WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Evaluating the Calderdale Framework in Practice: Clinical Task Instructions for IBS, Healthy Eating, and Falls & Fracture

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EXECUTIVE SUMMARY

Since 2023, WellSouth has been implementing the Calderdale Framework (CF) to support the safe and structured delegation of clinical tasks within primary care through Clinical Task Instructions (CTIs). The CF is intended to enhance role clarity, optimise workforce utilisation, and, in WellSouth's context, enable Health Coaches (HCs) and Community Support Workers (CSWs) to deliver defined clinical and practical interventions within general practices at an agreed scope. This evaluation examined three pathways where implementation is most established: Irritable Bowel Syndrome (IBS), Healthy Eating, and Falls & Fracture (Super Seven). A qualitative methodology was used, drawing on interviews with WellSouth staff, HCs, CSWs, clinicians, dietitians, and service users. The evaluation aimed to explore implementation of the framework, safety and scope considerations, workforce sustainability, and patient and system-level impact.

Implementation and operational integration

CTI implementation is variable and pathway dependent. The Healthy Eating pathway is well embedded and routinely utilised, aligning closely with the established HC role. In contrast, IBS uptake is inconsistent and influenced by clinician hesitancy, and referral variability. The Falls & Fracture pathway was developed to address a recognised service gap and demonstrates high patient need; however, referral flow and workload distribution vary across practices and staff roles.
Integration across general practices is not yet systematic. Awareness of the Calderdale Framework and specific CTIs among practice teams remains uneven, and implementation often relies on frontline staff to promote and embed pathways within existing clinical hierarchies.

Safety, scope, and workforce capability

The evaluation highlights differing professional perspectives on delegation. Clinician caution, particularly in relation to IBS, is grounded in concerns about safety and professional accountability. At the same time, HCs and CSWs report confidence working within structured CTIs and value the clarity and boundaries the framework provides. CTIs function as intended in defining scope and supporting safe practice. While some staff with advanced skills perceive the protocols as restrictive, this reflects appropriate role containment and oversight rather than limitation of capability. For many staff, CTIs provide a necessary safety net and structured professional development pathway. However, systems for tracking training attendance, refreshing competencies, and verifying ongoing proficiency are underdeveloped.

Patient experience and service impact

Across all three pathways, service users report high satisfaction, access to support, and positive relationships with HCs and CSWs. Despite these positive experiences shared by the service users, the broader system impact, particularly on clinician workload, timeliness, and efficiency, cannot yet be quantified due to limited activity and outcome data.

Workforce sustainability and capacity

Sustainability of the model is influenced by workforce turnover, training demands, and supervisory capacity. Both frontline staff and supervising clinicians report capacity constraints. Expansion of delegated tasks without strengthening training systems, reporting processes, and workforce support structures may risk inconsistency and reduced service quality.

Conclusion and recommendations

Overall, the Calderdale Framework at WellSouth is operating as a structured and safe delegation model that enhances access to care and supports patient-centred service delivery. CTIs provide clarity of scope and clinical safeguards, and patients report positive experiences. However, implementation remains uneven, competency assurance systems require strengthening, reporting infrastructure is limited, and communication and visibility across practices need improvement.

While ongoing efforts are underway, there is a need to proactively strengthen clinician engagement and strategic communication to improve awareness, clarify scope, and address pathway-specific hesitancy, particularly for IBS. Workforce capability systems should be enhanced through formalised training registers, structured competency assessments and refreshers, and maintenance of a single, reliable repository of up-to-date CTI documentation. Strengthened competency assurance will build clinician confidence and support workforce development.

System-level reporting must also be improved. Supplementing the planned “CTI used” reporting function with CTI level activity logging by HCs and CSWs will provide meaningful data on utilisation, referral patterns, and patient reach. This data collection will enable WellSouth to demonstrate impact, guide service planning, and support improvement.

Finally, expansion of new CTIs should proceed cautiously. Existing pathways should be fully stabilised, with effective training, monitoring, clinician engagement, and adequate workforce capacity in place, before additional delegation initiatives are introduced. Scaling without resolving current capacity and infrastructure gaps risks compromising consistency, safety, and service quality.

