CPCT Evaluation: Part Two
Summary Report

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. There were two key phases in the national roll out of CPCT. In the first phase, Te Aka Whai Ora commissioned kaiāwhina roles for some Hauora Māori and Pacific partners and, in partnership with Te Whatu Ora, directly contracted the twelve early localities that were established under the Pae Ora legislation to establish CPCT in their area. In the second phase, Te Whatu Ora contracted Primary Health Organisations (PHOs) to carry out the remaining implementation of the programme across each of their respective districts.

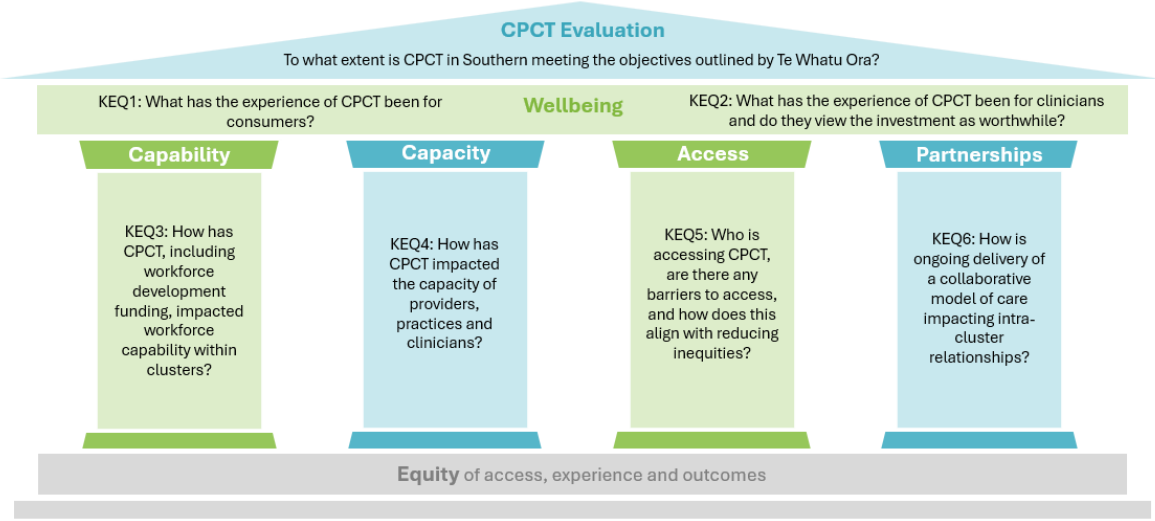
Therefore, except for one team operating through the Hokonui Locality, which was part of the first localities phase of the roll out, WellSouth were contracted to implement CPCT across Otago and Southland (Southern). In alignment with the national objectives to increase collaboration and meet the differing priorities of local communities, WellSouth chose to do this by establishing a series of location-based clusters consisting of general practices, Māori community providers, and Pacific community providers. Eight clusters have been established across the district: Clutha, Dunedin, Fiordland, Invercargill, Queenstown, Southland, Waitaki and Wānaka.

The Evaluation

Purpose

The evaluation of CPCT has been conducted in two parts. Part one, published in March 2025, focused on the design and implementation processes.[1] The second part of the evaluation, presented here, focused primarily on service delivery and outcomes. The aim of the evaluation was to understand how the service is being delivered and to whom, and the difference it is making to consumers and clinicians. This was to be achieved through answering a series of key evaluation questions, set out in Figure 1. As CPCT is a relatively short-term contract, there was also an appetite to know whether evidence suggests there is value in ongoing funding.

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



[1] https://wellsouth.nz/about-us/about-us/reports-and-publications/research-reports

Methods

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. Integrating different types of data on the same topic helps to offset the limitations of each method, allows the triangulation of findings to strengthen the robustness of conclusions drawn, and enables a more comprehensive understanding of the evaluation subject.

