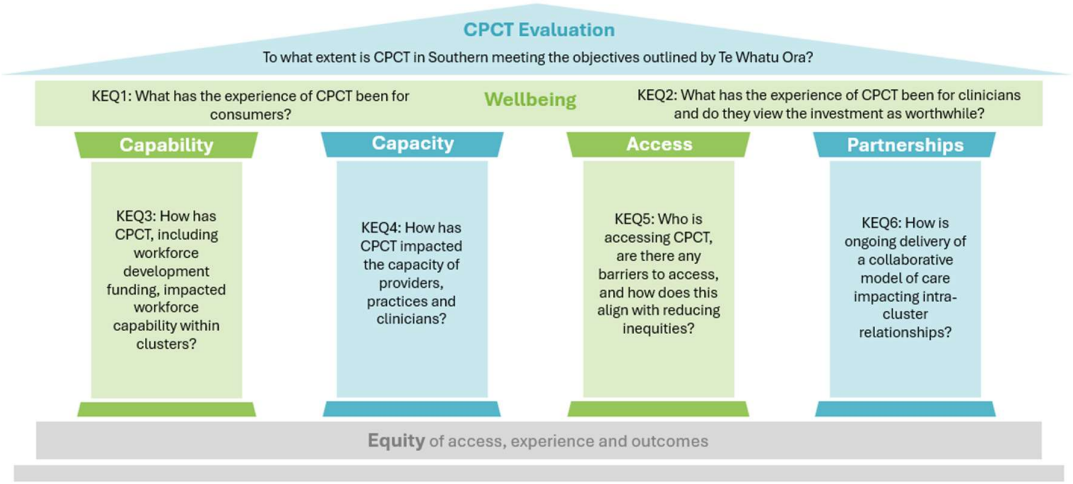
Aligning with the focus on strengthening partnerships and collaboration set out in the contractual service specifications, WellSouth made the decision to support the original localities-based model to establish collaborative clusters across the district involving general practices, Māori community providers and Pacific community providers. WellSouth established eight clusters across Otago and Southland (Southern): Clutha, Dunedin, Fiordland, Invercargill, Queenstown, Southland, Waitaki and Wānaka. An additional cluster is also operating through the Hokonui Locality that was part of the first localities phase of the roll out. These nine clusters involve a total of 33 general practices, 6 Māori community providers and 3 Pacific community providers (several community providers are involved across multiple clusters). Details on the composition of CPCT can be found in the first part of the evaluation and is expanded upon within the evaluation findings section of this report.

EVALUATION METHODOLOGY

Key evaluation questions

Informed by the national CPCT objectives, an evaluation structure was developed that comprises four pillars: capacity, capability, access and partnerships, which together support the concept of wellbeing. These five components are built on a foundation of equity and are guided by several key evaluation questions. The evaluation of CPCT has been carried out in two parts: part one primarily focused on the design and early implementation and part two (presented here) focuses on outcomes of the service. Each part was guided by a separate set of evaluation questions. The key evaluation questions that underpin the approach to the second part of the evaluation are illustrated within the evaluation structure in Figure 1 below. Additionally, the overarching evaluation question, *to what extent is CPCT in Southern meeting the objectives outlined by Te Whatu Ora*, will be answered through a synthesis of information from across all aspects of the evaluation.

Figure 1. Evaluation structure and key evaluation questions (KEQs) for part two of the evaluation



Data collection and analysis

Data collection

A mixed methods approach was employed for the evaluation, consisting of five core data collection components: [1] analysis of contract reporting data, [2] a review of workforce development applications, [3] quantitative analysis of available and relevant primary care data, [4] qualitative interviews with staff at CPCT providers, and [5] qualitative interviews with consumers of CPCT.

All quantitative data was extracted from existing sources, with support from WellSouth's Data and Digital team, and the CPCT project team. Sources included documents submitted for contract reporting, and routinely collected general practice primary care data and secondary admissions data available to WellSouth as the PHO for purposes of monitoring and evaluation. Where possible, data was extracted for the period 01/01/2022 to 01/03/2025.

Semi-structured interviews were conducted with clinicians delivering CPCT and other practice or provider staff members with oversight of the impact of CPCT. Invitations were issued leveraging relationships established during the first part of the evaluation, as well as through the CPCT project team. Semi-structured interviews were conducted with a small number of CPCT consumers identified and contacted by staff working within the CPCT roles, who also accompanied the interviewee throughout the interaction. Ethical research protocols were followed, as agreed by the WellSouth's ethical guidance committee, including obtaining informed consent. Interviews were conducted by the lead evaluator and priority was given to conducting interviews in person.

Participants

Qualitative interviews were conducted with 23 individuals, including staff working in CPCT roles, staff working in other roles within CPCT practices or providers, and consumers that have used (or were actively using) the CPCT service. The distribution across these groups is provided in Table One.

Table 1. Breakdown of the number of interview participants by role and organisation affiliation

Interview type (role category)	Participants	Organisations
CPCT staff	12	10
Other practice or provider staff	7	6
CPCT consumers	4*	2
Total	23	18

*This refers to only those who had a full interview where they shared personal insights and stories. A group observation where more general comments were heard was also attended.

Data analysis

Analysis of the contract reporting data involved collating the quarterly reports produced by the WellSouth project team, which are a consolidation of the individual reports submitted by CPCT organisations with contracted staff. Simple descriptive statistics were then used to summarise the data, including as a rate of the enrolled Southern population. A document review was conducted to summarise the workforce development data. This involved reviewing each workforce development application to identify the proposed uses for each organisation and for how many people. The data was then grouped into key themes and the number aggregated to rank the themes in frequency order.

Analysis of the quantitative primary care data was carried out in two stages. Firstly, data was plotted visually, and trend line analysis (r) was used to explore any trends and patterns in all CPCT practices compared to all non-CPCT practices. This stage identified any variables of interest prior to formal statistical testing.[1] Next, interrupted time series (ITS) and difference in differences (DiD) analyses were used to further examine variables of interest. ITS measures change over time with a focus on changes in trends before and after an intervention, thus the analysis was used to determine any statistically significant changes in outcomes before and after the implementation of CPCT for the CPCT practices. DiD analysis was then used to compare any changes in trends for CPCT practices

[1]Analysis by quintile, rurality, and splitting CPCT practices into with and without contracted FTE was also conducted initially but this did not offer a meaningful contribution to the evaluation findings and so has not been included within the report.

with non-CPCT practices, to help isolate the effect of CPCT from other external influences. Required prior assumptions were met for all statistical tests undertaken.

Each qualitative interview was analysed using inductive reflexive thematic analysis[2] to identify key themes. The findings across each cluster were then brought together to create a composite case study. This was achieved through narrative construction; insights were woven into a narrative that endeavoured to emphasise the recurring themes while preserving the richness in the individual stories shared[3]. Prior to being finalised, case study narratives were also shared with the participants to ensure they were satisfied it accurately reflected their experience. Finally, cross-case analysis synthesised the data to compile an overarching summary of CPCT in Southern[2].

Strengths and limitations

The evaluation utilised a mixed methods approach to triangulate findings and strengthen the robustness of the conclusions drawn. Integrating different types of data on the same topic can help to offset the limitations of each method and enable a more comprehensive understanding of the evaluation subject.

There was a high level of engagement from staff working in the clusters, both CPCT staff and other clinicians. They provided a valuable insight into how CPCT was operating as well as real life examples that helped to bring the programme to life in a way that would not be possible through numbers alone. It should be acknowledged that many of the staff interviewed were motivated by a desire to justify ongoing funding, which would not only mean the continuation of the service but also their own job security. This personal investment does mean that there is a risk that participants over-emphasised the positive outcomes and value in the service. However, the views shared by clinicians were supported by additional sources, including the consumer stories. Only a small number of consumers participated, which reflects the well-recognised difficulty of recruiting patients from vulnerable populations likely managing health burdens. Despite the small sample size, the inclusion of the consumer voice is a strength, as it adds further breadth to the perspectives captured and recognises the importance of consumer involvement in research.

As patient level data was not available for statistical analysis, general practice-level data was explored. The time frame of available data is also relatively short. These factors made it difficult to isolate with full certainty any changes caused by CPCT from other programmes, initiatives and external factors, especially when the FTE employed by each general practice is relatively small. The data also solely captures the enrolled population, missing unenrolled patients who have accessed CPCT through community providers. Despite these limitations, inferential statistics did yield some significant results, which aligned with some of the key areas of focus and anecdotal outcomes shared by the interview participants.

Overall, the different methods yielded complimentary findings. Thus, through the combination of data sources, the evaluation was able delve into the nuances of different clusters, share impactful patient stories, quantify the scope of CPCT, and explore clinical indicators and outcomes measures.

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

[3] Patton, M. Q. (2015). *Qualitative Research & Evaluation Methods (4th ed.)*. Thousand Oaks, CA: SAGE Publications

EVALUATION FINDINGS

CPCT delivery across Southern

Extent of CPCT roles

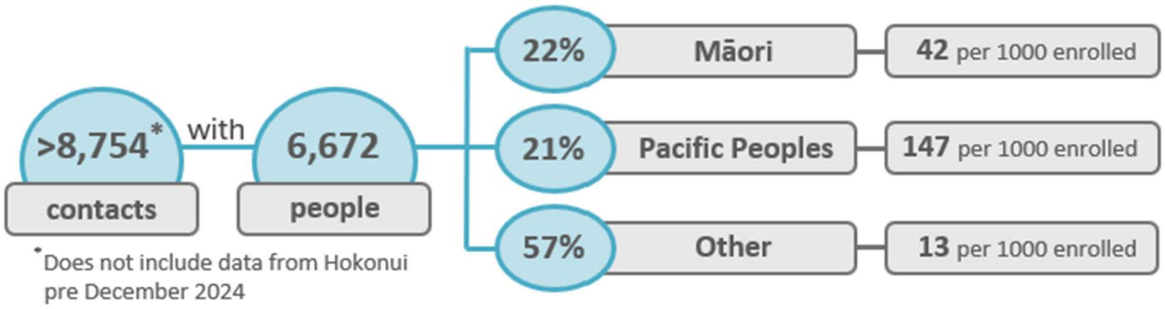
Across the eight WellSouth clusters, a total of 17.3 FTE has been added to primary care through CPCT contracts administered by WellSouth. The roles consist of care coordinators (11.0FTE), kaiāwhina (5.0 FTE), physiotherapists (0.5 FTE) and pharmacists (0.8FTE). Additionally, there are 3.0 FTE working within the Hokonui cluster, working across four care coordination roles (2.5 FTE) and a dentist (0.5 FTE), plus approximately five further kaiāwhina roles commissioned directly by Te Aka Whai Ora.

Access to CPCT

At the time of writing, there have been four quarterly contract reporting periods (12 months) since the inception of CPCT. Using data from these reports, it is estimated that CPCT in Southern has engaged with 6,672 individuals[4]. Over a fifth of those individuals were Māori, and a similar proportion were Pacific Peoples. When this proportion is calculated as a rate per 1000 enrolled population, it is highly elevated for Pacific Peoples at 11 times higher than for non-Māori, non-Pacific Peoples. Whilst the rate for Māori is lower than for Pacific Peoples, it is over three times higher than for non-Māori, non-Pacific Peoples (see Figure 2).

Access data suggests that CPCT in Southern is aligning with the objective of increasing equity of access to primary and community care, especially for the district's Pacific population. Data is not available to determine access rates for other priority groups, such as tāngata whaikaha (disabled peoples) and patients living in high socio-economic deprivation. In relation to rural communities, 87% of the practices involved with CPCT in Southern have a rural GCH classification.

Figure 2. Access to CPCT in Southern, broken down by ethnicity and compared to enrolled population demographics

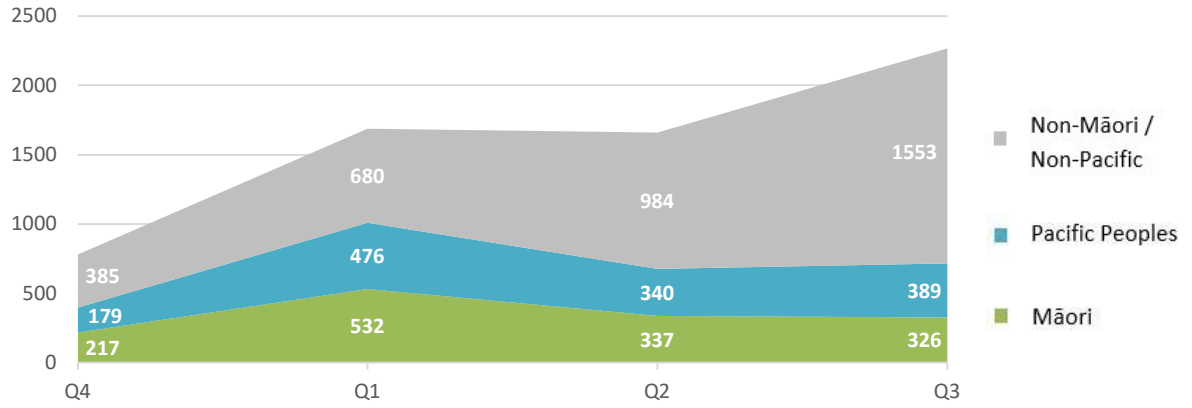


Since the first reporting quarter, the number of people accessing the service (unique service users) has been gradually increasing over time, with the slight exception of quarter 2, which may be expected due to the festive period. Numbers have increased from approximately 800 in the first quarter up to

[4] Figures are totals from four quarterly reports; a unique individual may be counted more than once if they had contact in multiple quarters. Data includes Hokonui's reporting but excludes Te Aka Whai Ora's kaiāwhina contracts.

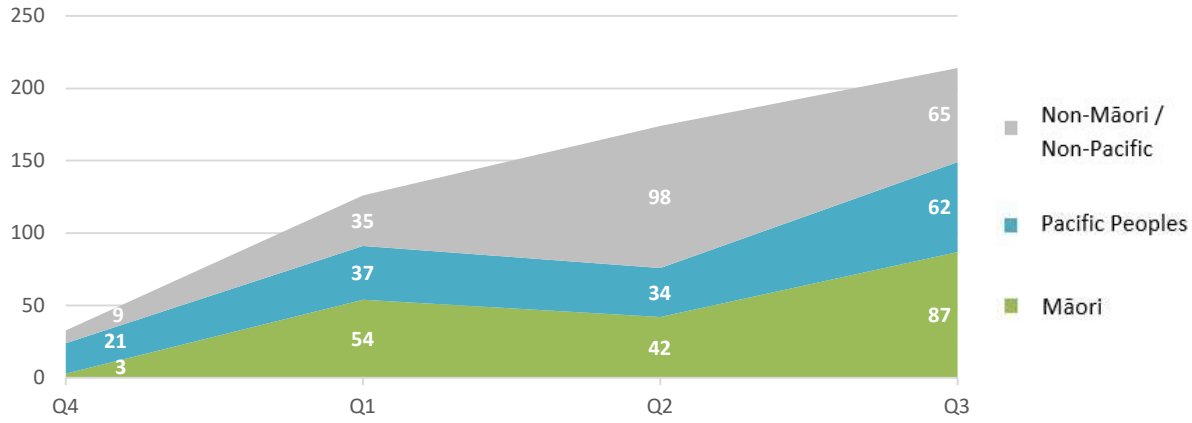
almost 2,400 in the most recent quarter (see Figure 3). This is approximately a 3-fold increase over the 12-month period, with much of the increase coming from non-Māori, non-Pacific Peoples in the most recent quarter.

Figure 3. Estimated number of unique CPCT service users per quarter, broken down by ethnicity, as per submitted contract reporting data[5]



An increase over time is also true for the number of interdisciplinary case meetings[6] held, which have increased from 33 in the first quarter to over 200 most recently (see Figure 4). Despite the difference in population sizes, the spread of interdisciplinary case meetings is relatively evenly distributed across the different ethnic groups.

Figure 4. Estimated number of CPCT interdisciplinary case meetings per quarter, broken down by ethnicity, as per submitted contract reporting data[4]



A more detailed breakdown of the data per quarter for both services users and interdisciplinary case meetings, including the rates per 1,000 enrolled population, can be found in Appendix One.

[5] Data within these figures does not include Hokonui locality as it was not possible to break the number of service users down into each distinct quarter and interdisciplinary case meeting data was not available.

[6] Interdisciplinary case meetings refer to multiple people, services or organisations coming together to discuss the provision of care for a patient.

CPCT and workforce development across Southern

In addition to funding new roles in primary care, CPCT also included funding for workforce development. Organisations in WellSouth clusters were given the opportunity to put forward a proposal for how they would like to utilise their allocation of the funding. The only parameters were that it should contribute toward strengthening or maintaining a sustainable workforce (in alignment with the objectives of CPCT and Te Whatu Ora's National Workforce Plan[7]).

Organisations chose to use the funding in a variety of ways, primarily attending training, clinical certification, educational courses, and conferences across a range of subject areas. Funding was not only used to pay for course fees, transportation, and accommodation costs (where required), but also to provide staff release cover. Analysis of the workforce development applications grouped the many different uses for the funding into 10 categories[8], which are set out in Table 2 below.

Table 2. Workforce development categories, in order of most frequent across CPCT organisations

Workforce development category	Organisations	Staff*
Upskilling in prevention	14	25
Advancing clinical skills	12	26
Other health education	10	16
Rural health expertise	9	25
Routine CPR/resuscitation training	5	10
Assessment and triage training	4	13
Professional development pathway	4	7
Training in IT systems	3	5
Cultural safety education	3	84
Personal and team development	2	98

* Not all applications included total staff numbers; figures are therefore an estimation of the minimum number of people.