Key Learnings

- Implementation is uneven and pathway dependent. Healthy Eating is well embedded, while IBS uptake is constrained by clinician hesitancy and safety concerns. The Falls & Fracture pathway shows variation in referral flow and workload distribution. Uptake reflects differences in practice awareness, referral habits, and practice integration rather than patient need alone.
- CTIs strengthen role clarity and safe delegation. HCs and CSWs value the structure, boundaries, and professional development that CTIs provide. While some highly skilled staff may feel constrained, this reflects appropriate scope control and supports safe practice within defined limits.
- Training, competency assurance, and workforce capacity require strengthening. Training experiences are mixed, and systems to track attendance, refresh skills, and verify ongoing

competency remain underdeveloped. Workforce turnover and supervisory capacity constraints affect sustainability and consistent integration across practices.

- Patients reported positive experiences with HCs and CSWs seen under CTIs, but system-level impact is not yet measurable. Service users report high satisfaction, good support, and person-centred care. CTIs also support earlier identification of complex needs and more appropriate referrals (IBS pathway). However, limited activity and outcome data restrict the ability to quantify impact on clinician workload, timeliness, and system efficiency. Strengthening monitoring mechanisms is therefore critical to demonstrating framework's value.
- Communication and clinician engagement are central to sustainability. Limited awareness of the Calderdale Framework and CTIs among general practice teams, particularly regarding IBS delegation, contributes to cautious referral patterns. Effective communication of scope, safety, and benefits is essential for consistent uptake.

Recommendations

Drawing on the findings and ongoing development work, the evaluation makes the following recommendations:

- **Strengthen and embed existing CTIs before expansion** by enhancing clinician engagement through targeted education and practical communication materials that clarify scope, safety processes, and patient benefits, particularly for pathways affected by hesitancy such as IBS. Ensure shared understanding between practices and Access & Choice teams to support confident and consistent delegation.
- **Strengthen workforce capability systems** to ensure safe and sustainable delivery, including formalising training registers, introducing structured competency assessments and refreshers, and maintaining a single, reliable source of up-to-date CTI documentation.
- **Improve system-level monitoring** by supplementing the planned "CTI used" reporting function with additional mechanisms, such as pathway-level recording by HCs and CSWs, to generate meaningful data on utilisation, referral patterns, and patient reach.
- **Expand new CTIs cautiously**, only after existing pathways are fully stabilised with effective training, monitoring, clinician engagement, and adequate workforce capacity to maintain consistency, safety, and service quality.

BACKGROUND

Since 2023, WellSouth has been implementing the Calderdale Framework (CF) to support the safe and effective delegation of selected clinical tasks across primary care. The CF was first introduced to Aotearoa New Zealand in 2015 as a structured workforce development framework designed to enhance role clarity and enable safe task delegation (Te Whatu Ora, 2023). The CF provides a systematic process for analysing services, developing competency-based training, and ensuring that tasks are delegated appropriately from registered clinicians to trained non-clinical staff. National and global evidence shows that the CF supports more efficient and effective use of the health workforce, improves role flexibility and sustainability, and enhances patient-centred care without compromising safety (Nancarrow et al., 2012; Calderdale Framework, n.d.).

At WellSouth, the CF has been implemented within the Access & Choice service, a free wellbeing support service embedded in general practice teams. Health Coaches (HCs) and Community Support Workers (CSWs) are central to this service, supporting patients to set goals, build self-management skills, and access practical and social support (WellSouth, 2025). Through the CF, HCs and CSWs have been delegated additional clinical and practical tasks, formalised through Clinical Task Instructions (CTIs). These CTIs extend their scope of practice within primary care and provide the foundation for this evaluation.

CTIs have been developed across several pathways in response to service gaps and workforce pressures identified through engagement with practices, Access & Choice teams, and clinical staff.

This evaluation focuses on three CTI pathways where implementation is most advanced.

Irritable bowel syndrome (IBS): HCs provide first-line dietary and lifestyle support, with referrals to CSWs for practical assistance such as meal preparation or access to community services.

Healthy Eating: HCs deliver standardised nutrition education, while CSWs provide complementary practical and social support to help patients apply dietary changes in daily life.

Falls and Fracture (Super 7): HCs and CSWs work with older adults on strength and balance exercises, home safety, and confidence-building to reduce fall risks.

The purpose of this evaluation is to assess how the CF, implemented through CTIs, is being applied in practice across WellSouth and to understand its effects on patients, the workforce, and service delivery. Findings from this evaluation will contribute to broader knowledge about safe delegation models in primary care and inform the ongoing development of WellSouth's workforce initiatives.