The primary care data was analysed in two stages. Firstly, visual plots and trendline analysis identified patterns and key variables of interest for further analysis. Next, inferential statistics were used to further examine the variables of interest. Interrupted time series (ITS) assessed any significant changes before and after the implementation of CPCT, and difference in differences (DiD) was used to compared changes in CPCT and non-CPCT practices to isolate the effect of CPCT from other external influences.

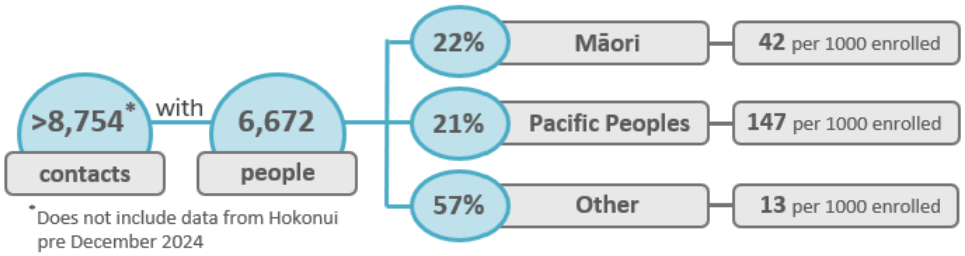
Each interview was analysed using inductive reflexive thematic analysis[2] to identify key themes. The findings across each cluster were brought together using narrative construction[3] to create a series of composite case studies that highlighted the recurring themes but preserved individual stories. Draft case study narratives were also shared with participants to ensure they were an accurate reflection. Finally, cross-case analysis[3] synthesised the data to compile an overarching summary of CPCT in Southern.

Evaluation Findings

Who is accessing CPCT in Southern?

Using contract reporting data, it is estimated that CPCT in Southern has engaged with 6,672 individuals in the first 12 months since inception (see Figure 2). 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. Whilst the rate for Māori is lower than for Pacific Peoples, it is over three times higher than for non-Māori, non-Pacific Peoples.

Figure 2. Access to CPCT in Southern, 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 from approximately 800 in the first quarter up to almost 2,400 in the most recent quarter (see Figure 3). An increase over time is also true for the number of interdisciplinary case meetings, for which the spread is relatively evenly distributed across the different ethnic groups (see Figure 4).

[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

Figure 3. Estimated number of CPCT service users per quarter, broken down by ethnicity

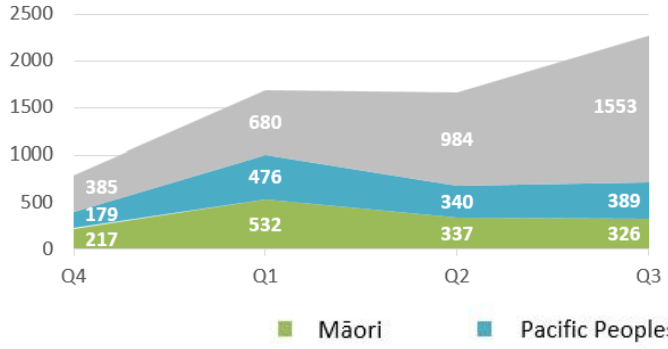
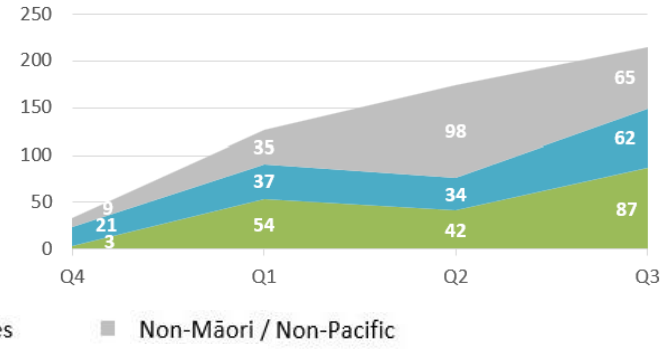


Figure 4. Estimated number of interdisciplinary case meetings per quarter, broken down by ethnicity



Workforce development across Southern

In addition to funding new roles in primary care, CPCT also included funding for workforce development. Organisations chose to use the funding in a variety of ways, primarily attending training, clinical certification, educational courses, and conferences. 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 uses for the funding into 10 categories, as per Table 1 below.