The most frequent category was 'upskilling in prevention' which primarily involved training and/or certification in cervical screening and vaccinations both for clinical and non-clinical staff. Within the next most common category, 'advancing clinical skills', the top options were advanced cardiac life support training and advanced palliative care planning. Making up the top three categories was 'other health education', which included topics such as Pacific health and wellbeing, sexual health, and long-term conditions. One of the most attended courses –categorised under 'rural health expertise'– was Primary Response in Medical Emergencies (PRIME). PRIME is a training course for rural practitioners to enable an emergency out of hospital response to be provided for a range of urgent

[7] Health Workforce Plan 2023/24 – Health New Zealand | Te Whatu Ora

[8] Many organisations used/sought to use the funding for more than one purpose, thus they may be counted in multiple categories and/or counted more than once within a single category if staff attended several courses falling within the same category. At the time of writing, some applications were still in the approval process.

medical situations, particularly for areas where ambulance response times are elevated due to their rurality. There were no notable differences in the workforce developed categories invested in by general practices compared to community providers.

Overall, the utilisation of workforce development funding by the organisations within the WellSouth CPCT clusters has met expectations to increase the capability of the primary care workforce beyond CPCT staff. The key areas of focus align well with the CPCT priority objectives, such as enabling more preventative care, broadening the range of clinical services available within primary and community care, and increasing equity of access to care for rural communities.

Exploring CPCT outcomes

This section utilises a series of case studies compiled from the qualitative data, to inform an overarching summary exploring how CPCT is operating in Southern, for whom, and the difference it is making for patients and clinicians. The anecdotal outcomes identified through this approach are then further explored using available primary care data, seeking to identify whether patterns in the quantitative data support the qualitative findings.

CPCT in Southern: A case study approach

The case study summaries presented here provide a limited snapshot of the work being undertaken through CPCT. The full case studies, which can be found in the appendices, not only provide a more detailed account of the range of services being delivered and how, but also offer richer insights into the extent of outcomes for both patients and clinicians.

Case Study One

Case study one was a small rural cluster, consisting of 0.36 FTE across two roles: a care coordinator and a pharmacist (see Appendix Two). The roles work well together, making internal referrals, and work with practice nurses and GPs, the local Māori community provider and other local social services. Since the inception of CPCT, relationships have grown between staff across the general practice, Māori community provider and Pacific community provider, especially at a management level.

Despite the small FTE, CPCT is providing care to a large number of people with a range of differing needs, including but not limited to: people recently discharged from hospital, people with a new diagnosis, people taking a high number of medications (poly-pharmacy), people struggling with long-term conditions, people with complex needs engaged with multiple services, recently bereaved members of the community and people overdue for preventative care (e.g. vaccinations). For this rural community, mobilising staff to conduct home visits, reducing hospital readmissions through discharge support, helping patients navigate multiple care providers in different towns or cities, and enabling elderly and/or disabled people to remain in their homes (as there is no local aged residential care facility) were highlights of CPCT.

In the spotlight

A home visit by the pharmacist not only removed a risk of medication misuse for one consumer but identified struggles with disability access and financial hardship. The care coordinator arranged for supports to be put in place for these issues.

Case Study Two

The second case study was also in a rural area but was a much larger cluster, both geographically and the number of organisations and FTE involved (see Appendix Three). The cluster included care coordinators, kaiāwhina and a physiotherapist. As with the previous case study, the rural context meant the mobilisation of the workforce was particularly valuable, not only to enable home visits to remote areas, but also to transport people to and from appointments and to attend community events, thereby removing barriers to access.

Staff working for the community providers in the cluster have increased access to primary care for Māori and Pacific Peoples by reaching into the community, building connections, and educating the community about the health system, particularly for new migrants. Other focus areas for this cluster included: elderly, disabled and socially isolated members of the community, people with a new diagnosis (especially cancer), people struggling with long-term conditions management (especially diabetes), people with language or other access barriers, those recently discharged from hospital and people suffering a recent bereavement. A success highlighted by the cluster was that, by having the flexibility to meet the nuanced needs of their local communities, they are breaking down barriers to access, thereby providing care earlier in a person's health journey.

In the spotlight

A consumer was supported to navigate the health system and overcome access barriers to care, enabling them to better manage their diabetes, not only resulting in improved overall wellbeing but also new referrals from their positivity about CPCT amongst friends.

Case Study Three

Case study three was in an urban area, focusing on a sub-cluster collaboration between one general practice and one community provider, with a care coordinator and new access routes into existing physiotherapy services (see Appendix Four). Strong partnership working to share resources, including shared access to a central patient management system, new referral pathways between organisations, and agreed distributions of tasks across the two organisations have been central to the success of this new way of working.

Primarily, the sub-cluster are filling gaps in service provision to increase access to care for people who would otherwise not be able to afford support, especially people with chronic pain conditions who are not eligible for ACC funding. Long-term conditions support and education, especially diabetes, is another primary area of focus. Around two thirds of the CPCT consumers across this partnership are Pacific Peoples, contributing to increasing equity of access. A further strength of the partnership approach includes having onward pathways to help people stay engaged with primary care following their initial engagement through CPCT.

In the spotlight

Access to physiotherapy then progression to a group class supported this consumer, who lives alone, to build their confidence and mobility, helping to regain independence at home and reengage with their community.

Case Study Four

The final case study was also classified as being across a rural area, but with a younger demographic than the other rural clusters explored, and with all roles employed by community providers (see Appendix Five). For this cluster, having the time and flexibility to identify and provide support for a wider range of social needs, thereby working toward addressing social determinants of health, was voiced as a key success of CPCT. Relationships between the community providers and general practices in the cluster are growing, with new referral pathways between the organisations increasing access to primary care and social support.

Like Case Study Two, helping people to overcome access barriers, especially by providing transport to, and support at, appointments, has been a central part of CPCT in this cluster. In addition to working with people who are struggling to engage with services, including their general practice, this cluster also frequently provides support for mental health concerns, works with people experiencing financial hardship to help them sustainably overcome these struggles, and delivers health education to the community. Having the flexibility to work at each individual's pace and in a way that works for them has helped build trust, and thus service engagement, especially for those were struggling with their mental health and/or were hesitant to engage with support services.

In the spotlight

The care coordinator and kaiāwhina worked together to provide practical and psychological support for a consumer struggling with a myriad of mental health and financial concerns, which enabled a large improvement in their mental health and facilitated their return to employment.

How do the WellSouth clusters compare to a Locality-based cluster?

As with each of the WellSouth clusters explored, the delivery of CPCT through the Hokonui Locality had many similarities in terms of the types of support being provided, to whom, and the outcomes being achieved. The CPCT clinicians emphasised the value of home visits, flexibility in the time they can spend with a patient, and the wide scope extending to clinical care and social support as well as advocacy and navigation services.

The primary difference between this cluster, and those established by WellSouth, is that all the FTE are contracted through the Locality, rather than a general practice or community provider. This means that they operate more as a single team that works across multiple organisations. Whilst recognising that this approach means added effort has to be made to maintain strong relationships with the organisations involved (which is central to maintaining good referral pathways), it was felt that the benefits of working this way made it worthwhile. For example, the team can spread their hours to ensure continuity of care despite part-time working, share their knowledge and expertise, have a greater availability of skillsets, attend initial assessments in pairs to protect their own safety, and provide internal clinical supervision to support their own mental wellbeing.

The cluster cautioned that being the only person in an organisation working in a certain role can often be isolating. Alternatively, being part of a team can be valuable for the sustainability of the workforce

through enhanced wellbeing. This finding reflects some of the views that were shared by the WellSouth clusters, especially during part one of the evaluation, in which they sought more connection with others.

Despite working in a supportive team, the Locality-based cluster had found it difficult to navigate establishing their model of care and service delivery without having external guidance. At times they felt isolated from what was happening elsewhere in the district and believed that they would have benefited from WellSouth's guidance. They were keen to work with WellSouth further in continuing to develop CPCT despite not being contracted to do so and to connect with the WellSouth clusters. This reinforces the value of WellSouth's role in establishing CPCT in Southern, facilitating networks for organisations and clinicians in similar roles, and providing support and guidance for practices and providers more broadly.

Overarching Summary of CPCT in Southern

The individual case studies demonstrate the breadth of services being provided by CPCT, with an average day for clinicians involving a mixture of proactive and planned care, and of in-practice and community or home visits, for a diverse range of needs. While there is some variation between clusters, there are many similarities in the way the delivery of CPCT was described by participants in this evaluation. This was particularly apparent in the main consumer cohorts, the outcomes being achieved, and the key aspects of the contracts or role parameters that participants believed were enabling the outcomes to be reached.

The services being delivered by CPCT are wide-ranging, encompassing delivering clinical care for physical and mental health concerns, increasing the provision of preventative care, supporting patients to access social support as well as to navigate the health system to access medical care, and delivering health education. The addition of new roles, new or strengthened relationships between organisations, and strong partnership working also means that CPCT is contributing to increasing the breadth of services available, and the coordination of care and knowledge sharing across clinicians, organisations, and clusters. Regardless of the type of support, CPCT was generally described as helping to fill gaps in existing healthcare provision. Participants were especially grateful for the flexibility in scope of the contract, meaning that care can be provided to anyone deemed in need, there is no time restriction, and they are able to travel to home visits and community events to maximise reach. Further enablers of CPCT included providing a free service and having staff embedded in the local community to build trust and rapport with patients who may be hesitant to engage. These factors are helping to support increased access to primary care and equity of access for priority groups, including Māori, Pacific Peoples, people experiencing high socio-economic deprivation and people in remote rural areas.

Overall, CPCT appears to be contributing to improving physical and mental wellbeing of people and communities in Southern, whether directly (through the provision of health care and health education) or indirectly (through helping patients to address social determinants of health, or by increasing the capability and cohesiveness of primary care).

Comparing qualitative outcomes with primary care data

Outcomes derived from the case study data analysis were considered alongside primary care data. Primarily, data was extracted for the period 01/01/2022 to 01/03/2025, although for a small number of measures data was only available for a shorter time frame. Analyses were undertaken on the following primary care datasets, which can be grouped into four main outcome areas:

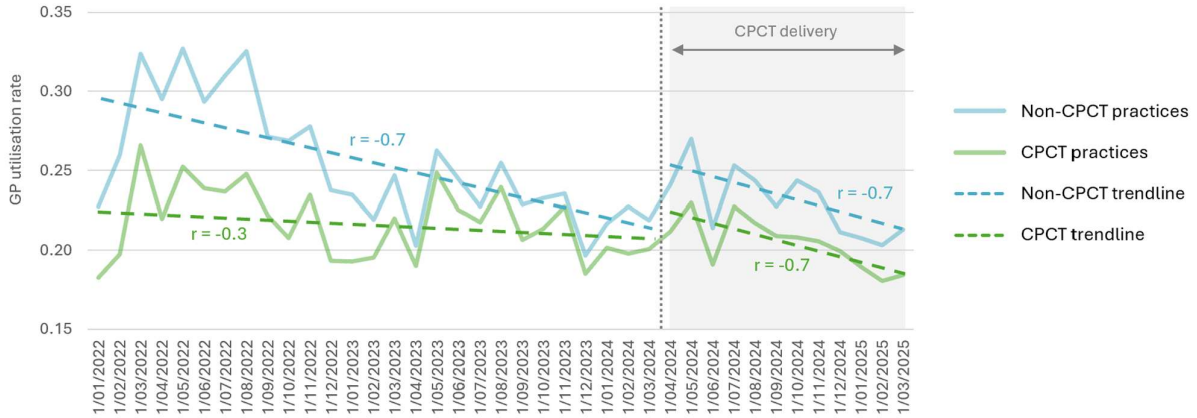
- Access to primary care:
    - Changes in general practice enrolments – proxy for new enrolments
    - General Practitioner (GP) utilisation rates
- Hospital re/admissions:
    - Hospital readmission rates
    - Ambulatory Sensitive Hospitalisation (ASH) rates
- Long-term conditions management:
    - Cardiovascular Risk Assessment (CVDRA) rates of eligible population
    - Diabetes Annual Review (DAR) rates for patients with diabetes
    - Median HbA1C of patients with diabetes and a HbA1C > 64mmol/mol
- Preventative care:
    - Cervical screening rates for eligible population
    - Immunisation rates for children aged 5 and under

Only findings of interest are discussed in the main body of the report; for transparency and completeness, the remaining analyses not presented here are provided in Appendix Six. Although separating the CPCT practices into those with and without an FTE contract did not yield any differences, and therefore the analysis is not included here, this suggests that the outcomes experienced appear to be cluster-wide.

Access to primary care

GP utilisation rates for both CPCT and non-CPCT practices have been declining over recent years. Since the implementation of CPCT, there was a steepening in the downward trend for the CPCT practices, whereas there was no change in trajectory for the non-CPCT practices (see Figure 5).

Figure 5. Average GP utilisation rates for CPCT practices and non-CPCT practices over time

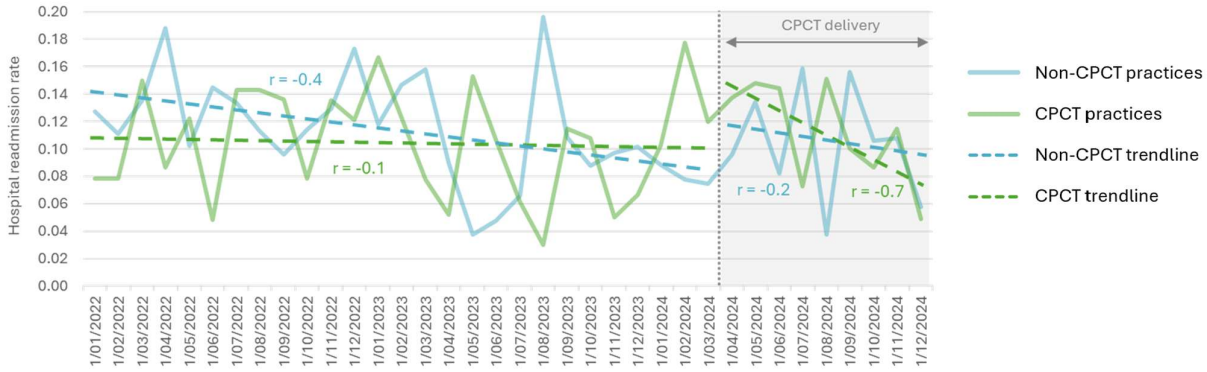


This finding suggests that CPCT may have had a small effect on reducing GP utilisation rates, potentially through the additional capacity and multi-disciplinary approach, reducing pressure on GPs. However, the difference was not statistically significant.

Hospital re/admissions

There is an early indication that CPCT may be an influencing factor in reducing hospital readmissions, however, a lag in hospital-level data means data is only available until the end of 2024. A slight shift in trajectory was seen for the CPCT practices, from a weak increase to a moderate decrease post CPCT implementation. However, for non-CPCT practices, the rate also decreased post CPCT implementation, meaning the change could be due to natural variation or other external factors. More data over a longer time frame is required to make a more meaningful interpretation. For Pacific Peoples, the evidence may be slightly stronger, with the change in trajectory being marginally significant for the CPCT practices compared with the steepness of the downward trend lessening for the non-CPCT practices (see Figure 6).

Figure 6. Average hospital readmission rates for Pacific Peoples at CPCT practices and non-CPCT practices over time



Long-term conditions management

There is some evidence to suggest that CPCT may have had a positive impact on CVDRA rates. As shown in Figure 7, CVDRA rates were declining in both CPCT and non-CPCT practices prior to CPCT. Following the implementation of CPCT, the downward trend has reversed for the CPCT practices, whereas for the non-CPCT practices, the downward slope has continued. However, as the non-CPCT practices have begun to decline at a lesser gradient, external factors may also be impacting on CVDRA rates, thus the observed positive changes are unlikely to be solely influenced by CPCT. The evidence does however indicate that CPCT may have helped to close the gap in CVDRA rates between the CPCT and non-CPCT practices.

When breaking the analysis down by ethnicity, CVDRA rates increased for Māori in both the CPCT and non-CPCT practices post CPCT implementation. However, the rate of increase was steeper for the CPCT practices (see Figure 8). This indicates that CPCT may, at least in part, be contributing to the increased trajectory for Māori. There were no clear differences identified for Pacific Peoples.