EVALUATION METHODS

This evaluation uses a qualitative approach to explore how CF is implemented through CTI pathways. Semi-structured interviews were conducted with purposively selected participants, including 6 WellSouth staff members, 6 HCs and CSWs (some are in dual roles), 3 clinicians in practices, and 6 service users who have been seen under either the IBS, Healthy Eating, and Falls and Fracture CTI pathways. One focus group discussion was conducted with Dietitians. HCs and CSWs supported the identification of suitable patients for interviews.

Interviews were analysed using an inductive thematic analysis approach, which involved reading and coding transcripts to identify patterns, themes, barriers, enablers, and outcomes that emerged directly from participants' experiences. Originally, pre- and post-care surveys for the IBS pathway were planned to provide quantitative insights. However, due to very low response rate particularly no responses for post-care, the survey was not included, and the evaluation focused on qualitative insights from interviews to understand the implementation and effects of the CTIs.

EVALUATION FINDINGS

The analysis identifies key patterns related to implementation, safety, outcomes, and sustainability. The findings are organised into four overarching themes.

Theme 1: Variable Implementation and Operationalisation

This theme captures the on-the-ground realities of how the CF and its associated CTIs have been put into practice.

1.1 Variable uptake and familiarity across CTI pathways
The three CTI pathways are not used uniformly. The Healthy Eating CTI is consistently reported as the most frequently and comfortably utilised. HCs described it as a core, daily tool. One noted, *"The ones that I use the most is definitely the healthy eating. I would probably say that I use it... probably once a day,"* and later added it was the one they were *"most comfortable with."* This CTI fits the HC role well, leading to steady referrals for routine lifestyle issues like high cholesterol or pre-diabetes.

In contrast, the IBS CTI shows a more variable pattern of use. Its uptake is heavily influenced by GP confidence and the perceived complexity of the pathway. One clinician from a practice shared, "*there are concerns referring [IBS] patients to health coaches,"* reflecting caution around delegation in this area.

Referral patterns were inconsistent. One HC described having "*five people a week*" at times, followed by periods of having none "*for a couple of weeks*." Other HCs reported very low referral numbers overall. This variation highlights the irregular and hesitant nature of IBS referrals across practices.

A significant challenge is managing patient expectations when GPs do not accurately communicate the scope of the intervention. One HC explained: "*a lot of the GPs talk to people around IBS, they're like, 'Oh, so you can go and see the health coach, and they'll talk about FODMAPs.' But that's not how it works... people are coming expecting that they're going to do FODMAPs."*

The Falls and Fractures (Super Seven) CTI presents a complex picture, characterised by a disconnect between referral routes and high patient need. HCs often reported needing to actively promote this pathway to GPs. One created a *"one pager"* for clinicians because they *"weren't getting really many referrals"* directly. For CSWs, who are responsible for the practical, in-home delivery of the Super Seven exercises, demand is frequently described as meeting or exceeding expectations. In some cases, referral volumes were particularly high, with one CSW covering multiple practices receiving "*25 referrals*" in a single day. Although this high demand raised questions about staffing capacity, it also reflects strong uptake of the pathway and clear patient need.

It is important to note that referral volumes for Super Seven CTI vary across CSWs and practices. Nonetheless, the pathway was intentionally developed to address a recognised service gap. As a WellSouth staff member from the Falls and Fracture team explained, there had been "*a huge amount*

of people that we were declining... a big gap. So, we thought health coaches could help plug this gap." The high level of engagement suggests that the CTI is responding to this previously unmet need.

1.2 Mixed perceptions of training effectiveness and logistical gaps

Feedback on the training provided for the CTIs was mixed among the workforces. While some staff found it useful, others felt it did not always build the confidence needed for practice. One HC described the fast-paced online sessions as difficult:

"just 50 minutes...I feel like it's way too fast. It's just, like, so much information, just all kind of crammed in." Another pointed out a disconnect between the foundational knowledge presented and the practical tool they were expected to use: *"a lot of it was more background information on general healthy eating... but didn't necessarily always kind of correlate to the checklist that we're given to work through with patients."*

The trainers (dietitians) and WellSouth staff noted logistical gaps. A key issue was the inability to track who attended training, making it hard to evaluate its reach or staff competency. One dietitian explained, *"You don't get a list of who's going to show up to the trainings. So if you only get three people show up to a training... it's really hard to assess how it's actually being taken on."*

Furthermore, a WellSouth staff member observed that systems for "*refreshing and really assessing if someone's confident*" were not yet robust. This was echoed by the dietitian focus group, who highlighted the absence of a structured competency check, such as a "*see one, do one, teach one*" model. Instead, the current approach relies on initial training followed by trusting staff to apply their skills independently. Staff at WellSouth reported that several initiatives are under consideration and in progress to address some of the issues discussed here.

