FINAL REPORT OF THE

Evaluation of the Implementation of the Primary and Community Care Strategy

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Southern District Health Board
Piki Te Ora

WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Southern Health
He hauora, he kuru pounamu

Te Whatu Ora
Health New Zealand

OTAGO POLYTECHNIC
Te Kura Matatini ki Otago

Health Research South

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Foreward

PROFESSOR ROBIN GAULD

This evaluation of the Primary and Community Care Strategy (PCCS) in the Southern District of New Zealand comes at an important time in the ongoing development of our health system. As noted in this report, mid-2022 saw the commencement of the implementation of new structures for the system which incorporates the Southern region and its functions within national arrangements for health planning and funding.

Known as Te Whatu Ora, the new national agency (Health NZ) works in partnership with Te Aka Whai Ora (the new Māori Health Authority). Key goals are to improve equity and to better coordinate and integrate services, particularly through creation of 'localities' which are locally planned and agreed services networks.

The above mentioned are goals and arrangements that long been pursued in the health system, including via the PCCS. The PCCS itself was developed in parallel with activities underway via Alliance South, the contractual planning and service delivery mechanism required by government to be in place from 2013 onwards between the then WellSouth PHO and Southern DHB. Alliance South was charged with implementing the PCCS, superseding its existing work programme. Having had some involvement in Alliance South, I can attest to cross sector strategy work being challenging and requiring some specific arrangements and levels of commitment in order to be effective. In 2021, the Southern DHB withdrew from Alliance South creating further challenges for implementing the PCCS.

This evaluation of the PCCS is important as it reports on progress against a series of areas of strategic value to any health system, including the new structures for Aotearoa New Zealand described above. What the evaluation reveals is that the basic people elements, along with organisational design and methods for allocating funding, are fundamental to progress.

As one of the first independent Aotearoa New Zealand evaluations of such a strategy, the findings described in this report are critical to all involved in the new Aotearoa New Zealand health system. One of the key objectives of evaluation is to inform and improve practice. Let us hope that the PCCS evaluation findings are used to support the development of the new health structures, and the good work of our health policymakers, professionals, planners, funders, and managers.

Professor Robin Gauld
University of Otago

Contents

Executive Summary

This report outlines the research findings from the Evaluating the Implementation of the Primary Community Care Strategy (PCCS) project, spanning 2019-2022. The evaluation was undertaken by academic researchers and health service leaders from the Southern District Health Board, WellSouth Primary Health Network, the Centre for Health Systems and Technology (CHeST) at the University of Otago, and staff from the Otago Polytechnic.

The Southern Primary and Community Care Strategy (PCCS) was developed in conjunction with the Southern District Health Board and the WellSouth Primary Health Network. The PCCS was launched in 2018 and proposed significant changes within the southern health sector, with the overall aim of providing services closer to where people lived.

The PCCS four main goals were:

- Consumers, whānau and communities are empowered to drive and own their own care.
- Primary and community care works in partnership to provide holistic team-based care.
- Secondary and tertiary care is integrated into primary and community care models.
- The health system is technologically enabled.

Evaluation of the implementation of the PCCS was undertaken through a suite of eight projects covering the main actions in the strategy. They explored if the PCCS implementation occurred as planned and achieved the anticipated outcomes. Projects were conducted by researchers with support from Academic and Service Leaders and a steering group provided general oversight.

Five projects were focused on aspects of the changes proposed in the PCCS, from the level of the individual person to the wider community:

- Client Led Integrated Care (CLIC), including shared care planning implementation: implementing the redesign of how general practices provide care and support to people with long term conditions using care planning and risk stratification.
- Health Care Home Implementation: re-engineering how general practices deliver their services.
- Rapid Response and Enablement Service Implementation: reorienting how health care of the elderly services are provided to enable people to stay at, or smoothly return to, their homes when they are unwell - known as the Home Team.
- Community Health Hubs Implementation: establishing facilities where hospital outpatient services, advanced primary care services, at least one General Practice operating in the Health Care Home model, diagnostic services and other independent and community-based healthcare providers work together in an integrated way.
- Locality Network Implementation: establishing seven geographically based networks within the SDHB district to support prioritisation and planning of health services locally.

Three further projects considered cross-cutting themes:

- Evaluation of the impact on Māori: examining the implemented changes to ensure they are addressing the longstanding inequities of access and outcomes for Māori.
- The effectiveness of approaches to engaging with communities, whānau and patients for system and service improvement.
- Overall evaluation of the PCCS: compare the work being undertaken against the aims and goals of the Strategy.

In addition to evaluating the PCCS implementation, the research project sought to build evaluation capacity within the Southern Health System to bridge the gap between research and service delivery.

Findings

There were common findings across many of the projects.

SUCCESSFUL PROJECTS BENEFITED FROM:

- Resourcing that included funding and time for staff to undertake the necessary changes
- Projects with clear goals and a clear plan for implementation worked well
- Utilising a well-developed existing model in use elsewhere
- Dedicated project manager or supervisor providing leadership and guidance, and support staff
- A common goal; even without a detailed plan, those involve with a strong sense of what was to be achieved can succeed
- Trusting and collaborative relationships, the building of strong relationships between those involved.

These facilitators are all outlined in the literature. Of the projects in this work, those that were well resourced (clear gaols and planning, leadership, funding etc) did manage to achieve some of their goals. Those projects that were not well resourced stalled.