Figure 7. Average CVDRA rates for CPCT practices and non-CPCT practices over time

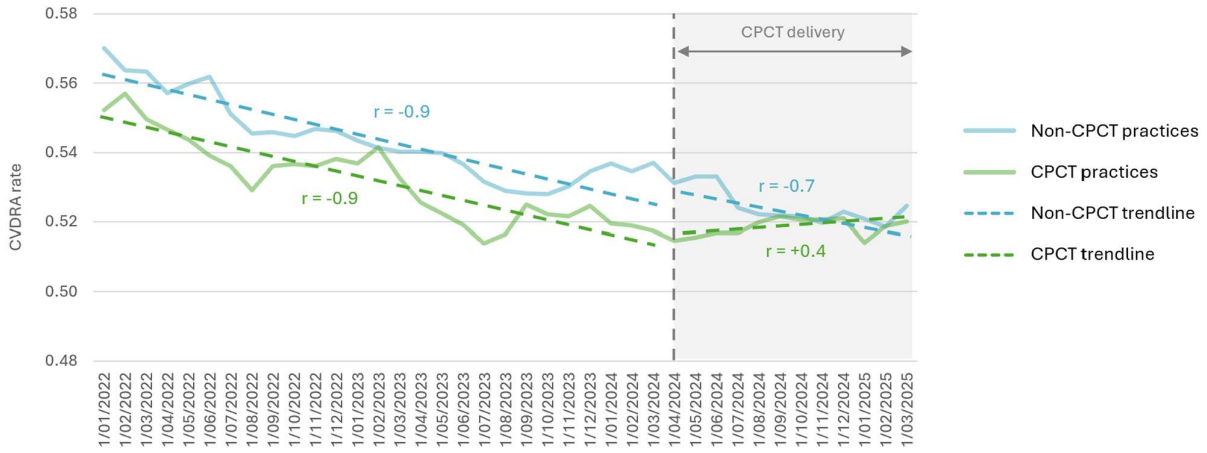
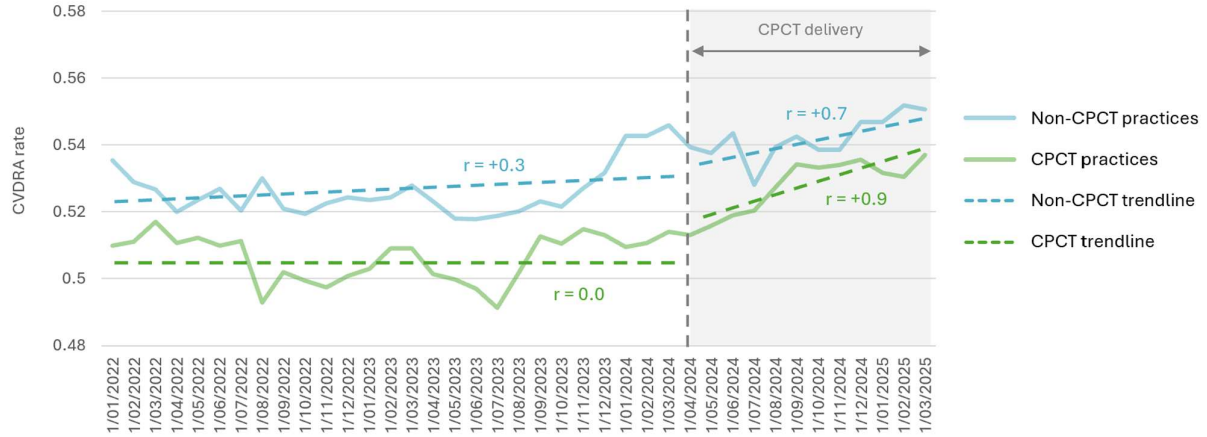


Figure 8. Average CVDRA rates for Māori at CPCT practices and non-CPCT practices over time



Diabetes data indicates that DAR rates may have been positively impacted by CPCT. Overall, DAR rates have been steadily increasing since mid-2022. As per Figure 9, this upward trend has continued since the implementation of CPCT at roughly the same rate for the non-CPCT practices. However, an initial drop for the CPCT practices has been followed by a significantly steeper rise. This suggests that, despite a temporary setback as CPCT was being embedded, CPCT has likely been contributing to positive change in DAR rates for patients enrolled in the involved practices.

Similar to CVDRAs, the continued increase for non-CPCT practices may suggest that additional factors are contributing to the increase beyond CPCT alone. However, there is stronger evidence when focusing on Pacific Peoples, with a significant difference between the trajectory of CPCT and non-CPCT practices following the inception of CPCT (see Figure 10). This strengthens the inference that CPCT had a meaningful impact on the observed changes in DAR rates for Pacific Peoples.

Figure 9. Average DAR rates for CPCT practices and non-CPCT practices over time

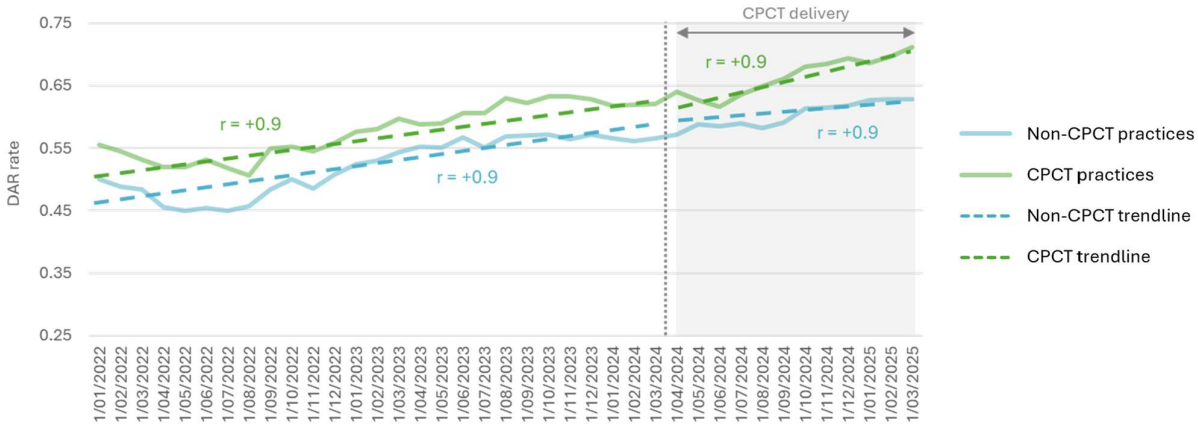
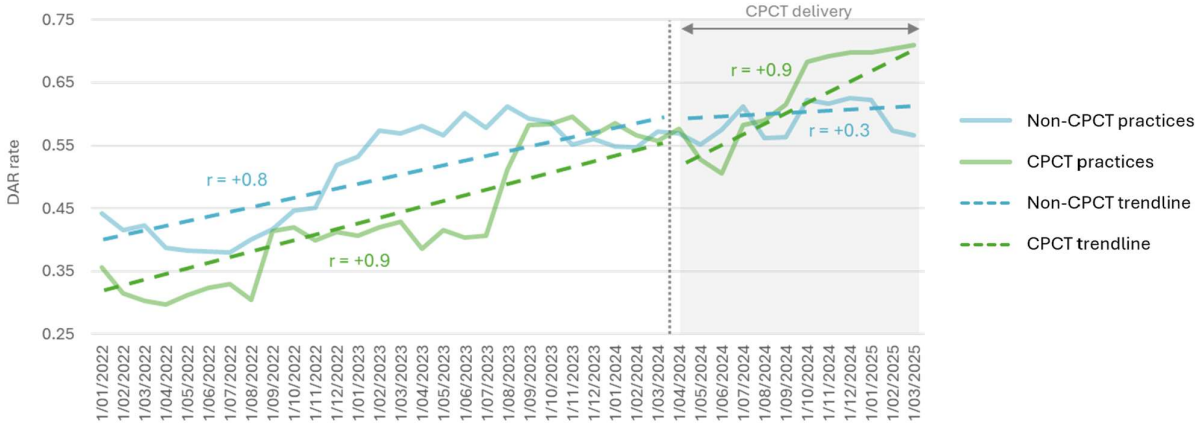


Figure 10. Average DAR rates for Pacific Peoples at CPCT practice and non-CPCT practices over time



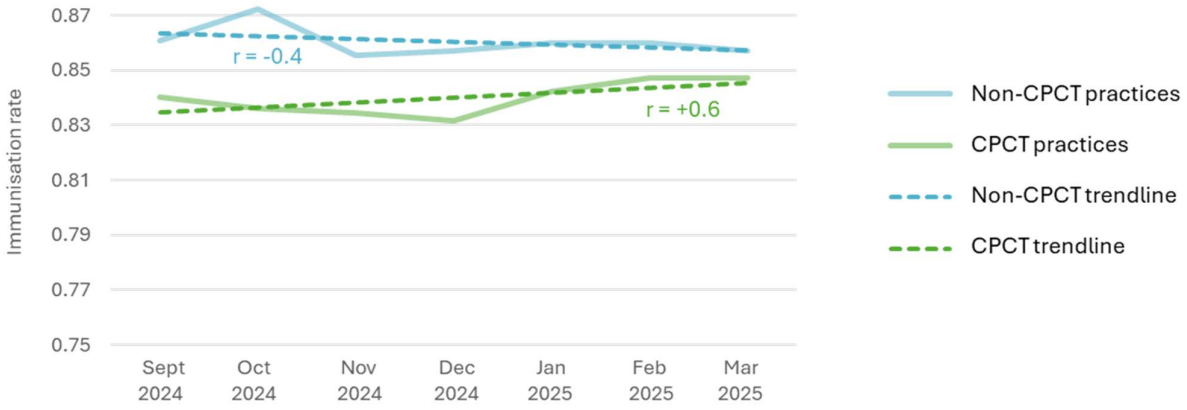
HbA1C, a measurement of a person's average blood sugar level over the past three months, was also considered as a potential marker of improved glycaemic control for people with diabetes. Visual exploration suggested HbA1C levels at non-CPCT practices have continued to follow the same slight upward trajectory, whereas CPCT practices generally displayed a small increase in patient HbA1C in the first 3-6 months following the start of CPCT, then plateaued before starting to decrease (see Appendix Six). Data over a longer time frame is required to make meaningful interpretations, but it is possible that the initial spike could represent an increase in access by patients who had previously not visited their general practice for an extended period of time, and therefore did not have an up-to-date HbA1C recorded, who have then re-engaged in diabetes care. This was especially the case for Pacific Peoples, aligning with diabetes as a core focus for the CPCT staff working at the Pacific community providers.

Preventative care

Early indications suggest total immunisation rates are increasing across CPCT practices, with data showing a moderate upward trend since September 2024. Consistent data prior to this date was not available, and therefore it cannot be determined whether this trend coincided with the start of CPCT in

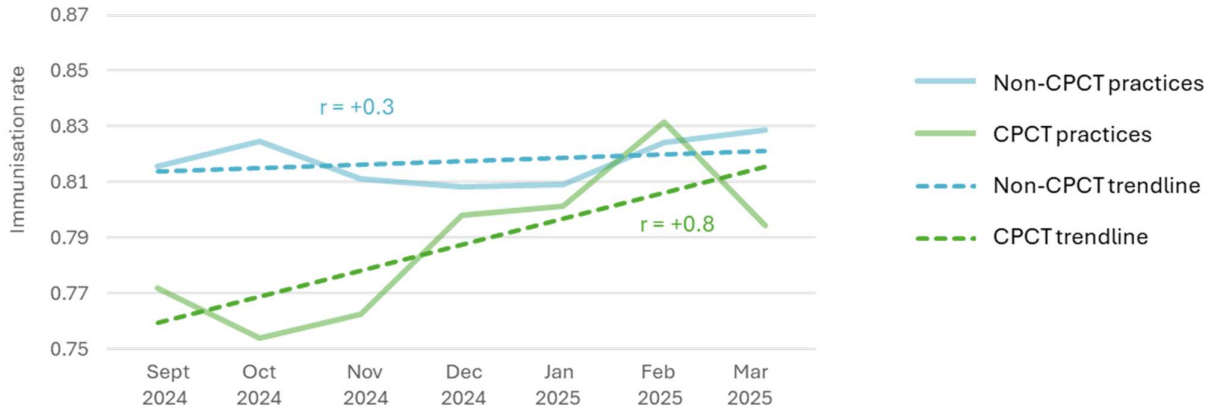
April 2024. However, as shown in Figure 11, the opposite trend is apparent for non-CPCT practices, suggesting CPCT practices are gradually closing a gap in immunisation rates.

Figure 11. Average immunisation rate of CPCT practices compared to non-CPCT practices



Furthermore, analysis by ethnicity determined that, whilst immunisation rates for Māori are trending upward for both CPCT and non-CPCT practices, the trend is much stronger for the CPCT practices (see Figure 12). Although it should be noted that the average rate for the CPCT practices did start at a lower baseline. There was no difference between CPCT and non-CPCT practices found for Pacific Peoples. Further statistical analysis was not conducted due to the limited time series data available.

Figure 12. Average immunisation rate for Māori at CPCT practices compared to non-CPCT practices



Bringing the qualitative and quantitative findings together

The quantitative analysis provided some early evidence that CPCT may be having a positive influence on several clinical metrics. These encouraging findings primarily centred around increasing immunisations, CVDRA rates and DAR rates. including for Māori and Pacific Peoples. Table 3 below provides a summary of the statistical analysis undertaken and associated findings for each measure investigated.

Table 3. Overview of primary care data analysis, split into results from the interrupted time series (ITS) and difference in differences (DiD) statistical tests and a summarised interpretation of those results

Measure	ITS - pre and post CPCT [#]	DiD - between groups	Figure location	Interpretation
Access to primary care				
Enrolments	N/A – trend analysis did not identify as variable for statistical analysis		Appendix 6, Figures 18-20	No clear differences linked to CPCT in total or by ethnicity.
GP utilisation - total	Pre-trend -.082% Post-trend -.336% p = .16	Difference +1.32 p = .34	Main report, Figure 5	Post CPCT, the downward trend steepened but not significantly. Small but non-significant difference between groups.
GP utilisation - Māori	Pre-trend -.068% Post-trend -.336% p = .16	Difference +0.62 p = .66	Appendix 6, Figure 21	Post CPCT, the downward trend steepened but not significantly. Little difference between groups.
GP utilisation - Pacific Peoples	Pre-trend -.168% Post-trend -.293% p = .66	Difference +0.01 p = .96	Appendix 6, Figure 22	Post CPCT, the downward trend steepened minimally. No difference between groups.
Hospital re/admissions				
Hospital readmissions - total	Pre-trend +.035% Post-trend -.043% p = .47	Did not meet assumptions	Appendix 6, Figure 23	Non-significant trend change from upward to downward post CPCT.
Hospital readmissions - Māori	Pre-trend -.048% Post-trend +.143% p = .54	Did not meet assumptions	Appendix 6, Figure 24	Non-significant change in trend same for both CPCT and non-CPCT practices.
Hospital readmissions - Pacific Peoples	Pre-trend -.028% Post-trend -.875% p = .09	Did not meet assumptions	Main report, Figure 6	Marginally significant trend change from upward to downward post CPCT.
ASH rates	N/A – trend analysis did not identify as variable for statistical analysis		Appendix 6, Figures 25-27	No clear differences linked to CPCT in total or by ethnicity.
Long-term conditions management				
CVDRAs - total	Pre-trend -.134% Post-trend +.032% p = <.001	Difference +0.61 p = .23	Main report, Figure 7	Significant trend change from downward to upward post CPCT. Small but non-significant difference between groups.
CVDRAs - Māori	Pre-trend +.002% Post-trend +.203% p = .001	Difference +0.55 p = .14	Main report, Figure 8	Significant trend change from flat to upward post CPCT. Small but non-significant difference between groups.
CVDRAs - Pacific Peoples	Pre-trend -.106% Post-trend +.019% p = .45	Difference -2.4 p = .003	Appendix 6, Figure 28	Small non-significant increase post CPCT. Significant difference between groups in unintended direction

Measure	ITS - pre and post CPCT [#]	DiD - between groups	Figure location	Interpretation
DARs - total	Pre-trend +.476% Post-trend +.810% p = .02	Difference +0.64 p = .74	Main report, Figure 9	Significant increase in trend slope post CPCT. Small but non-significant difference between groups.
DARs - Māori	Pre-trend +.795% Post-trend +.805% p = .98	Difference -1.2 p = .69	Appendix 6, Figure 29	No change pre and post CPCT. Little difference between groups.
DARs - Pacific Peoples	Pre-trend +1.16% Post-trend +1.86% p = .056	Difference +11.8 p = .005	Main report, Figure 10	Increase post CPCT approached significance. Significant difference between groups.
HbA1C - total	N/A – trend analysis did not identify as variable for statistical analysis		Appendix 6, Figures 30-32	Visually appears to be an increase initially post CPCT, then plateaux or slight decrease.
Preventative care				
Cervical screening	N/A – trend analysis did not identify as variable for statistical analysis		Appendix 6, Figures 33-35	No clear differences linked to CPCT in total or by ethnicity.
Immunisations - total	Trend analysis* - CPCT practices: r = + 0.6 Non-CPCT: r = - 0.4		Main report, Figure 11	Moderate increase for CPCT practices compared to decrease for non-CPCT practices.
Immunisations - Māori	Trend analysis* - CPCT practices: r = + 0.8 Non-CPCT: r = + 0.3		Main report, Figure 12	Strong increase for CPCT practices compared to weak increase for non-CPCT practices.
Immunisations - Pacific Peoples	Trend analysis* - CPCT practices: r = + 0.3 Non-CPCT: r = + 0.4		Appendix 6, Figure 36	Weak increase for both CPCT and non-CPCT practices.

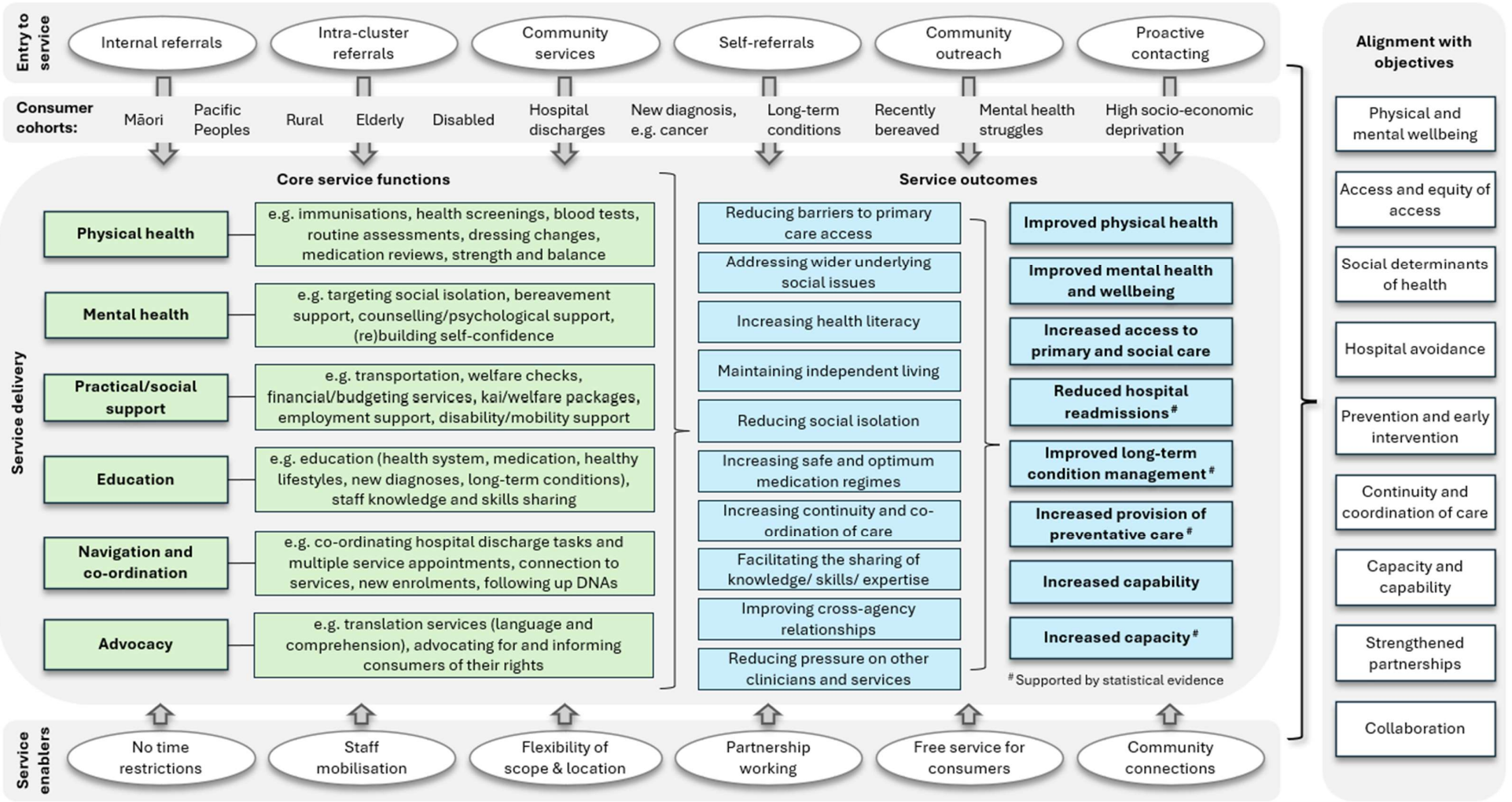
[#] Displayed as the trend (per month) prior to CPCT compared to the trend (per month) after the start of CPCT

*Limited data to enable statistical analyses, so trend analyses using r correlation coefficient utilised: 0.1-0.3 = very weak, 0.3-0.5 = weak, 0.5-0.7 = moderate, 0.7-0.9 = strong, 0.9-1 = very strong.