1.3 Reliance on frontline staff for practice integration and promotion

A central strategy for embedding CTIs in GP practices has been limited. As a result, it has mostly relied on the personal advocacy and relationship-building skills of frontline HCs and CSWs. A HC described this as: *"the introduction to practice... it was put on to the health coaches and support workers to have to do."* This means the unregistered staff themselves must navigate clinic hierarchies and convince clinicians to delegate tasks to them. It is noteworthy that HCs are formally required, as part of their role description, to promote the scope of support they can provide to clinical staff and practices. However, given the hierarchical structure of the clinical environment and the professional accountability held by registered clinicians, assigning primary responsibility for promotion of the CF to unregistered staff may not be appropriate and warrants careful reconsideration.

This reliance on frontline promotion leads to very different results in each practice. Success depends mostly on the individual staff member's skill, time, and the culture of the clinic. One HC in a well-integrated team said, *"I do feel really supported in there"* while another described a more gradual approach: *"just kind of word of mouth talking at huddles, also putting something in the GP in trays."* For CSWs covering many clinics, feeling part of the team is especially hard. One explained, *"I feel it's impossible for me to be part of that team when I can't devote the time,"* suggesting integration is directly linked to their capacity and physical presence in the practice

1.4 Awareness and strategic communication
A recurrent finding across all stakeholder groups is the limited awareness and understanding of the Calderdale Framework and the specific CTIs among general practice teams. This knowledge gap is identified as a primary barrier to effective referral. A WellSouth staff member acknowledged this directly: *"I don't think the practices know enough about Calderdale. They're just so busy and bustling... they're just like, oh yeah, they've got a new skill behind it."*

Practice staff confirmed this view. A practice nurse shared, *"We haven't been told about it, taken through it... we don't know anything about it. I don't think it's been properly used here."*

A perspective from another practice highlighted a different aspect of the communication challenge. Here, staff perceived WellSouth's communication as focused on administrative and funding requirements. A practice representative explained: *"I don't think in the format that comes through from WellSouth, it's actually the best for patient care. I feel like it gets more used for auditory purposes, for their funding, as opposed to helping patients."*

These statements point to a considerable communication deficit. The gap exists not only in basic awareness but also in the perceived intent of the communication. This can lead to misunderstanding, underuse, and a perception that the initiative is driven by reporting needs rather than clinical support.

1.5 challenges in measuring activity and accessing current resources
Two practical, systemic issues were identified as barriers to consistent implementation.

First, WellSouth staff noted a significant gap in data. The Calderdale Lead explained they cannot currently measure basic activity: "*Is the Healthy Eating CTI being used 50 times a month or 500 times a month? We don't know. That's an interesting one, because how do we gather data from all the different practices?"* Without these basic data, it is difficult to understand how much the CTIs are used, what impact they have, or to guide decisions about resources.

Second, frontline staff faced problems accessing the correct, up-to-date resources. A few participants (HCs) described challenges in finding the latest CTI documents. One shared their experience: "*I just printed off a whole lot of the questionnaires for the IBS CTI... and then realised it was the 2023 version. And it's like, well, where's the 2025 version?"* Another noted that updates promised during meetings were not always provided. This lack of a single, reliable source for current materials may affect consistency and the quality of care.

While the above findings are grounded in participant data, WellSouth staff confirmed that work is underway to collect CTI activity, although this will not distinguish between individual CTI pathways yet.

Theme 2: Differing Perceptions of Safety, Scope, and Competency

This theme explores the contrasting views on delegating clinical tasks.

2.1 Clinician caution and concerns over diagnostic safety
A prominent finding, particularly regarding the IBS pathway, is caution from General Practice clinicians. This caution is rooted in concerns about safety and professional accountability. A practice nurse articulated this clinical perspective:

"...from a clinician point of view, I would be quite worried that we would refer and someone would just directly go to a health coach about bowel related symptoms, if you haven't ruled out any red flags... you'd have to have several appointments with a GP before you'd be confident that it was IBS." This indicates clinicians perceive a significant risk in delegating.