Table 1. Workforce development categories, in order of most frequent across CPCT organisations

Workforce development category	Organisations	Staff*
Upskilling in prevention [e.g. cervical screening training, vaccination certification]	14	25
Advancing clinical skills (e.g. advanced cardiac life support training, advanced palliative care training]	12	26
Other health education [e.g. Pacific health & wellbeing, sexual health, long-term conditions]	10	16
Rural health expertise [e.g. Primary Response in Medical Emergencies (PRIME) training course]	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

Organisations have used the funding to increase the capability of the primary care workforce beyond solely CPCT staff. The key areas of focus align with the CPCT priority objectives, such as enabling more preventative care, broadening the range of clinical services available, and increasing equity of access for rural communities.

Exploring CPCT outcomes – a case study approach

This section of the report utilised a series of case studies compiled from the qualitative data to inform an overarching summary how CPCT is operating in Southern, for whom, and the difference it is making. The individual case studies can be found in the full evaluation report; these comprehensive accounts provide a richer insight into the nuances across different clusters, the range of services being delivered, and the extent of the perceived outcomes for both consumers and clinicians.

An average day for the CPCT clinicians across Southern involves 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. 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 support being delivered by CPCT is 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 partnership working (especially between practices and providers) 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 there is little restriction in time or patient eligibility criteria, and they can travel to home visits and community events to maximise reach. Additionally, offering a free service and having staff embedded in the local community to build trust and rapport with patients who may be hesitant to engage were noted as key enablers for CPCT's success at increasing access to primary care and improving equity of access for priority groups.

Overall, the anecdotal evidence indicates that CPCT is 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).

Exploring CPCT outcomes – primary care data

Outcomes derived from the case study analysis were then considered alongside primary care data. The full data analysis can be found in the full evaluation report; only findings of statistical significance are presented here. Causal inferences should be made with caution as data is limited due to the short time frame.

Early evidence suggests that CPCT may have had a positive impact on Diabetes Annual Review (DAR) and Cardiovascular Risk Assessment (CVDRA) rates. As shown in Figure 5, CVDRA rates were declining in both CPCT and non-CPCT practices prior to CPCT. However, following the inception of CPCT, this trend reversed for the CPCT practices, a significant change in trajectory ($p < .001$). Although the rate of decline for the non-CPCT practices has begun to stabilise, this finding indicates that CPCT may have helped close the gap in CVDRA rates between CPCT and non-CPCT practices. Additionally, for Māori, analysis found that an increase in CVDRA rates that began prior to CPCT across both groups continued more steeply following the start of the programme for the CPCT practices only ($p = .001$) (see Figure 6).

Figure 5. Average CVDRA rates (total)

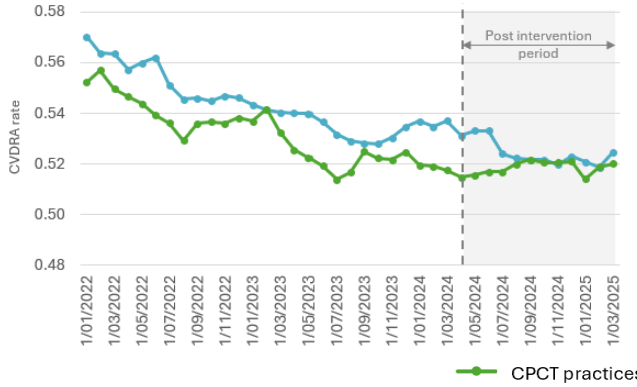
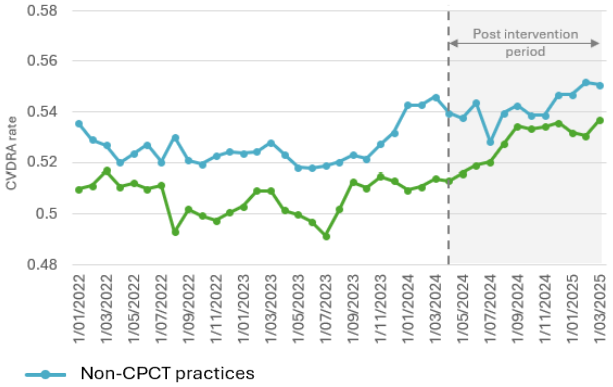