Overall, the primary care data provides some evidence to corroborate the anecdotal outcomes presented through the qualitative data. In particular, the data supports the case study findings that CPCT is increasing preventative care, supporting long-term condition management, potentially reducing hospital readmissions, and being delivered in a way that aligns with the objective of increasing equity of access and outcomes for priority groups. It should however be acknowledged the data available was limited, especially for some measures, and the impact of CPCT cannot be fully isolated from other external influences. Analysis of data over a longer time frame post CPCT implementation, once available, may help to strengthen any causal inferences made.

Bringing all the data together, Figure 13 provides a visual summary of how CPCT is being delivered across Southern.

Figure 13. The delivery of CPCT in Southern, including who is entering the service and how, different types of support being delivered, key factors enabling this support to be provided, predominant outcomes being achieved and how these service outcomes align with the national objectives



KEY LEARNINGS

Addressing the evaluation questions

What has the experience of CPCT been for consumers?

The consumers who spoke directly to the evaluation team could not speak highly enough of the service they received. They saw great value in the care provided and detailed how it had made a positive difference to their physical and mental wellbeing. Key examples patients shared included identifying potentially harmful medication use, enabling regular blood tests to be completed at home, maintaining independent living by building strength, stability and self-confidence, and supporting mental wellbeing through reduced social isolation. All the consumers spoken to highlighted that CPCT was providing a service that would not have otherwise been available to them. For example, one patient noted that the care co-ordinator was the only person who had contacted them since being discharged from hospital and another explained that the physiotherapy service available through CPCT is the only option in their local area and they, like many in their community, cannot travel further afield. Concern and disappointment were also voiced at the prospect of the service provided through CPCT no longer being available, either for them going forward or for other members of their community who may be in need.

Participating CPCT clinicians also shared consumer stories, with experiences primarily centred around making access to health and social care easier, more seamless and better co-ordinated. This is not only supporting patients to directly manage their health conditions but also to address social determinants of health, supporting their physical and mental health in the immediacy and in the longer term. Whilst these stories were shared from the perspective of the clinicians, their positivity was reinforced through the voices of the consumers.

What has the experience of CPCT been for clinicians and do they view the investment as worthwhile?

Clinicians, both working in and alongside CPCT roles, emphasised the value of CPCT in terms of benefits being delivered directly to CPCT patients and wider impacts for primary and secondary care. Albeit anecdotal evidence only, there was a prevailing view that the funding is providing value for money and those spoken to at management level advised that if they were provided with sufficient funds to keep the service going, then they would use it to do so.

Beyond the direct outcomes for patients, clinicians shared several other aspects that have made delivering these new models of care a positive experience. CPCT was described as providing the ‘gift of time’ for those working within general practices who are generally used to being restricted to 15-minute appointments; clinicians working within the CPCT roles felt they can invest the necessary time to help patients with complex and multifaceted issues. Those working alongside CPCT spoke highly of having somewhere they can refer patients who need more time and support than they can provide, and the flexibility in scope of CPCT meaning they do not feel they have to turn anyone in need away. This was the case for the general practices who employed an FTE directly so could make internal referrals, and for general practices who now have stronger relationships to make referrals through to

their local Māori and/or Pacific community provider. Additionally, CPCT was described by some as reducing pressure on both primary and secondary care, thereby enabling some clinicians to work more at the top of their scope. It was believed that this has the potential to contribute to the sustainability of the workforce by increasing job satisfaction and reducing the risk of burnout.

How is the ongoing delivery of a collaborative model of care impacting intra-cluster relationships?

Part one of the evaluation revealed that the process of being brought together for the purpose of collaboration helped to build new and strengthen existing intra-cluster relationships. Further evaluation has found that relationships have continued to grow and in doing so have resulted in new referral pathways and ways of partnership working being developed. For instance, community providers are helping general practices to contact patients who are overdue routine healthcare but may face barriers to attending, and community providers and general practices are working together to ensure patients with complex needs have wraparound care. Furthermore, as new ways of working take time to embed, it was envisioned that these pathways and the subsequent benefits to patients will only continue to grow should CPCT continue.

How has CPCT, including workforce development funding, impacted workforce capability within clusters?

CPCT has positively impacted on workforce capability through several different avenues. Firstly, the addition of new roles into general practices and community providers has increased the capability of those organisations by expanding the available skillsets and areas of expertise, meaning they have the capability to offer a wider range of services to their community. For example, the addition of a pharmacist or physiotherapist to an organisation who did not previously have these roles means they now have the capability to offer these services in-house rather than making onward referrals (which, for some areas, would mean travelling to another town).

Examples were also given of CPCT staff sharing some of their knowledge and expertise with other clinicians, both within their organisation and with others across their CPCT cluster. There is anecdotal evidence that the new and strengthened relationships achieved through WellSouth's cluster approach to CPCT have enabled a wider spread of knowledge through these networks, both in terms of clinical skills and cultural safety. For instance, stronger links between general practices, Māori community providers and Pacific community providers is helping to enhance cultural competency by providing an avenue where advice and guidance can be sought.

The CPCT workforce development funding has also been utilised to expand the capability of organisations across a range of areas, including prevention (e.g., cervical screening, vaccinations), clinical skills (e.g., cardiac life support training, palliative care planning) and the Primary Response in Medical Emergencies (PRIME) training course to upskill rural practitioners to provide interim emergency out of hospital medical care whilst waiting for the ambulance service. The funding was not restricted only to development for CPCT staff, and has been a core component of enhancing the capability of the CPCT general practices, Māori community providers, and Pacific community providers more broadly.

How has CPCT impacted the capacity of providers, practices and clinicians?

By adding extra FTE to primary care this has not only increased capacity through available support hours but also by altering the way clinicians use their time. Primarily, examples were given of releasing GP capacity, such as a pharmacist carrying out medication audits or a care co-ordinator attending a house call with the district nurse to manually lift a disabled patient who needs dressings changed after surgery, when both these roles would have been done by a GP previously. Data also shows that GP utilisation rates are following a steeper downward trend at CPCT practices compared with non-CPCT practices.

Together, the qualitative and quantitative data suggest that the care being delivered by CPCT and the multi-disciplinary approach it supports, especially for patients with high needs, may be reducing the burden on GPs, thereby freeing up capacity for a GP to see more individual patients. Furthermore, the work to support people recently discharged from hospital, potentially reflected through some positive trend changes in hospital readmission data, may also indicate that CPCT is helping to alleviate some demand on hospital resources. Whilst difficult to measure over the short timeframe, it also stands to reason that the preventative work being undertaken by CPCT would have a long-term impact on reducing the pressure on primary and secondary care, thus increasing long-term capacity.

Who is accessing CPCT, are there any barriers to access, and how does this align with reducing inequities?

Quarterly reporting data illustrates a steady increase in the number of people accessing CPCT since its inception, with around a fifth of those people identifying as Māori and a further fifth identifying as Pacific Peoples. Considered alongside the demographics of the enrolled population in Southern, this equates to a rate approximately 11 times higher for Pacific Peoples and 3 times higher for Māori than for non- Māori/non- Pacific, suggesting CPCT is reducing inequities of access.

It was also found that being able to provide the services offered through CPCT at no cost to the patient has helped to reduce barriers to accessing primary care for those experiencing high socio-economic deprivation. Furthermore, having the flexibility and mobilisation to visit patients at their homes or alternative location of their choice, being able to provide patients with transportation to and from appointments, and being able to provide services outside of normal office hours when needed, has also helped to break down access barriers both to CPCT and wider primary and social care.

To what extent is CPCT in Southern meeting the objectives outlined by Te Whatu Ora?

Access to CPCT continues to grow, with evidence to support that many people being reached were previously struggling to access, or were not engaged with, primary care. Breaking down access barriers and supporting smoother referral pathways, especially for priority groups, is a core component of CPCT, demonstrating alignment with improving access to and coordination of care, as well as increasing equity of access.

The addition of new roles into primary care and the new partnerships between organisations have enabled new collaborations and referral pathways, thereby enhancing the range of healthcare services available, the provision of care to address social determinants of health and more holistic wellbeing needs, and ease of access to these services. This, alongside increased knowledge sharing

and the workforce development funding, appears to be contributing to increasing the capacity and capability of the primary and community care sector.

The flexibility afforded by the CPCT roles and WellSouth's approach was praised as supporting models of care that can adapt to better meet individual, whānau and local community needs. Key areas of focus align with enabling condition management, supporting hospital discharge activity and delivering preventative care. Anecdotally, this is providing consumers with a better experience of primary care, as well as improving their physical and mental wellbeing.

Considered together, the data collected throughout the evaluation (parts one and two) from a range of sources provide evidence that CPCT in Southern is achieving the wide-ranging national objectives, from broadening the scope of care available and the access to it, to working more collaboratively and sustainably to better meet the needs of communities, thereby improving experiences and outcomes for consumers and clinicians.

Lessons learned and future considerations

- The findings show that CPCT appears to be meeting the national objectives outlines by Te Whatu Ora and is achieving a range of positive outcomes for patients directly through the immediate provision of care and indirectly through the benefits of improved cross-agency relationships. Access to CPCT has been steadily building since its inception, and participants described new referral pathways and models of care as still continuing to develop and strengthen. All evidence thus far indicates that funding for CPCT should continue.
- Given the recent extension to the funding and considering the limitations associated with the relatively short time frame of available data, especially for some variables, there is an opportunity to refresh the analysis of primary care data in early 2026. This would provide an additional ~9 months of data to investigate whether further quantitative evidence may strengthen the case for ongoing funding beyond the current contract end date.
- Whilst there were some similarities in the outcomes being achieved, each of the CPCT roles (care co-coordinator, kaiāwhina, pharmacist, physiotherapist) demonstrated their own value. In areas where there were more than one role working together, this appeared to work well to harness the expertise of each role and provide a more seamless experience and comprehensive wraparound support to patients.
- Aspects of CPCT such as health education, social and practical support, and help with navigation or advocacy were regarded by participants as just as relevant to improving health and wellbeing, and preventing the risk of escalation to serious health concerns, as the provision of clinical healthcare. Whether through CPCT or another avenue, there appears to be value in advocating for the provision of funding to resource work to address social determinants of health as a vital form of prevention.
- Several key enabling factors were identified as contributing to the success of CPCT, that could have implications for the development of future programmes and initiatives. This included incentivising and supporting partnership working, affording flexibility in the scope of roles and eligibility criteria of patients, mobilising the workforce to deliver care within the community

(including at people's homes), and not having restrictions on the number or duration of patient appointments.

- Participants appreciated the role of WellSouth in facilitating networking across the organisations and clusters. Despite not being a WellSouth cluster, those working in Hokonui Locality's CPCT would like to be included to a greater extent. This demonstrates the value of WellSouth providing wider network support and guidance for and between participating organisations or individuals when setting up any new initiatives in future.
- The workforce development funding was used to cover costs for staff to attend a wide range of training courses, clinical certification programmes and health education conferences. Not only did this include costs such as course fees, travel and accommodation, but to backfill the roles of staff whilst out of the office. This is an aspect that may be overlooked and should be incorporated into future workforce development budgets.

Conclusion

Overall, the evaluation found that CPCT is highly valued by consumers and clinicians, including those working within CPCT roles and those working alongside CPCT through WellSouth's cluster approach. CPCT appears to be contributing to improving the physical and mental wellbeing of people and communities in Southern through the delivery of a vast range of services. In addition to the increasing clinical capacity through expanding the FTE of primary care, CPCT appears to have a key role as a health system enabler, supporting people to better understand and access health care and plugging gaps in current provision. CPCT also appears to be reducing the burden on other areas of the system, for example by increasing the focus on prevention and early intervention, working with people discharged from hospital, and supporting people to remain in their home for longer rather than progressing to aged residential care.

The findings in this evaluation align with work undertaken by other PHOs that explored CPCT, either through a formal evaluation or more informal reporting, where outcomes included: improved engagement in healthcare, increased health literacy, increased practice capacity, more confidence and trust in the health system, greater continuity and co-ordination of care, better management of diabetes and cardiovascular risk, increased partnership work, a greater focus on social determinants of health, and early indications of reduced hospital admissions or readmissions.[9] This evaluation therefore not only provides evidence that CPCT in Southern is delivering a valuable service, but also contributes to a pool of national evidence that indicates the service is making a meaningful difference not only to our communities but to the health system more broadly.

[9] 250401 GPNZ workforce: current state, future opportunities_FINAL

APPENDICES

Appendix 1: Quarterly access data for WellSouth CPCT clusters*

	Q4			Q1			Q2			Q3			Totals		
	No.	%	Rate per 1,000	No.	%	Rate per 1,000	No.	%	Rate per 1,000	No.	%	Rate per 1,000	No.	%	Rate per 1,000
Service user contacts	783	-	-	2,245	-	-	2,130	-	-	3,001	-	-	8,159	-	-
Unique service users	781	-	2.3	1,688	-	5.0	1,661	-	4.9	2,268	-	6.7	6,398	-	18.9
○ Māori	○ 217	○ 28%	○ 6.2	○ 532	○ 32%	○ 15.1	○ 337	○ 20%	○ 9.6	○ 326	○ 14%	○ 9.2	○ 1412	○ 22%	○ 40.0
○ Pacific Peoples	○ 179	○ 23%	○ 19	○ 476	○ 28%	○ 50.5	○ 340	○ 20%	○ 36	○ 389	○ 17%	○ 41.2	○ 1384	○ 22%	○ 146.7
○ Non-Māori / non-Pacific	○ 385	○ 49%	○ 1.3	○ 680	○ 40%	○ 2.3	○ 984	○ 59%	○ 3.4	○ 1553	○ 68%	○ 5.3	○ 3602	○ 56%	○ 12.3
Interdisciplinary case meetings	33	-	0.1	126	-	0.4	174	-	0.5	214	-	0.6	547	-	1.6
○ Māori	○ 3	○ 9%	○ 0.1	○ 54	○ 43%	○ 1.5	○ 42	○ 24%	○ 1.2	○ 87	○ 41%	○ 2.5	○ 186	○ 34%	○ 5.3
○ Pacific Peoples	○ 21	○ 64%	○ 2.2	○ 37	○ 29%	○ 3.9	○ 34	○ 20%	○ 3.6	○ 62	○ 29%	○ 6.6	○ 154	○ 28%	○ 16.3
○ Non-Māori / non-Pacific	○ 9	○ 27%	○ <0.1	○ 35	○ 28%	○ 0.1	○ 98	○ 56%	○ 0.3	○ 65	○ 30%	○ 0.2	○ 207	○ 38%	○ 0.7

* excludes Hokonui Locality and service users engaging with Te Aka Whai Ora contracted FTE

Appendix 2: Case Study One

Employment model category: General practice(s) manage FTE

Geographic classification: Rural

Composition: x1 general practice, x1 Māori community provider, x1 Pacific community provider

CPCT roles: care coordinator, pharmacist

Total FTE: 0.36

An illustrative day in the life of case study one:

Generally, each day starts with a huddle, where staff discuss patients of concern and the upcoming day. Here CPCT staff often receive verbal referrals, such as for complex patients who indicated additional support needs out of scope or capacity for the GP. In this rural community services are relatively sparse, so the general practice is often a place people go when they don't know where else to turn rather than only for immediate health needs. The flexibility of CPCT facilitates this more holistic wellbeing. Information may also be given following partnership meetings, e.g. the Practice Manager has regular catch-ups with the Māori and Pacific community providers in the cluster and can share updates through the staff huddle. The CPCT staff then review their appointments for the day.

Time dedicated to proactive care

Next, time is dedicated to proactive contact, including reaching out to possible new patients and following up care for existing patients. For the care coordinator, this involves contacting people recently discharged from hospital to ensure all discharge tasks have been actioned and any required supports are in place. Often it is found that onward referrals have not been made or have been made to services that do not extend coverage to their rural area. Navigating the health system and knowing their rights can be a challenge for people, plus the added complexity of rural post means people frequently fail to get appointment notifications until too late (see consumer 'A' spotlight).