Since CTIs are highly structured protocols with clearly defined *do* and *don't*, a WellSouth staff member described this hesitancy as "*professional protection,"* where registered clinicians can be reluctant to delegate what they see as core clinical work. One HC noted, "*the IBS one hasn't been as used, and it's mainly my practices, hesitancy around it."* Dietitians added another layer of risk, noting that HCs might be seeing patients without a confirmed diagnosis, as "*the health coach is unable to pick that up."*

2.2 Workforce confidence, role satisfaction, and the value of defined boundaries
Confidence and satisfaction among HCs and CSWs are influenced by their prior experience and the structure the CTIs provide. Staff with advanced qualifications (e.g., in exercise science or nutrition) can sometimes find the standardised protocols restrictive. A WellSouth staff member from the Falls and Fracture team observed: *"the people who are really highly skilled in exercise, do feel this CTI have sort of ring fenced them a bit."* A dietitian echoed this sentiment regarding staff with nutrition knowledge. It is noteworthy that CTIs restricting HCs to practice under the boundaries of the scope, is a success of Calderdale Framework, and shows the framework acting as intended.

On the contrary, those without such specialised backgrounds often value the CTI structure for providing clear guidance and a "*safety net."* A HC explained: *"I like it because... it gives me a safety net. And that's what I'm all about as well, because I realise that we aren't registered."* Job satisfaction was also linked to the variety and professional development CTIs add. One HC said, "*I like it because it's a way for us to learn more... it gives me a goal,"* while a CSW noted the protocols provide important "*consistency*" for patients and practices.

2.3 2.3 Gaps in ongoing competency assurance

Beyond initial training, a significant issue relates to the absence of formal mechanisms to monitor and assure ongoing competency. While earlier sections identified limitations in training design, this theme highlights the lack of structured oversight once staff begin independent practice.

Registered clinicians and staff described the current model as operating on a *"high trust"* basis, without systematic observation, peer review, or formal reassessment. As one dietitian explained, *"we don't really see the health coaches applying the CTI... we don't do any peer review of them using that CTI."* Although there was expressed willingness from dietitians to provide supportive peer review, this had not been embedded in routine practice. A WellSouth staff member similarly noted the need to be *"a bit more robust*" in competency oversight.

This gap is less about initial preparation and more about ongoing clinical oversight. Without structured review processes, there are few opportunities to provide feedback, check that protocols are being followed, or reassure referring clinicians.

Theme 3: Impact on Patients and Services

This theme explores the impact of the model on patients and services, highlighting improvements in access and support.

3.1 Improving access and providing holistic support
A clear benefit of the CTI model appears to be positive patient experiences, as reported by both service users and HC/CSWs. HCs described patients being seen *"the same day"* or *"really soon"* compared to long waitlists for specialists. A WellSouth staff member confirmed the IBS CTI meant patients were *"no longer like just sort of sitting there buffering."* A CSW shared a patient feedback saying that the Super Seven *"made a massive difference to him."* Patients consistently emphasised the quality of the supportive, person-centred relationship, with one describing their CSW as *"very caring"* and skilled at *"picking up on little signs."* Another service user who was seen under the IBS pathway reported that he did not have to "*wait long*" to receive advice regarding his condition. Across all three pathways, service users described being satisfied with the support they received. However, due to the lack of comparative data on referral volumes and CTI utilisation, it is difficult to determine the system-level impact of the CTIs on timeliness and clinician workload.

3.2 Identifying complex needs and impacting dietitian/physiotherapist workloads
An important, perhaps unintended, system outcome is the model's role in identifying patients whose needs exceed the CTI scope, leading to more appropriate referrals to specialists. Dietitians reported that, rather than immediately reducing their workload, the initial implementation of CTIs "*increased our demand*." This occurred because HCs were identifying more patients who required additional or specialist-level support. As one dietitian summarised, "*more people are getting reached and influenced. But then... we're getting more demand for our service.*"

However, dietitians noted that this increase was most evident during the early phase of implementation. Over time, referral patterns have begun to stabilise, as dietitians have redirected referrals that fall within CTI scope back to HCs and clarified pathway expectations. This suggests the model supports patient needs by directing to the most appropriate level of care.

Theme 4: Workforce Sustainability and Capacity

The final theme examines the challenge of maintaining a stable workforce and the need to balance new developments with the capacity of staff and support systems.