Figure 6. Average CVDRA rates for Māori



DAR rates have been steadily increasing since mid-2022. The upward trend has continued at roughly the same rate for the non-CPCT practices, but an initial drop for the CPCT practices at the start of CPCT has been followed by a significantly steeper rise (see Figure 7). This suggests that, despite a temporary setback as CPCT was being embedded, it has likely been contributing to positive change alongside external influences. Evidence is stronger for Pacific Peoples. As per Figure 8, since the start of CPCT, DAR rates for Pacific Peoples have remained static at non-CPCT practices but have followed a significantly different (positive) trajectory at CPCT practices (p = .005).

Figure 7. Average DAR rates (total)

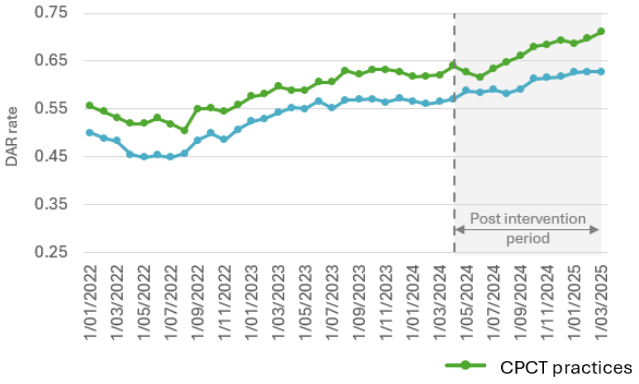
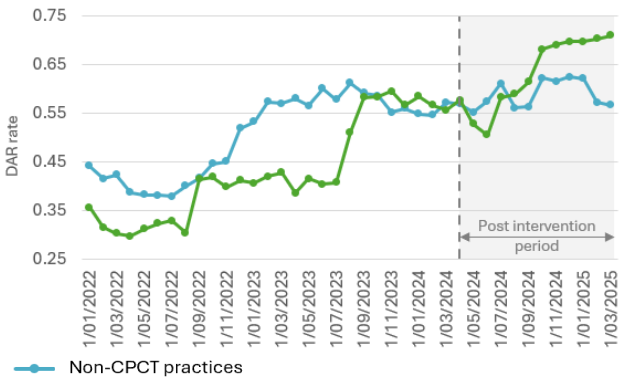


Figure 8. Average DAR rates for Pacific Peoples



In the prevention space, despite limited data, there are early indications that immunisation rates are increasing at CPCT practices, especially for Māori. Trend line analysis shows a moderate increase for CPCT practices compared to a decrease for non-CPCT practices overall (see Figure 9), and a strong increase for Māori at CPCT practices compared to only a weak increase for those non-CPCT practices (see Figure 10).