Consumer 'A' Spotlight

Consumer 'A' was involved in an accident that caused multiple serious injuries which are being treated by numerous departments and services. Navigating appointments in different cities on the same day, being expected to travel extensively despite the injuries, and finding out about appointments too late, was resulting in many missed appointments and therefore loss of care. The GP was able to refer consumer 'A' to the care coordinator, who had time to read through the wealth of medical notes and bring all the elements together, advocate for the patient to have a manageable schedule, support safe travel, and provide a single point of contact throughout the journey to recovery. The consumer was at risk of being permanently disabled, due to injury complications, had this service not been available to support access to the care needed.

Outcomes: *Increased access to care, reduced hospital attendance, improved coordination and continuity of care*

Consumer 'B' Spotlight

"It's the first time I've ever understood what all my medications are for and why I need to take each one"

Consumer 'B' was referred to the pharmacist due to uncontrolled diabetes that had progressed to high risk of liver failure and limb loss. The consumer was also presenting to hospital for mental health concerns multiple times per week. Having the time to explain the medications and to build ongoing rapport with just a 5-minute phone call each week, is having a wealth of positive outcomes. Medication adherence has increased from zero to ~80%, hospital attendance for mental health distress has largely reduced and consumer 'B' is now attending routine tests and appointments.

Outcomes: *Improved condition management, reduced hospital attendance, increased access to care, improved mental and physical wellbeing*

For the pharmacist, there is a list of people to contact to arrange a medication review or to talk through a new medication regime. Follow-up calls are also made to promote medication adherence and, if time, WellSouth's Thalamus data dashboard can be used to identify and proactively contact those who are eligible but not receiving novel diabetes medication. Capacity to provide proactive and ongoing care is supporting people to improve their long-term conditions management, reducing the risk of complications from polypharmacy, and enhancing holistic wellbeing (see consumer 'B' spotlight). Routinely, time is taken to conduct medication audits and safety checks, ensuring products are stored correctly and do not expire, an example of utilising expertise to free up GP capacity.

Home visits inspire partnership working

Now it's time for some home visits, something both CPCT roles frequently carry out, which not only increases accessibility, but often reveals more about a person's circumstances than if they attended the practice. This can be a catalyst for preventative care, as people often do not ask for help until it escalates to become an emergency. For instance, improving someone's living conditions before they have a serious accident or illness (see consumer 'C' spotlight). In a town where there is no local aged residential care, keeping people in their own home is imperative to reduce the social isolation that is associated with being forced to move away from where lifelong connections have been made, so the care coordinator makes several welfare checks.

Consumer 'C' Spotlight

Consumer 'C' is an elderly and recently widowed patient whom the care coordinator visited for a bereavement welfare check. During the visit it was evident that they were no longer able to look after themselves and their beloved pet dog, with the house in an unsanitary and unsafe condition. Working with the patient and their family, the care coordinator was able to arrange in-home care services to help consumer 'C' and their dog remain safely together in their home.

Outcomes: *Improved wellbeing, maintained independent living, avoided impact on ARC*

The range of issues identified often means CPCT staff working in partnership with other people and services. Today one of the care coordinator's visits follows an internal referral from the pharmacist (see patient 'D' spotlight) while the pharmacist accompanies the local Whānau Ora navigator from the Māori community provider, combining their skillsets to best meet the client's needs. Although the navigator is not funded by CPCT, relationships between the general practice and the Māori and Pacific community providers in the cluster have grown.

Consumer 'D' Spotlight

Consumer 'D' had recently received a cancer diagnosis. The pharmacist carried out a home visit, due to limited mobility, to talk through their medications. In doing so, a cupboard full of old and expired medications that were still being used was found – something that could be extremely harmful. The home visit also enabled the pharmacist to identify that the disabled couple were struggling with the accessibility of their property, and the fridge and cupboards were bare, later determined to be a consequence of the added expense of travelling to weekly cancer treatment appointments.

Noting these additional struggles, the pharmacist made an internal referral to the care coordinator, who attended the property and helped to organise ramp access as well as a taking them to the local community house where they could be connected to other support services, including food parcel deliveries.

Outcomes: *Improved wellbeing through increased access to support service, reduced risk of complications from medication misuse*

Skill utilisation and knowledge sharing at in-practice appointments

It's now time for a series of in practice appointments. As the care coordinator is also a registered nurse, patients have been booked in for blood tests. With less of a time restriction, the care coordinator can take this opportunity to check for any overdue preventative care. One patient requires their HPV screening, and another has attended with a child due for immunisations, tasks that can also be completed during the appointment.

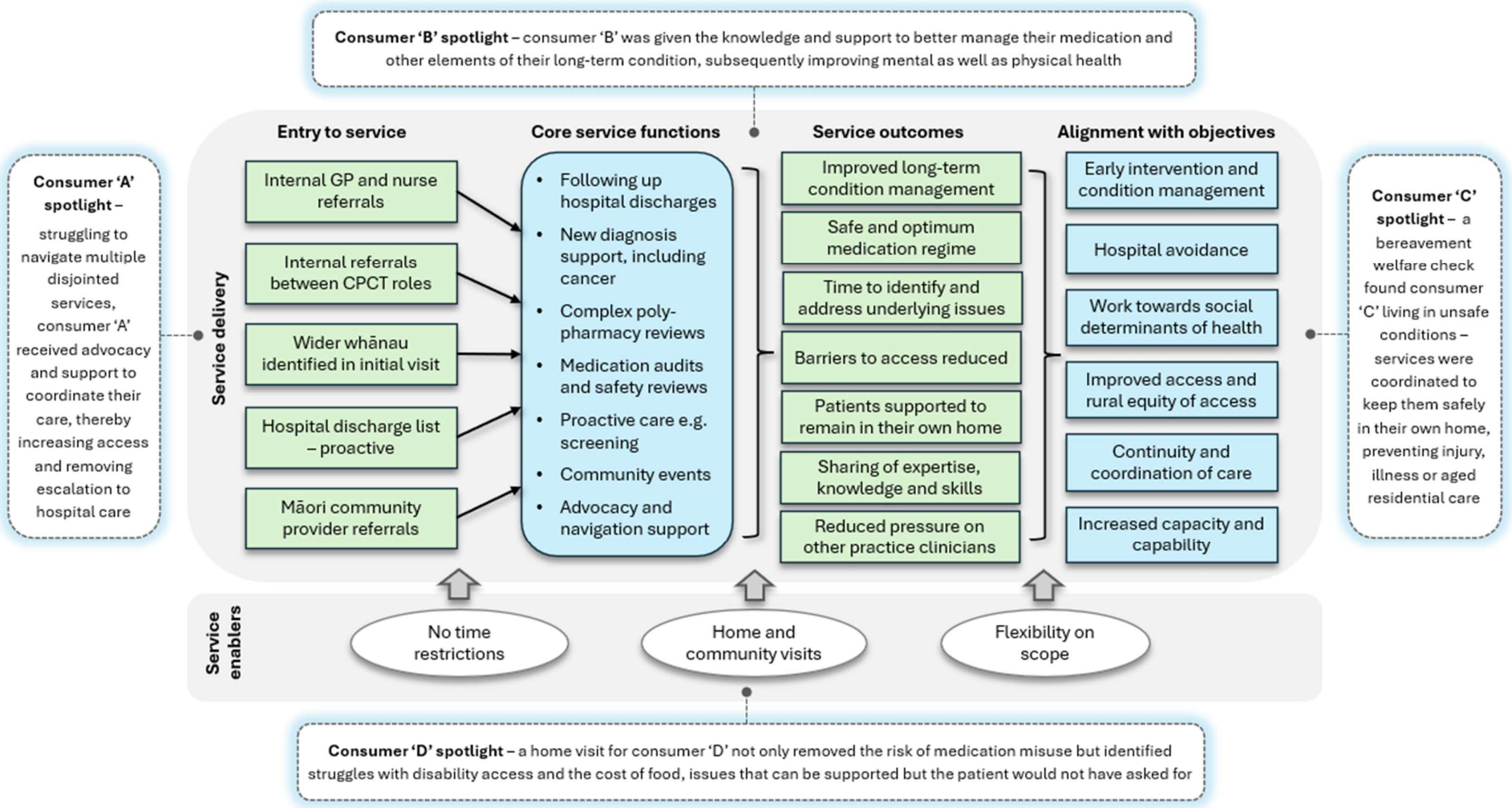
Meanwhile, the pharmacist carries out a review with someone taking a large number of medications for numerous comorbid conditions. It is revealed that they have been accidentally double dosing on some medications, which could have caused long-term harm if not detected. Polypharmacy can be difficult for people to manage, risking reduced adherence, and comes with a danger of adverse drug interactions. The pharmacist also attends a GP appointment where a patient has a new diagnosis, which enables the two clinicians to observe and learn from each other.

Conclusion

As an average day draws to a close, the number of patients who have interacted with the service varies depending on the time each patient needs and the travel requirements for any home visits that day. Across the two roles, around 15 to 20 patients are being supported each week for a range of holistic needs that either directly or indirectly contribute to their health and wellbeing. It was noted that this number could be greater if the staff hours were increased, as the need in the community exists, recognising the small FTE contracted in this cluster.

A summary of the key activities and subsequent outcomes for consumers and clinicians is presented in Figure 14 (overleaf). It should be acknowledged that this list is not intended to be exhaustive but rather to provide an indicative representation of the primary ways in which CPCT is operating in this cluster.

Figure 14. Summary of how CPCT is being delivered, the outcomes reported, and alignment with national objectives, in case study cluster one



Appendix 3: Case Study Two

Employment model category: FTE split across general practices and community providers

Geographic classification: Rural

Composition: x5 general practices, x1 Māori community provider, x1 Pacific community provider

CPCT roles: x3 care coordinators, kaiāwhina, physiotherapist

Total FTE: 2.16

An illustrative day in the life of case study two:

The organisations within this cluster agreed to split the FTE between them as, due to the large geographical area, there were concerns that travel would absorb too much staff time. This means numerous part-time CPCT staff working are throughout the cluster, each employed by a different organisation. Although everyone is working in a way to best meet the needs of their local community, intra-cluster partnership working was still evident.

Benefits of working out in the community

As the day starts, the care coordinator employed by the Pacific community provider heads out to see several new migrants that they met the previous week when attending a community church event; one of the benefits of having the flexibility to go into the community and proactively engage people. Time is spent providing education regarding the New Zealand health system and understanding their medical and family history, as they did not arrive with medical notes. It is established that they both have diabetes. With money identified as a barrier to accessing healthcare, the care coordinator arranges free dietitian appointments through the Pacific provider, advises them of the free support available through Toitū Takata and helps them to enrol at the local general practice. It is reported that enrolments in general practice for this Pacific community have increased since the inception of CPCT.

Also this morning, the cluster's physiotherapist is running a community strength and balance class, which has around 15-20 attendees each week, more than double than when it began 12 months ago. Routines can be adapted to suit all abilities and a class in the local pool takes place on another day for those with low mobility. Classes are not only supporting physical health and enabling people to stay in their own homes for longer but are also building self-confidence and, by being in a group setting, are reducing social isolation – a key issue for rural farming areas (see consumer 'A' spotlight).

Consumer 'A' Spotlight

Consumer 'A' regularly attends the strength and balance class. Although she initially joined after a hip replacement, it was predominantly to encourage her husband to attend – it is one of the only social interactions he has as well as keeping him able to work on his farm despite his age. However, following a fall on her farm, which made her realise the vulnerability of living so isolated, the class became incredibly valuable. Consumer 'A' described how she was able to revert to the beginner level and build her way back up, building her self-confidence as she went and giving her reassurance that she was capable of looking after herself and her husband within their home. As they would not travel elsewhere, the proximity was a key component.

Outcomes: *Increased access to care, maintaining independent living, reduced social isolation*

Several attendees reported that they feel more stable, can now to do tasks at home that they had stopped being able to, and can generally be more active. One lady spoke of how she has returned to helping with the sheep on the farm and, for another, her daughter's concerns about her ability to live alone had been alleviated. The clinician believed classes are reducing pressure on GPs and hospital admissions through falls prevention, as well as the community realising that falls do not have to be an inevitable part of aging. Classes also provide an avenue for the physiotherapist to see if anyone may need one-on-one support or to be connected to other services, such as the health coach.

Consumer 'B' Spotlight

The kaiāwhina received a referral from a local GP who was concerned regarding a patient recently diagnosed with diabetes for whom they had been unable to arrange initiating insulin. The kaiāwhina was able to go to consumer B's home, talk them through the process, help them navigate the complexity of the health system to arrange various appointments, transport and accompany them to those appointments, and help them to obtain and understand the new medication. Since then, numerous self-referrals have been received from people in similar situations who heard from consumer 'B' about how much the service helped and how much better they now feel.

Outcomes: *Increased access to care, improved condition management, improved coordination and continuity of care*

Elsewhere in the cluster, the kaiāwhina employed by the local Māori community provider spends the morning taking people with comorbid conditions to different medical appointments, appointments that the role also helped to arrange. It is unlikely these people would have attended without someone who understands the health system having made the appointments for them or the free transportation. Having someone to accompany them also helps to consolidate understanding and provides a single point of contact across multiple services (see consumer 'B' spotlight). Over lunchtime, the kaiāwhina also reaches out to the community by attending one of the large local employers to host an education session. It has taken time to build relationships with employers for these sessions to take place, and they are increasing access to health care. After the sessions, word of mouth often spreads and triggers more self-referrals, with the realisation that the service is free being a driving factor.

Another care coordinator, based in one of the most rural practices of the cluster, also spends the morning out conducting home visits. They are pivotal to the role as many in the community are elderly, struggle with mobility or cannot drive. These visits not only remove the travel barrier, but more complex issues (such as living conditions) are often revealed, and people open up more in their own space (see consumer 'C' spotlight). As a registered nurse, today's visits include changing a dressing, health checks for a patient who is undergoing chemotherapy, and collecting bloods for

Consumer 'C' Spotlight

During a bereavement welfare check, the care coordinator identified that consumer 'C' was incredibly isolated, and it was impacting her mental health. She had recently lost her husband, had no other family, lived in a remote area and could not drive. Elderly people in these situations are associated with high suicide risk. Over several home visits, it was realised that her husband had dealt with bills and banking, so she did not know how to access her money to support herself. The care coordinator linked consumer 'C' to the Health Improvement Practitioner for mental health support and provided practical life skills and links to local social groups.

Outcomes: *Improved mental and physical wellbeing, maintained independent living*

routine testing for a patient with multiple conditions, all of which free capacity for the district nurse. The latter patient is registered to a GP in another area as the local general practice is closed to new enrolments, so being able to access this service is the only way they can keep up to date with regular tests as they cannot repeatedly travel across the region.

The power of a phone call

The afternoon for the aforementioned care coordinator is spent calling through the recent hospital discharges (upwards of 10-15 people a week) and people with new diagnoses, to address any unmet support needs. It has been found that people in these circumstances are often overwhelmed by information initially and then are unsure where to go to ask questions, putting them at risk when they make uninformed decisions about their own care (see consumer 'D' spotlight). A host of follow-up calls are also made to check in with existing clients, including a someone who did not attend a scheduled MRI scan as part of cancer screening, a recent widow who had stopped taking her medication as a result of the bereavement, and a gentleman with memory difficulties who can forget to take his medication or even to eat but doesn't want and cannot afford to leave his home for residential care. Just a short phone call can make a huge difference to maintain continuity of care and support wellbeing, especially for those who are socially isolated.

Consumer 'D' Spotlight

Consumer 'D' was introduced to the service when she received a phone call from the care coordinator following discharge from hospital after hip replacement surgery. From this it was revealed that she had not been taking her aspirin as she was concerned about taking so many medications, especially painkillers. She was not aware of the link to blood thinning and her high risk of blood clots, meaning this could have escalated to something serious or even fatal. With regular check-ins, the care coordinator was also able to answer questions and give reassurance around pain, swelling, progress rates and physio exercises, as well as facilitating mobility aids. Consumer 'D' emphasised how valuable it was having someone alongside her through the journey and helping her maintain her independence. As she received no follow-up communication from any other services, her questions would have gone unanswered otherwise as she "didn't want to bother" the hospital.

Outcomes: *Reduced risk of hospital admission, increased access to care, maintained independent living*

Partnership work improving patient access and care

The Pacific provider's care coordinator works closely with one of the larger general practices in the cluster, and it is here that they have a consultation room. Their return to the office starts with a patient who has been booked in by the practice GP following a new diagnosis requiring regular medication; this role often supports Pacific Peoples with medication hesitancy, processes for repeat prescriptions, and how to set up and use online systems.

In the office next door, the general practice's care coordinator has been providing diabetes education to a someone who had recently been diagnosed. Both care coordinators then come together for the afternoon to work through a list of people who did not attend scheduled appointments over the previous week, with a view to reduce barriers and support future attendance. Being based at the same site means they are easily able to work together, share ideas and allocate workload based on each of their areas of expertise. Whilst carrying out the follow-up calls, a knock at the door from a practice

nurse requests translation support with someone for whom English is not their first language. Another plus of the Pacific provider's CPCT staff being based within the general practice is that it encourages warm handovers between the organisations, removing the dropout risk associated with cold referrals. Meanwhile, the practice's care coordinator returns to the office next door to finish the day working on a new oral health project being delivered in partnership with another area (see consumer 'E' spotlight).

Consumer 'E' Spotlight

Consumer 'E' has been struggling with dental issues for 15 years but has not been able to afford any treatment. This led to serious tooth decay, tooth loss, and pain that was so intense it was impacting on their ability to eat and work. Through an oral health project that the care coordinator is in the process of establishing, working in partnership with the CPCT service in another cluster, consumer 'E' has been able to receive free care for the first time, having a wide-ranging impact on their quality of life.