4.1 Staff turnover and continuity
The stability of the HC and CSW workforce was noted as a factor influencing consistent CTI implementation. Staff turnover can disrupt client relationships and the integration of these roles

within practice teams. A dietitian observed, "*there seems to be quite a big turnover of health coaches"*. This requires repeated training cycles. A WellSouth staff member from a clinical team also shared the experience of frequently *"training people from the same practice a lot."* Building and maintaining the good, trusted relationships with general practice teams that facilitate effective delegation can be affected by frequent staff changes.

4.2 Capacity constraints for support and development
The potential to maintain or expand the CTI model is linked to the capacity of both the unregistered workforce and the registered clinicians who train and support them. WellSouth staff emphasised the importance of considering existing workloads. The Calderdale Lead stated, *"we have to be very careful that we don't overwhelm the unregistered workforce as well."*

Similarly, the dietitian team, which provides key training and clinical support for several CTIs, reported they are "*already quite stretched*." A HC Lead also noted that decisions on new initiatives must be "*thought about… capacity of the team."* These points highlight that any future growth of the model depend on carefully matching new tasks or CTIs with the available capacity for frontline delivery, supervision, and clinical support.

Ongoing Developments

Following the sense-making session with the CF implementation team, several initiatives are underway to address key implementation challenges identified in this evaluation. The team has clarified the scope of the HC role, highlighting that promotion of CTIs falls within their formal job description, and emphasises the full range of tasks they can safely deliver, including strength and balance support. To strengthen workforce capability, mechanisms for tracking training and ongoing competency are being developed, including a centralised training register on SharePoint and the implementation of tools such as the Healthy Eating Competency Quiz to identify knowledge gaps and support skill maintenance. Awareness and understanding of the Calderdale Framework and CTIs among general practice teams is being actively addressed and communicated.

A key development has been the establishment of a dedicated Calderdale Advisor role (0.6 FTE) in February 2025 on a two-year contract. This role has focused on centralising information, coordinating communication between teams, and developing resources to support competency checks. It also reduces the burden on clinical teams and Access & Choice leads by facilitating and coordinating additional work.

System-level improvements are also in progress: data collection on attendance at training and competency review outcomes has begun, a SharePoint page continues to serve as the single source of up-to-date CTI resources, and a 'CTI used' button will be added to the reporting platform to track overall CTI activity. Collectively, these initiatives aim to strengthen implementation, improve workforce confidence, and support more consistent, safe, and effective delivery of delegated tasks across primary care.

KEY LEARNINGS

- Implementation is uneven and pathway dependent. Healthy Eating is well embedded, while IBS uptake is constrained by clinician hesitancy and safety concerns. The Falls & Fracture pathway shows variation in referral flow and workload distribution. Uptake reflects differences in practice awareness, referral habits, and practice integration rather than patient need alone.
- CTIs strengthen role clarity and safe delegation. HCs and CSWs value the structure, boundaries, and professional development that CTIs provide. While some highly skilled staff may feel constrained, this reflects appropriate scope control and supports safe practice within defined limits.
- Training, competency assurance, and workforce capacity require strengthening. Training experiences are mixed, and systems to track attendance, refresh skills, and verify ongoing competency remain underdeveloped. Workforce turnover and supervisory capacity constraints affect sustainability and consistent integration across practices.
- Patients reported positive experiences with HCs and CSWs seen under CTIs, but system-level impact is not yet measurable. Service users report high satisfaction, good support, and person-centred care. CTIs also support earlier identification of complex needs and more appropriate referrals (IBS pathway). However, limited activity and outcome data restrict the ability to quantify impact on clinician workload, timeliness, and system efficiency. Strengthening monitoring mechanisms is therefore critical to demonstrating framework's value.
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RECOMMENDATIONS

Drawing on the findings and ongoing development work, the evaluation makes the following recommendations:

- **Strengthen and embed existing CTIs before expansion** by enhancing clinician engagement through targeted education and practical communication materials that clarify scope, safety processes, and patient benefits, particularly for pathways affected by hesitancy such as IBS. Ensure shared understanding between practices and Access & Choice teams to support confident and consistent delegation.
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- **Expand new CTIs cautiously**, only after existing pathways are fully stabilised with effective training, monitoring, clinician engagement, and adequate workforce capacity to maintain consistency, safety, and service quality.

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