Figure 9. Average immunisation rates (total)

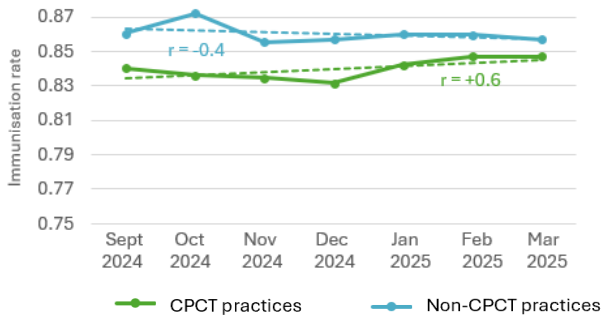
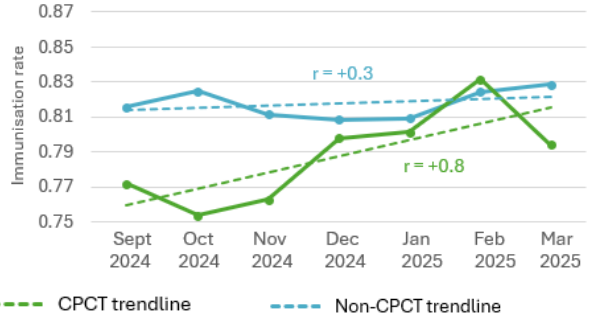


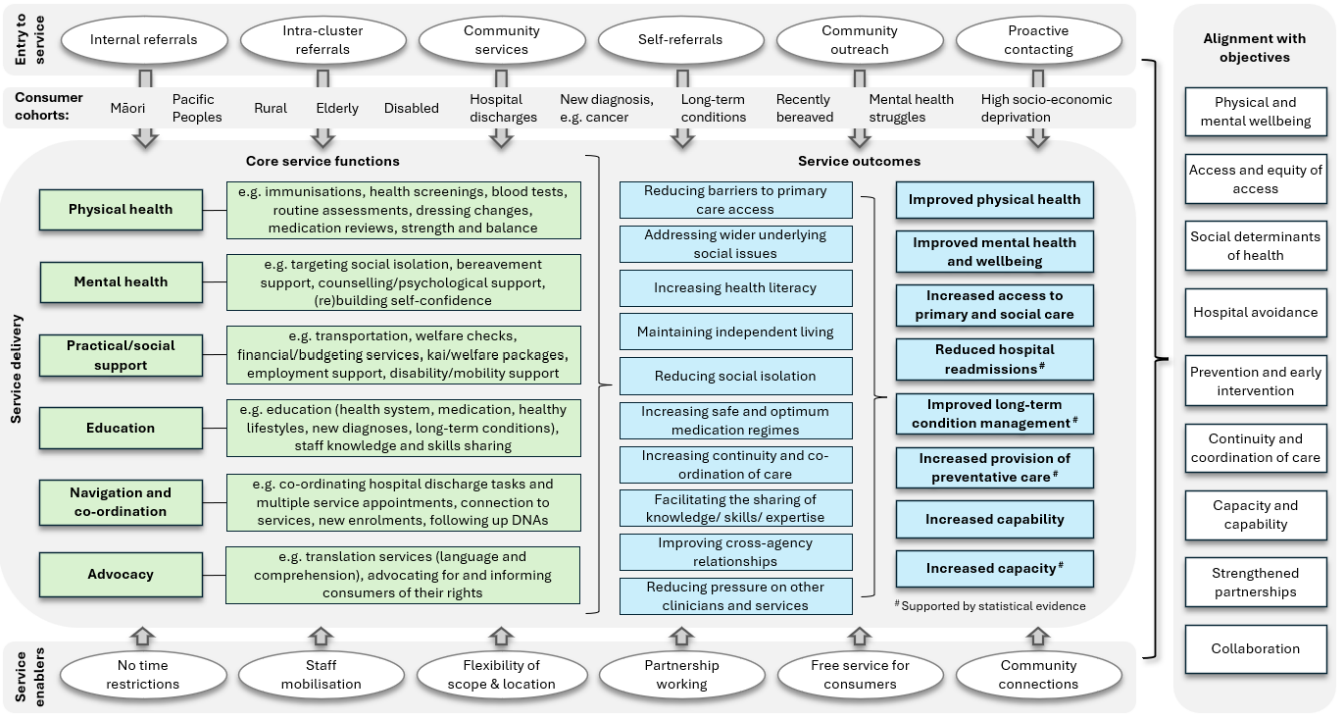
Figure 10. Average immunisation rates for Māori



Synthesising the findings to answer the evaluation questions

Bringing together the qualitative and quantitative data, Figure 11 provides a visual summary CPCT in Southern.