Outcomes: *Increased access to care, improved holistic wellbeing and social determinants of health*

The physiotherapist's afternoon involves two home visits, both of which involve working with other services to fill gaps in provision. The first is for someone who is part of WellSouth's falls and fractures programme but has been struggling with the exercises. The physiotherapist supports WellSouth when people need more intensive support. The other appointment is attended with the district nurse for a patient just discharged from hospital after a serious accident; they can now safely lift the patient together rather than requiring another nurse or GP to attend and exercises can be started straight away rather than waiting for ACC approval. The day is then finished with a series of in-practice appointments, some of which take place at the practice's aged residential care facility.

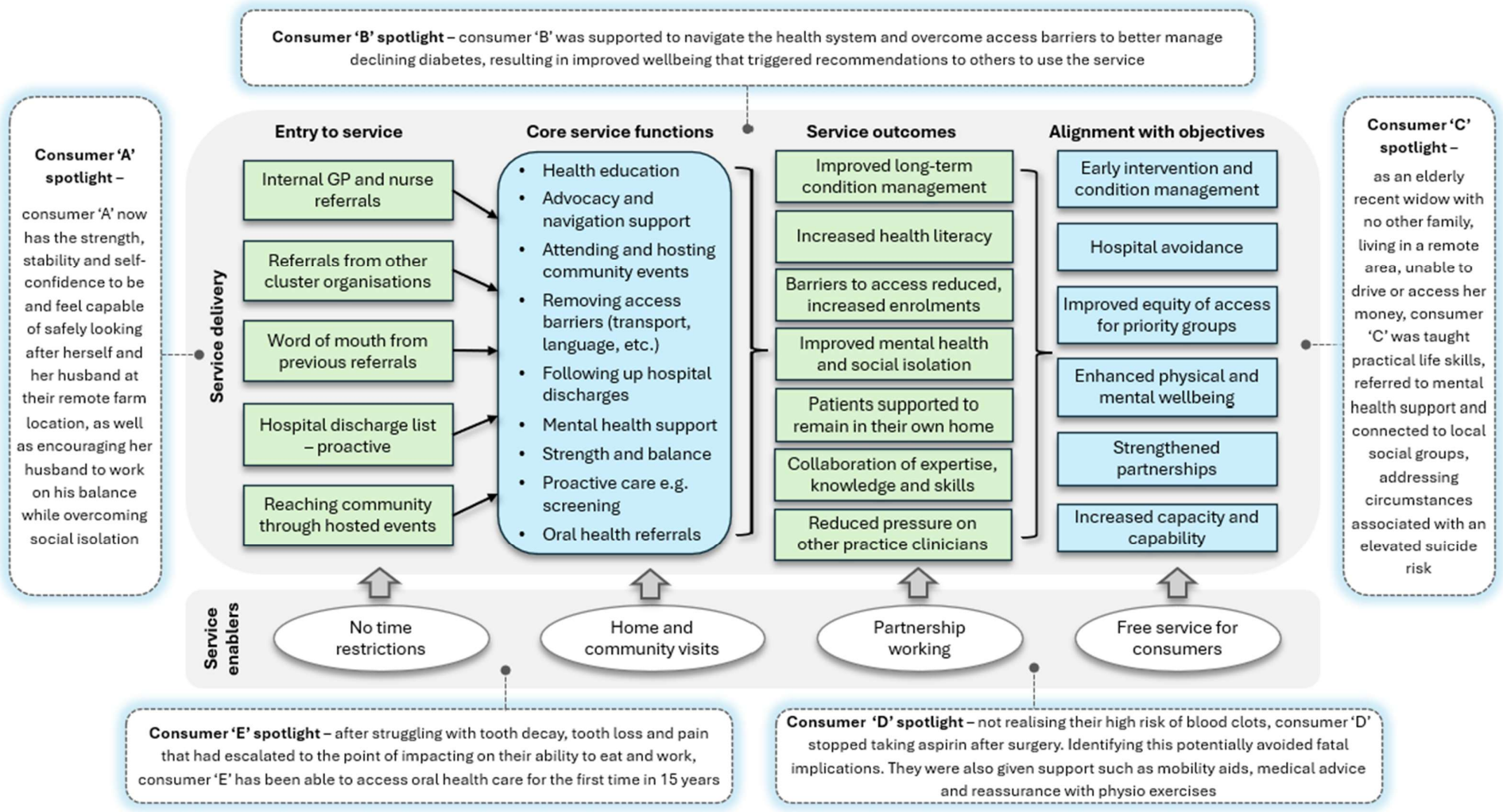
On the return to the office from the lunch session, the kaiāwhina visits someone who has been referred from one of the cluster GP practices due to having a wider scope of social needs identified, for instance they are able to connect this consumer to work and income. The remainder of the afternoon is then spent finalising the details for a community event that they are hosting that coming weekend. The event aims to raise of awareness of what services are available and how to access them, provide advice, and bring proactive care (such as vaccinations and screening) to the community who may not otherwise be engaged with a healthcare provider. Despite the split FTE contract model in this cluster, events like this bring the other organisations across the cluster together in attendance.

Conclusion

By the end of an average day, the five CPCT staff members spread across the cluster have supported a large range of individuals with different needs, from overcoming barriers to understanding and accessing healthcare, and long-term condition education and management, to services that are helping people to be able and feel able to remain safely in their own home, and addressing holistic needs including practical and mental health support. Furthermore, many of the stories shared highlighted improved access to healthcare for Māori, Pacific and rural communities, as well as disabled people.

A summary of the key activities and subsequent outcomes for consumers and clinicians is presented in Figure 15 (overleaf). It should be acknowledged that this list is not intended to be exhaustive but rather to provide an indicative representation of the primary ways in which CPCT is operating in this cluster.

Figure 15. Summary of how CPCT is being delivered, the outcomes reported, and alignment with national objectives, in case study cluster two



Appendix 4: Case Study Three

Employment model category: Community provider(s) manage FTE

Geographic classification: Urban

Composition: x1 general practice, x1 Pacific community provider

CPCT roles: x1 care coordinator, physiotherapy

Total FTE: 1.33 (including vouchers)

One of the urban clusters decided to primarily separate into two sub-clusters. Although communication channels are maintained across the wider cluster, this case study focuses on the model of care being delivered by one sub-cluster.

An illustrative day in the life of case study three:

While the care coordinator in this sub-cluster has been directly employed by the Pacific community provider, the addition of physiotherapy into primary care for this sub-cluster has been achieved by working closely with two existing physiotherapy services using a voucher system. This approach removed the barrier of recruitment from a limited pool of qualified professionals and instead focuses on improving access to existing services for people who will benefit from them.

Plugging a gap in funded care provision

For the care coordinator working within the Pacific community provider, being able to access the service for free is the biggest driver for people; although many of their consumers are enrolled with a general practice, cost is a barrier that can lead to health deterioration (see consumer 'A' spotlight). People often drop into the centre or are referred through a warm handover when seeing another member of staff, so the care coordinator keeps the morning open to ensure they can see these people straight away, removing drop out risk. Today, a previous consumer returns with their whānau for health checks after realising the service was free; the care coordinator administers an overdue vaccination, conducts a HPV screening, checks blood pressure, and provides some education around different medications. Several other staff members pop by and ask if the blood pressure of their clients can also be checked whilst they are on site. In between delivering care, the care coordinator reaches out to some individuals who are due or overdue various health checks, but the cluster general practice has been struggling to

Consumer 'A' Spotlight

Consumer A is a young person who dropped into the Pacific provider as they were told by someone in the community that they might be able to help. They were struggling with very bad eczema, which got significantly worse when they tried using a family member's cream (which was for a different condition) because they could not afford to go to the GP for a new prescription. However, as a registered nurse prescriber, the care coordinator was able to determine the right medication and write a prescription free of cost. This also provided an opportunity to give consumer A education on the risks of using someone else's medication and the possibility of repeat prescriptions.

Outcomes: *Increased access to care, improved condition management, reduced risk of complications from medication misuse, increased health literacy*

engage with. Sometimes the connection to the Pacific community can help to reduce hesitancy and increase access.

Elsewhere, the physiotherapist from one partner organisation starts their day with two appointments with people have been referred from the cluster's general practice. Through the CPCT contract, the physiotherapist provides anyone referred with two free private physiotherapy sessions. Both consumers this morning are suffering from chronic pain from osteoarthritis, with one on a waitlist for a joint replacement. As neither has health insurance and they cannot afford to pay for private sessions, they would not have been able to access care without this free service. Chronic pain, particularly among people aged 50+ who are struggling with socio-economic deprivation, constitutes a large proportion of referrals. For these people, having physiotherapy at an earlier stage can delay or in some cases prevent degeneration to the need for a joint replacement, but without CPCT they are not otherwise eligible for funded physiotherapy.

The physiotherapist from the second partner organisation holds their consultations at the Pacific community provider's premises, which is increasing access for people who are not engaged with health care elsewhere. Although their referrals primarily come directly from the provider rather than general practice, they see a similar cohort of people who would otherwise fall through a gap in funded care provision. Their first appointment this morning is with someone suffering from chronic back pain. The next is someone who was injured several years ago, did not seek help at the time and their condition has gradually deteriorated, but they are no longer covered by ACC funding. Where someone is eligible for ACC, an onward referral will be made, but sometimes people are still unable to pay subsided fees and therefore will go without care.

Continuity and co-ordination of onward care through partnership working

The physiotherapist then supports a senior's exercise class also held at the Pacific community provider. It provides an opportunity to further strengthen relationships with the Pacific community, meaning people are more likely to share concerns, and to identify people who may benefit from a more specialist intervention. Being able to remain active is pivotal not only to physical health but also mental wellbeing, such as by making social interaction easier, and the class is also an option for people to continue building their activity levels following one-on-one physiotherapy sessions with some familiarity (see consumer 'B' spotlight).

Consumer 'B' Spotlight

Consumer B was referred to the physiotherapist working out of the Pacific provider by another internal service due to their decline in mobility. They had withdrawn from their usual social activities due to their struggles to walk and was therefore starting to feel isolated. The physiotherapist was able to work with consumer B to the point where they felt comfortable to join the Pacific provider's exercise group and to return to attending church. Over time they built up to rejoining a social walking group. As someone who lives alone, being able to manage better at home and reconnecting to the community have both made a big difference to this individual's quality of life.

Outcomes: *Improved physical and mental wellbeing, maintained independent living, reduced social isolation*

The cluster's other physiotherapist also runs an exercise class, which mainly focuses on strength and balance. This class is one of a series of six weekly group classes that is available for all CPCT-referrals to help continue their progress after the two private sessions are completed. The health coach from the cluster's general practice is also in

attendance; here they can build relationships with the community, raise awareness of the Access and Choice programme, and connect them to further support if required. Again, this approach provides an avenue for onward care as well as continuity in that care.

Meanwhile, the care coordinator has some appointments booked in, predominantly regarding diabetes management and education; diabetes support is one of the main focuses of their role. While several people have been referred from internal members of staff, others have come from the cluster's general practice. Through CPCT and the cluster approach, the care coordinator has access to the general practice's PMS, which makes referrals much easier between the two organisations and means medical records can be checked and updated. This helps to reduce the risk of duplication of work, misdiagnosis, contraindications, double doses of vaccines and missing due health checks or appointments (see consumer 'C' spotlight). It also means the patient does not have to repeat themselves to different healthcare providers or be relied upon to pass on accurate medical information. Working from the same premises means that, for the final appointment of the day, the care coordinator and physiotherapist jointly see a patient with multiple health conditions. This partnership working supports access by the patient only having to attend a single appointment.

Consumer 'C' Spotlight

During a conversation about diabetes, consumer C mentioned that they did not know anything about their blood sugar. They were able to be immediately taken to see the care coordinator, who carried out a prick test. As the reading was very high, they went on to do several other diabetes health checks, including a foot check, which revealed the patient urgently needed podiatry care. Reaching out to known contacts failed to find anywhere with prompt availability. However, as consumer C was enrolled with the cluster's general practice, the care coordinator was able to check their medical records and determined that a podiatry referral had already been made but the patient was not aware as they did not speak English well. The consumer was able to attend the appointment, and a translator was arranged to attend also. Had they not seen the care coordinator, they would have missed the appointment, and their feet would likely have deteriorated to potential amputation point, as they never proactively raised any concerns.

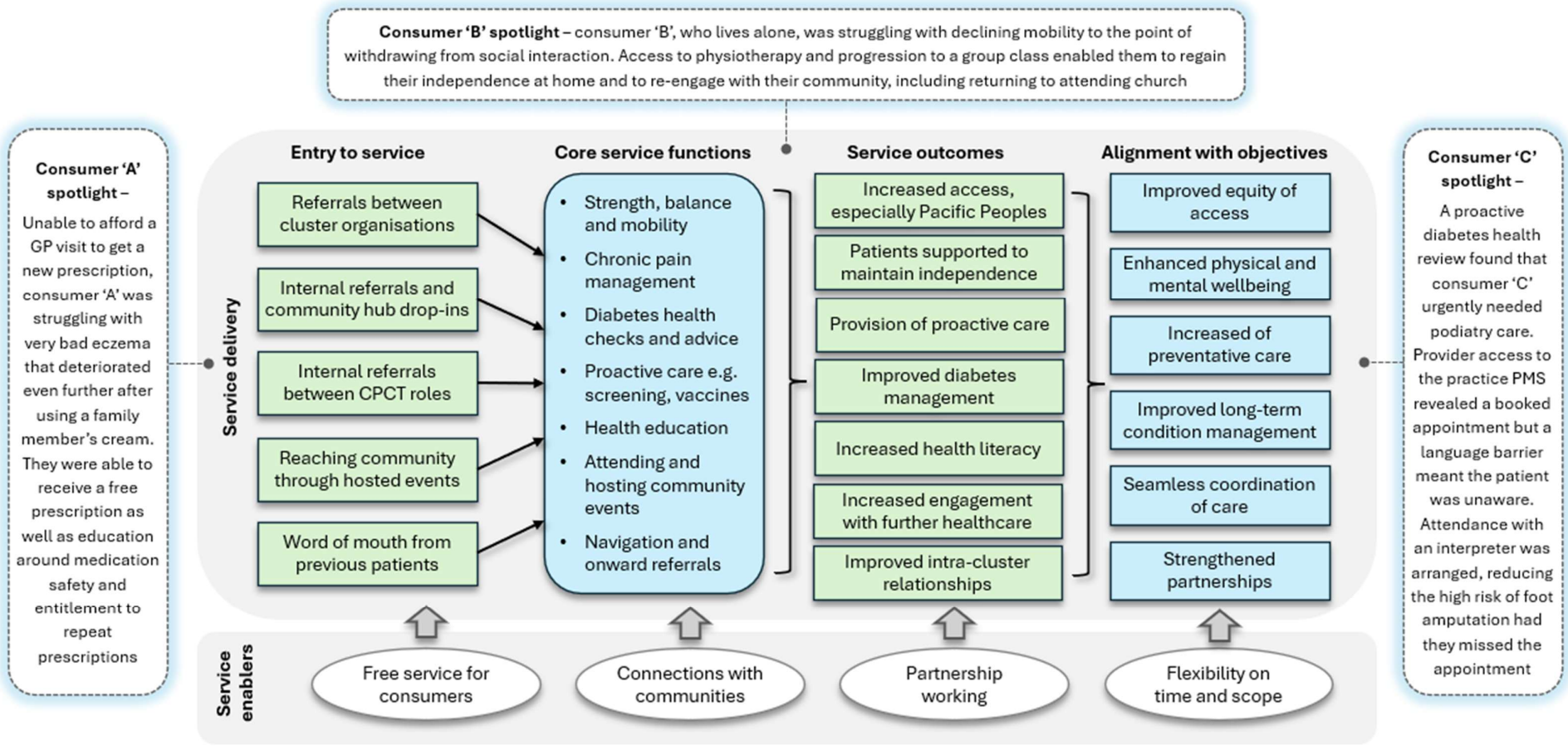
Outcome: *Increased access to care, improved condition management, reduced risk of hospital admission*

Conclusion

For CPCT in this sub-cluster, the average day sees access to physiotherapy and nursing services for multiple people, around two thirds of whom are Pacific Peoples, who would not be able to afford this healthcare otherwise. The addition of the care coordinator has brought these skills to an organisation that previously did not have any nursing capability. Strong partnership working, including shared PMS access, is central to the success of this model of care. The new relationships are extending beyond CPCT staff within the organisation, resulting a range of benefits for consumers, including a more seamless experience of care and transition or referrals between services.

A summary of the key activities and subsequent outcomes for consumers and clinicians is presented in Figure 16 (overleaf). It should be acknowledged that this list is not intended to be exhaustive but rather to provide an indicative representation of the primary ways in which CPCT is operating in this cluster.

Figure 16. Summary of how CPCT is being delivered, the outcomes reported, and alignment with national objectives, in case study cluster three



Appendix 5: Case Study Four

Employment model category: Community provider(s) manage FTE

Geographic classification: Rural

Composition: x4 general practices, x1 Māori community provider, x1 Pacific community provider

CPCT roles: x2 care coordinators, kaiāwhina

Total FTE: *3.0*

An illustrative day in the life of case study four:

The key demographics and associated needs of this community appeared to differ from the other case study clusters; generally, the population is younger and pressure from the rising costs of living has resulted in more acute mental health needs, as well as the social needs that are impacting on declining physical health across the rest of the district.

Partnership working increasing access to primary care

The first appointment of the day for the care coordinator employed by the Pacific community provider is a home visit with someone who has been referred from one of the cluster's general practices because they have not attended routine medical appointments for a long-term condition. It is believed this may be because they owe money to the practice, which is a frequent barrier to accessing healthcare, but something that growing relationships between community providers and general practices in the area is helping with. The care coordinator provides budgeting support, begins to work with the consumer to put a plan in place to reduce their debt, and connects them to several free services through the Pacific community provider in the interim. This service is helping people to get through temporary financial crises (see consumer 'A' spotlight) or to manage financial hardship in a sustainable way.