Figure 11. Delivery of CPCT in Southern, including who is entering the service and how, the support being delivered, key enabling factors, the main outcomes being reported and alignment with national objectives



KEQ *What has the experience of CPCT been for consumers?*

The consumers who spoke 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, including identifying potentially harmful medication use, maintaining independent living, and supporting mental wellbeing through reduced social isolation. 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 supporting patients to better understand and therefore directly manage their health conditions immediately, as well as over the longer term.

KEQ *What has the experience of CPCT been for clinicians?*

Clinicians, both working in and alongside CPCT roles, emphasised the value of CPCT in terms of benefits being delivered to CPCT patients and wider impacts for primary and secondary care. Albeit anecdotal evidence, the prevailing view was that the funding is providing value for money. CPCT was described as providing the 'gift of time' for those used to restricted appointment slots, an avenue for GPs to make onward referrals for patients with complex needs, and reducing pressure on primary and secondary care thereby enabling more work at the top of scope.

KEQ *How is delivery of a collaborative model of care impacting relationships?*

As CPCT progresses, relationships continue to grow and in doing so new referral pathways and ways of partnership working have developed. For instance, community providers are helping general practices to contact patients who are overdue routine and preventative healthcare but facing barriers to attending, and community providers and general practices are working together to provide wraparound care for people with complex needs. Furthermore, it was envisioned that new pathways and subsequent benefits to patients will continue to thrive should CPCT remain.

KEQ *How has CPCT impacted workforce capability?*

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. Examples were also given of CPCT staff sharing some of their knowledge and expertise with other 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 the capability of organisations across a range of areas, including prevention, clinical skills training and emergency response in rural areas.

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

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. Examples primarily centred around new roles conducting tasks previously done by GPs and supporting more of a multi-disciplinary team approach to care, which is freeing up some GP capacity to see more individual patients. It also stands to reason that the preventative work being undertaken may have a long-term impact on reducing the pressure on primary and secondary care, thus increasing long-term capacity. Although, the extent a small FTE can have on the system should be recognised.

KEQ *Who is accessing CPCT, are there barriers, 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. 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. As a free service, CPCT is reducing barriers to accessing primary care for those experiencing high socio-economic deprivation and having a more mobile workforce is also helping to break down access barriers to CPCT and to wider primary and social care.

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

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

- Given the range of positive outcomes of CPCT illustrated through this evaluation, and that access, new pathways and new collaborative models of care continue to grow, all evidence indicates that funding for CPCT should continue as a long-term investment into primary care.
- There may be opportunity to refresh the quantitative data analysis closer to the new contract end date, thereby removing the limitation of short timeframes and potentially strengthen the case for ongoing funding.
- The ability to provide a wider scope of support beyond immediate clinical healthcare was well received, therefore, if it is not continued through CPCT, there appears to be value in advocating for the provision of funding to resource work to address social determinants of health as a form of prevention.
- Incentivising and supporting partnership work, flexibility in role scope and patient eligibility criteria, mobilising the workforce to deliver more care within the community, and not having restrictions on the number or duration of appointments were key enabling factors that could apply beyond CPCT.
- Appreciation for WellSouth's role in facilitating networking across the organisations and clusters demonstrates the value of PHOs 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 extended to being used to backfill the roles of staff whilst out of the office attending training. 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, although data over a greater time span may help to strengthen this early finding. The outcome of this evaluation aligns with work undertaken by other PHOs to investigate the value of CPCT, either through a formal evaluation or more informal reporting. WellSouth's 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 CPCT is making a meaningful difference to the health system.