Consumer 'A' Spotlight

Consumer example 'A' involves a young couple, expecting their first child, who recently moved from one of the Pacific Islands and so had no family or social support. The care coordinator firstly helped the couple register with a midwife, a service which is extremely oversubscribed in the area. Later, pregnancy complications meant the mother having to leave a physical job and attend hospital several hours away. Reducing to one income and the additional travel costs were a huge financial strain, so the care coordinator was able to help with some free support services, such as kai packages to reduce some of the pressure during this difficult period.

Outcomes: *Improving physical and mental wellbeing through addressing social determinants of health*

Next is an appointment with another patient who the general practice has been struggling to engage with, who agreed to meet with the care coordinator because their name was recognised from their involvement in the Pacific community. Already having this connection encourages trust that supports engagement. It turns out that the individual did not understand that their medication was meant to be a repeat prescription or that their condition would need ongoing monitoring. It is not unusual for limited understanding to inadvertently result in low medication adherence. As a registered nurse, the care coordinator also carries out several health

checks, such as checking blood pressure. Having this range of skills is increasing access to care by not expecting people to make the time or have the resource to attend multiple appointments (see consumer 'B' spotlight).

As the Pacific community provider's offices are several hours away, most appointments in the area are home visits. However, if this is not appropriate, such as having children or other family members at home, an appointment can be offered at the local Māori community provider's premises instead. Through the new relationships established since CPCT, there is a growing partnership developing between these two organisations.

Consumer 'B' Spotlight

Consumer 'B' was referred from paediatrics after hospital discharge to support the family with illness management. The family were struggling to manage regular testing around school and work commitments, particularly with limited transport. The care coordinator was able go to their home after school, take the necessary swabs, then deliver them to the lab. This also coincided with strikes and lab closures, which the care coordinator was able to navigate by obtaining new order forms and retaking the swabs. Without this support, the family would not have been able to get the tests completed and instead would likely have only sought medical help if the illness escalated to consumer 'B' requiring further hospital level care.

Outcomes: *Increased access to care, improved condition management and reduced risk of hospital readmission*

Meanwhile, the care coordinator working at the Māori community provider primarily spent their morning processing new referrals. One of the cluster general practices has sent through several referrals after a staff huddle where they discussed any patients with complex social needs and people who may benefit from any of the free support the staff at the Māori community provider can offer. Since CPCT, some general practices in this cluster have started to periodically make calls to patients who may benefit from proactive care, such as people recently discharged from hospital and women who are overdue HPV screening, who they then refer to the Māori community provider when appropriate. A referral has also come from the health coach at another cluster general practice; the CPCT and Access and Choice programmes are working well together, referring between organisations or working together to meet an individual's holistic needs.

The care coordinator calls each person to introduce the service, collect initial details, and to arrange a more detailed needs assessment. Following the Te Whare Tapa Wha model, these assessments are primarily conducted in person with whānau to understand whose skills are best placed to provide support – as a qualified counsellor, the organisation's care coordinator prioritises clinical needs and mental health, while the kaiāwhina focuses on social support and navigation. However, they often work together to meet holistic needs and, despite having their own areas of expertise, working as a team means they can also offer personal and professional support to each other.

Time spent navigating social as well as health systems

Elsewhere, the kaiāwhina spends most of the day out on the road. The first task is distributing some kai packages to people's homes. To save travel, if they are in the same community, they can drop off packages for the Pacific care coordinator too if needed. Like the Pacific community provider, this service is to help people get back on their feet, being managed sustainably alongside budgeting support. In doing so, this also gives the opportunity to carry out some welfare checks with whānau.

Consumer 'C' Spotlight

Consumer 'C' was struggling with a myriad of mental health concerns. It was quickly ascertained that financial struggles were a key contributing factor, starting with their car being off the road, leading to losing their job and becoming isolated. Working together, the care coordinator was able to address the person's immediate mental health needs, whilst the kaiāwhina provided social support, starting with connecting them to MSD to get financial support and to get the car repaired, providing interim transport to appointments, and connection to a budgeting service. Once they felt ready, the kaiāwhina was also able to help with job applications and appropriate work clothes. Consumer 'C' is now back in work and their mental health is much improved.

Outcomes: *Improved mental wellbeing and social determinants of health*

The kaiāwhina then spends the remainder of the day taking people to and from both medical and social care appointments, attending these appointments alongside them to help them understand and navigate the complex systems, and helping to connect them to other services they may need. There are many services available in the area that are relatively unknown, therefore without the kaiāwhina to make these connections, these people would be unlikely to ever access these services. For people with complex needs and mental health struggles, being engaged with various services can be challenging and overwhelming, so having the kaiāwhina to provide continuity of care, and reduce some of this pressure by making appointments and breaking them down into the most immediate needs first can be valuable (see consumer 'C' spotlight). Today, two of the consumers ask if they can also be taken to the local pharmacy as they have multiple outstanding prescriptions that they have not been able to collect and therefore have been without their medication; having someone to help with transport is also helping people who would otherwise be unable to not only attend appointments but access other care.

Similarly, the afternoon for the Pacific community provider's care coordinator involves escorting several people, for whom English is not their first language, to their appointments. Alongside providing transportation, this service helps to break down language barriers by connecting them to a translator if needed or having someone who can spend time explaining in more detail and answering questions after a 15-minute GP consultation is over. The care coordinator has found that people will often save up multiple issues for one appointment to save money, meaning the time a GP or nurse can spend on each issue is restricted. This can be problematic, especially for people with low health literacy, as people often do not follow up on advice if they do not understand, meaning conditions are then left to escalate.

Being flexible on times and locations for delivering support

The care coordinator from the Māori community provider also then heads out for the afternoon to visit some consumers, including someone who has been struggling with self-harm and someone in recovery from drug addiction. Today, one of the visits is to a local park, as this removes the need for the perosn to find childcare, and another appointment involves heading for a walk. It is felt that removing the clinical setting, at the individual's preference, can help people to feel more comfortable and build rapport. These regular welfare checks can help with social isolation as well as pick up early signs of mental or physical health deterioration. New relationships with general practices also mean that the care coordinator can contact a consumer's GP for advice if medical concerns are noted during a welfare check that they are unsure about.

The final visit is for a first appointment, and as much time as necessary will be spent exploring their needs. Not having time restrictions on appointments or care duration means they can go at the speed of each individual, again building rapport and supporting engagement (see consumer 'D' spotlight).

Consumer 'D' Spotlight

Consumer 'D' was referred by a social worker, who was required to discharge the individual from their service due to not engaging but still had concerns about their welfare. The care coordinator contacted them, but they refused an in-person appointment. Concerned consumer 'D' was isolating themselves from interaction, the care coordinator instead dedicated time to phone calls, which led to agreeing to drop a kai package om their doorstep. Going at consumer 'D's pace and providing agreed support for immediate physical needs enabled rapport and trust to be built, which progressed to being invited into their home and being able to provide more social and psychological support. This helped consumer 'D' to rebuild confidence in interacting with people, to the point where they decided to move to be closer to family who they had previously been separated from.

Outcomes: *Increased access to care, improved condition management and reduced risk of hospital readmission*

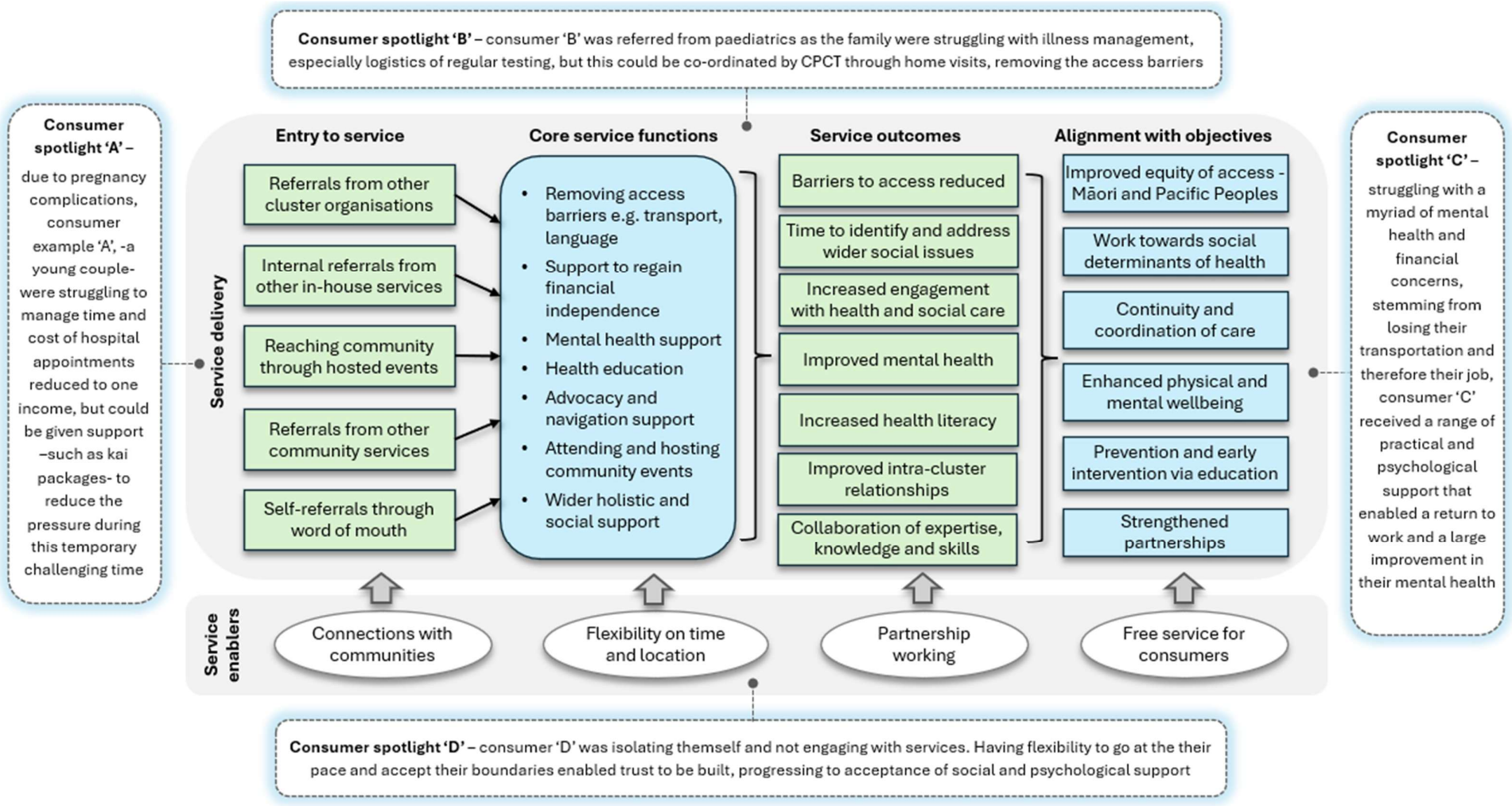
As the usual working day comes to an end, the care coordinator from the Pacific community provider heads to one of the local churches to finish the day by hosting an education session. Tonight's session is on healthy diets and nutrition, but the health education offered covers a range of topics. With a large portion of the community being in the younger working age-group, it is a good opportunity to provide preventative health education at an early point, but having the flexibility to take the session to the community and do so outside of working hours is also important.

Conclusion

Across the cluster, around 10-15 consumers are engaging with the service each day, with many benefiting from the mobilisation of the workforce, either through home and community visits or by having support attending their appointments. Partnerships are growing in the area, expanding the reach and scope of some services, and general practices feel that, with time, this will continue to grow if the new CPCT services on offer become embedded in the area.

A summary of the key activities and subsequent outcomes for consumer and clinicians is presented in Figure 17 (overleaf). It should be acknowledged that this list is not intended to be exhaustive but rather to provide an indicative representation of the primary ways in which CPCT is operating in this cluster.

Figure 17. Summary of how CPCT is being delivered, the outcomes reported, and alignment with national objectives, in case study cluster four



Appendix 6: Results of exploratory analysis not included elsewhere

Figure 18. Average change in enrolments – total

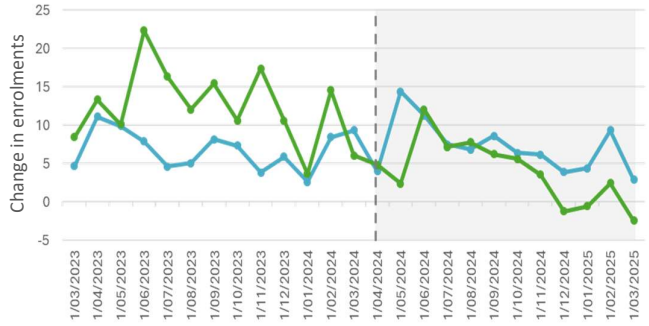


Figure 19. Average change in enrolments – Māori

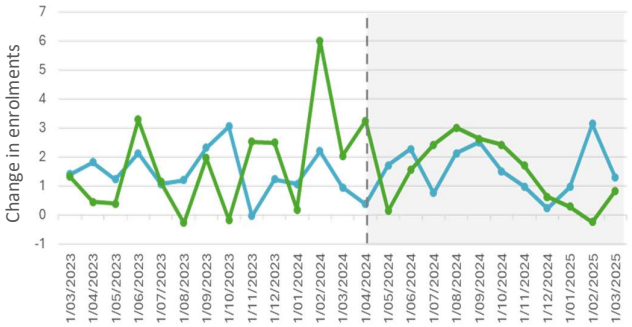


Figure 20. Average change in enrolments – Pacific Peoples

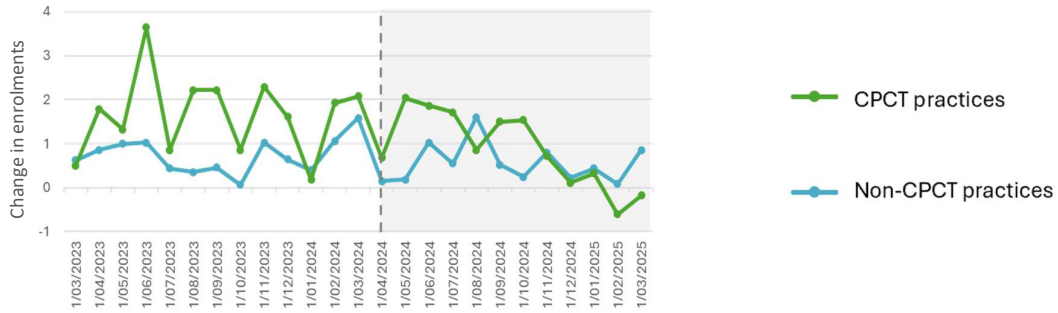


Figure 21. Average GP utilisation rates – Māori

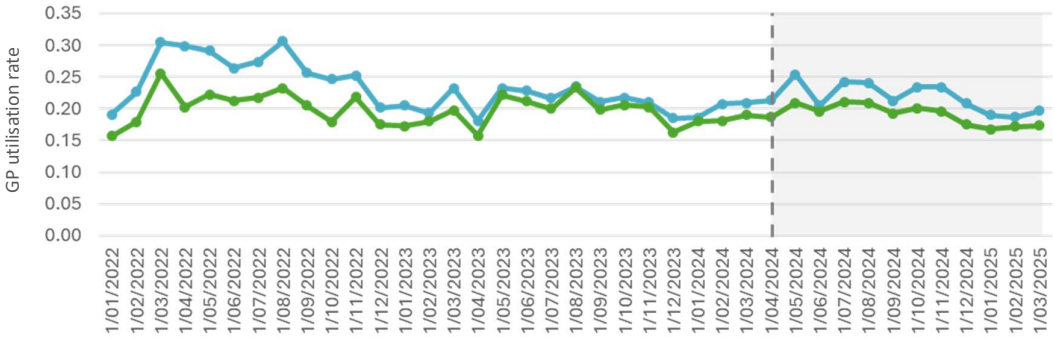


Figure 22. Average GP utilisation rates – Pacific Peoples

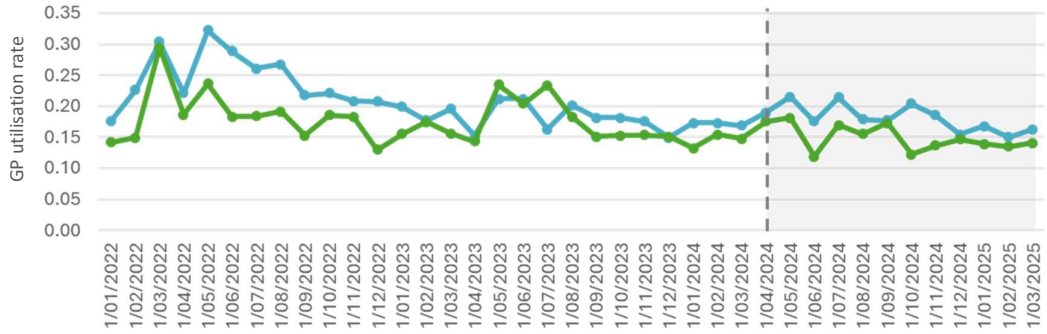


Figure 23. Average hospital readmission rates – total

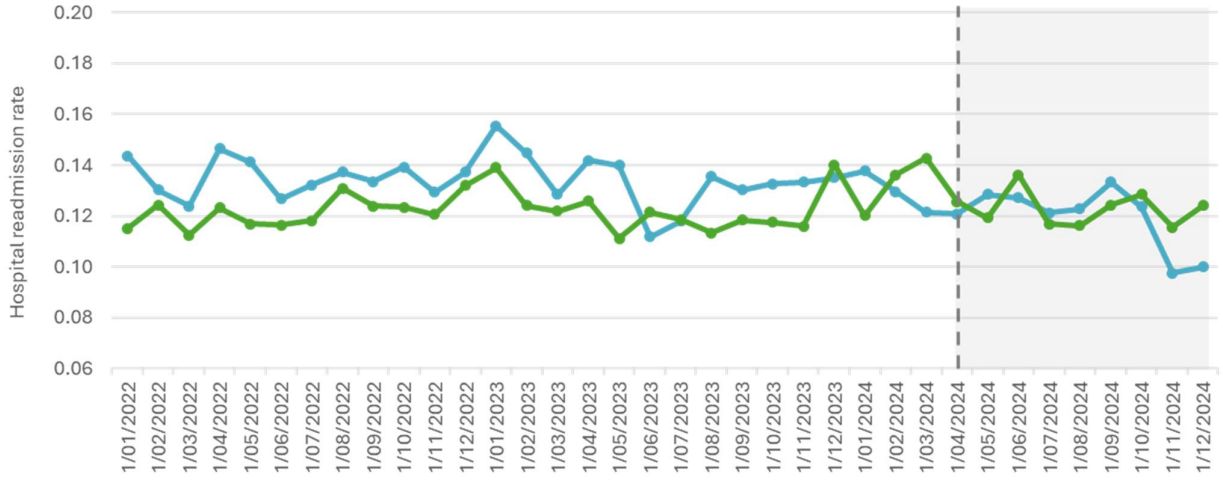


Figure 24. Average hospital readmission rates – Māori

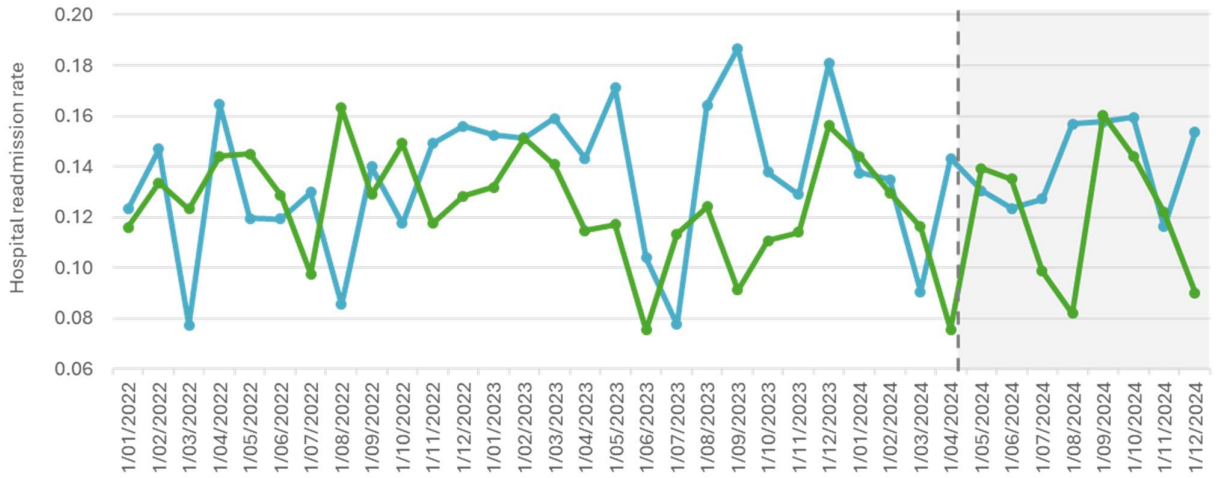


*Figure 25. Average ASH rates – total**

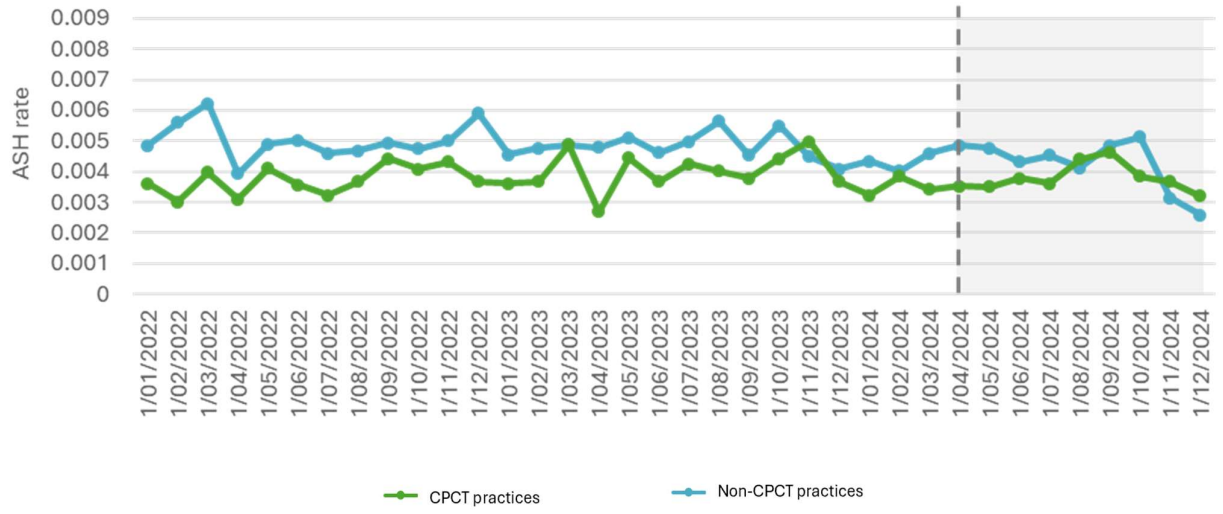
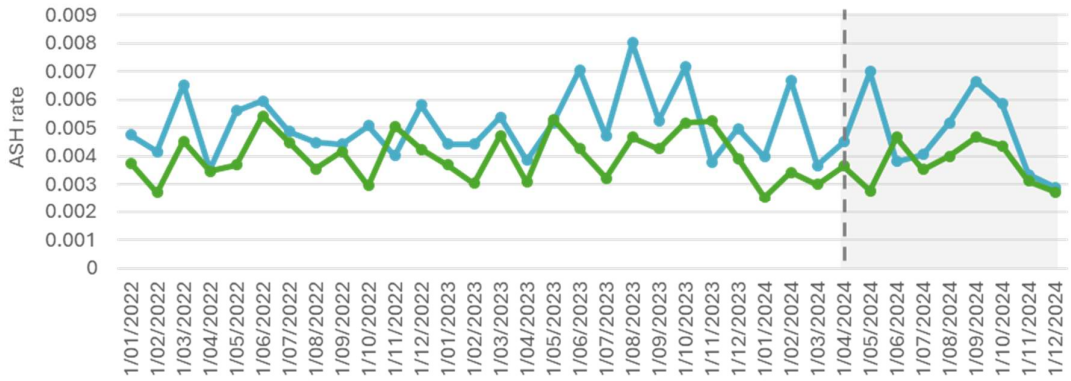


*Figure 26. Average ASH rates – Māori**



*Reliable data only available until end of 2024 due to national data lag

*Figure 27. Average ASH rates – Pacific Peoples**

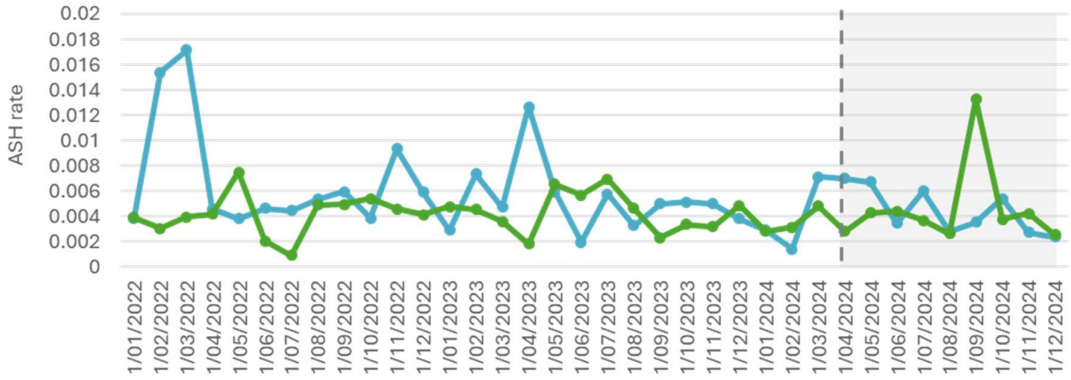


Figure 28. Average CVDRA rates – Pacific Peoples

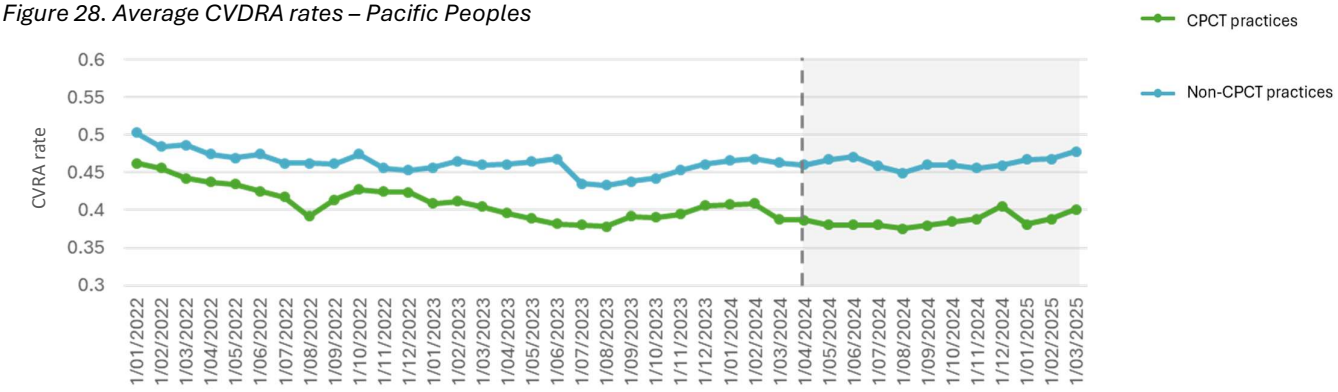


Figure 29. Average DAR rates – Māori

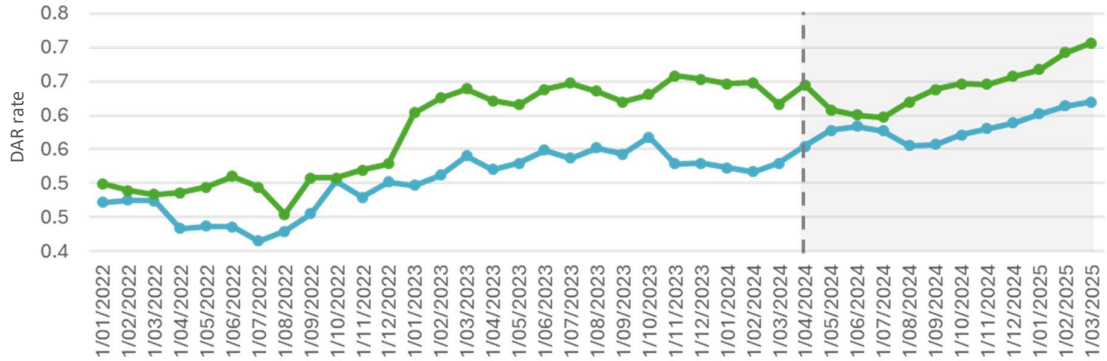


Figure 30. Average median HbA1C – total

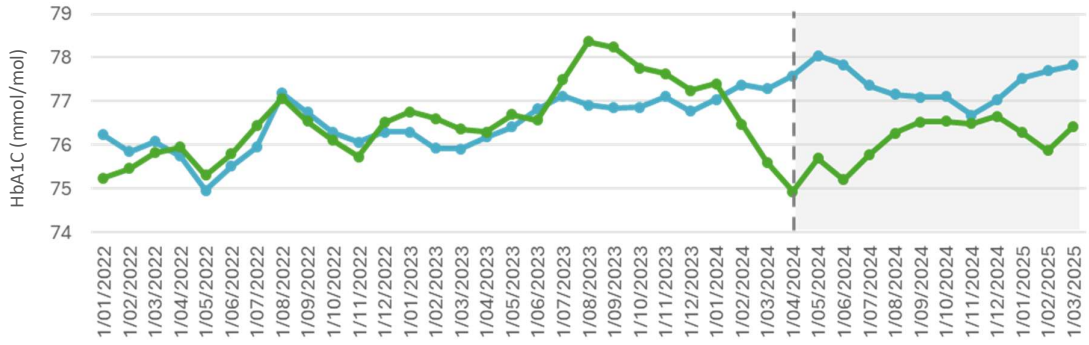


Figure 31. Average median HbA1C – Māori

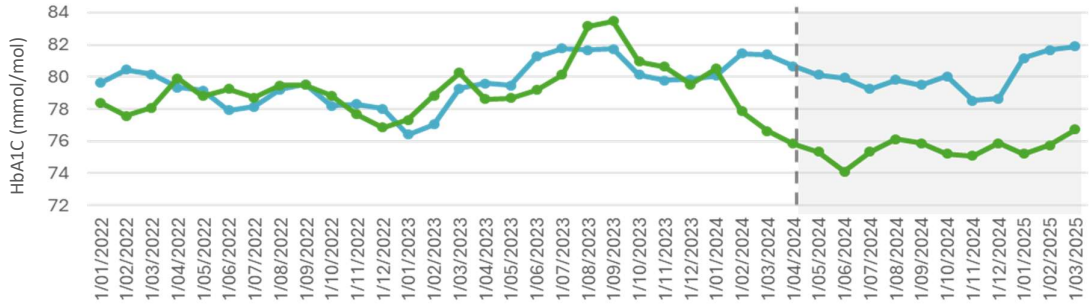


Figure 32. Average median HbA1C – Pacific Peoples

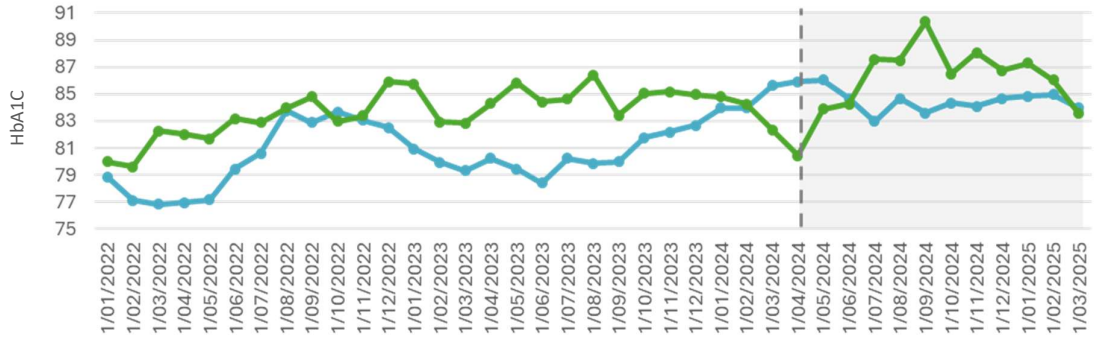


*Figure 33. Average cervical screening rates – total**

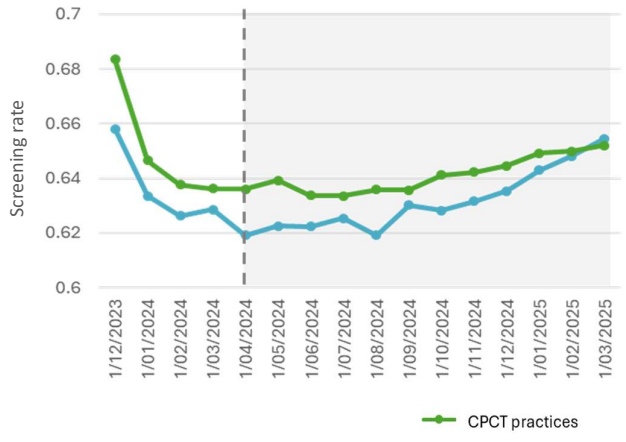


*Figure 34. Average cervical screening rates – Māori**

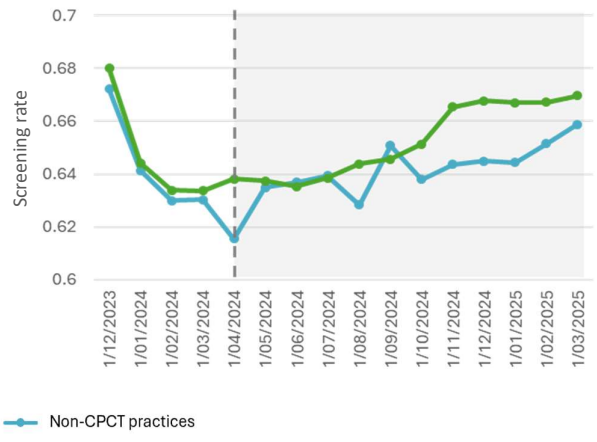


*Figure 35. Average cervical screening rates – Pacific Peoples (*Data only available from December 2023*)*

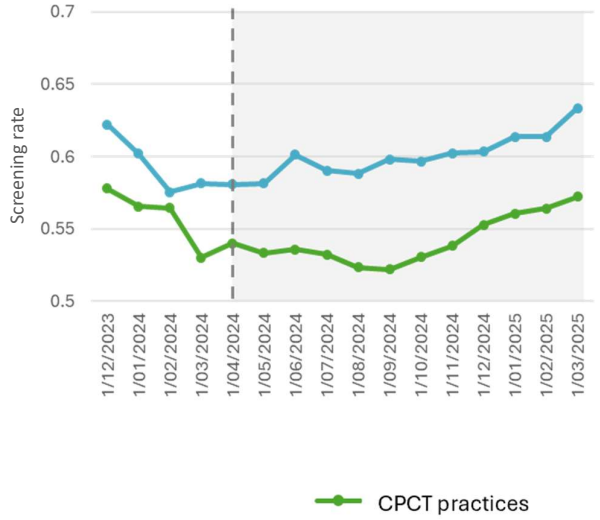


Figure 36. Average immunisation rates – Pacific Peoples (Data only available from September 2024)