FACTORS THAT LIMITED THE SUCCESS OF PROJECTS INCLUDED:

- A lack of meaningful involvement of Māori and community in design and implementation.
- A perceived lack of focus on equity
- Limited integrated working between primary, secondary, and tertiary care
- Competition for funding that did not encourage co-operative working
- A siloed approach to information, and the lack of sharing of patient information as this did not improve patient care.

There was a need for increased development of the information sharing capacity of the system. A truly integrated system was seen as some way off. If the identified success factors above were not available or utilised during the implementation process, then individual projects did not achieve their aims.

The arrival of COVID-19 had a substantial impact on the roll out of the Strategy, both positive and negative. The time for people to focus on change processes became very constrained, as staff were diverted to COVID-19 work. There were some unforeseen positive impacts from Covid's arrival. Necessity became a huge driver for change and peoples' willingness to adopt new ways of working increased. Changes in models of care and ways of doing things differently became possible, as was seen by the rapid uptake of telehealth in general practice settings.

Recommendations

PARTNERSHIP WITH MĀORI

1. Embed Te Tiriti o Waitangi principles to provide power to the process. The principles of partnership, options, active protection, tino rangatiratanga and equity will drive the journey to improve health outcomes for Māori.
2. Give voice to whānau to provide direction. This includes talking to the people in the community, and development of a whānau voice that is heard at all levels, driven from the community upwards.
3. Embed culturally safe systems, structures and policies - this will make the journey smoother and allow change to happen faster. There needs to be a shift in the system, the system values need to align with the needs of the community.
4. Change the model of care so that whānau access care as a single process whether in primary,secondary or tertiary levels, through improved integration of services. Facilitators to success in implementation

COMMUNITY ENGAGEMENT

5. Build community engagement and partnership, having people involved from the inception to evaluation. Māori and Iwi should be engaged early, inclusively and broadly for large scale health changes, to honour Te Tiriti o Waitangi obligations.
6. Be innovative in approaches for people with disabilities to increase their accessibility to the engagement process.
7. Use and maintain meaningful relationships and networks, tapping into the connections that currently exist.

LEADERSHIP

8. Ensure those who lead the change share a common vision, common goals and work together as a team. They must be committed to collaboratively apply their resources and work effort. This teamwork needs to be based on trust, strong relationships, and open communication.

RELATIONSHIP BUILDING.

9. Invest in nurturing and maintaining high trust relationships at all levels between individuals and partner organisations.

CLEAR GOALS, PLANS AND DIRECTION

10. Develop a detailed and achievable implementation plan using project management approaches.
11. Ensure robust staff and stakeholder engagement and buy-in.
12. Develop an overall quality improvement approach for the whole strategy and a performance measurement framework to track the progress against strategic objectives.

DEDICATED RESOURCES

13. Ensure availability of adequate resourcing and agreement regarding the distribution of available resources, including:
    a. Time - for dedicated staff to get work underway, and dedicated change agents to map out the implementation.
    b. Education and training - through the life of the project to ensure all staff can upskill where appropriate for new models of care.
    c. Funding - development of funding that is flexible to accommodate new models of care and service delivery.
    d. Technology - to allow appropriate information sharing between providers, with technology changes established before programmes are implemented.

EVALUATION

14. Build in evaluation at project inception, with adequately resourced robust processes to identify if equitable improvements were achieved, with realistic timelines to see change.

CONCLUSION

The implementation of these projects did not happen as envisaged in the PCCS documents. Even with a significant amount of research identifying facilitators to draw on, a disconnect was seen between theory and practice. Those projects that did incorporate these learnings performed well and those that did not had significant issues.

The lack of success in the implementation of the Strategy should not be seen as the fault of staff not working hard, but rather dedicated people were working in the absence of clear goals, leadership and without sufficient resources or training, which made their task difficult. While COVID-19 can be blamed for some of the lack of progress, it added another dimension to projects that were not progressing, rather than being the sole cause.

To date the implementation saw an increased level of consumer empowerment via portal use and some team-based working was seen. The goal of integrated care is still some way off with a technologically enabled system a work in progress. It is too soon to see improvements in health outcomes as this can take considerably more time than the time span of three years for these projects.

Remedies to these issues will form the basis of successful implementation of ongoing change in our local health system in the future. Given the next phase of health reforms coming, this report is timely. Its findings should be heeded by the current and new leaders aiming to achieve Pae Ora in the Southern district. These lessons are also relevant to other health systems across Aotearoa, and more widely when local context is taken into account.

> "It's an ongoing theme in health and in the public sector, which is we've got fantastic ideas and we're good at analysing the problem and we're good at knowing what we need to do, but we're not so good at the implementation piece."
>
> **- Interview Participant**

Introduction

WHAT IS THE STRATEGY?

The introduction and implementation of the Primary and Community Care Strategy (PCCS) [1] and its associated Action Plan [2] involved a significant change in the provision of health services to the Southern region. The strategy was launched in 2018 with its development being led by Ernst Young, for the Southern District Health Board (SDHB) and WellSouth Primary Health Network (WellSouth), with support from the University of Otago and input from consumers, primary, community, and secondary care stakeholders.

Figure 1. Front page of the Southern Primary and Community Care Strategy

The strategy built on existing national health strategies and plans, local strategies and plans and the opportunities for change created by the planning for the new Dunedin Hospital.

THE FOUR AIMS WERE:

1. Consumers, whānau and communities are empowered to drive and own their own care.
2. Primary and community care works in partnership to provide holistic team-based care.
3. Secondary and tertiary care is integrated into primary and community care models.
4. The health system is technologically-enabled.

The Implementation of the Strategy was to be undertaken by Alliance South, a Health Alliance between WellSouth and SDHB, and overseen by an Alliance Leadership Team.

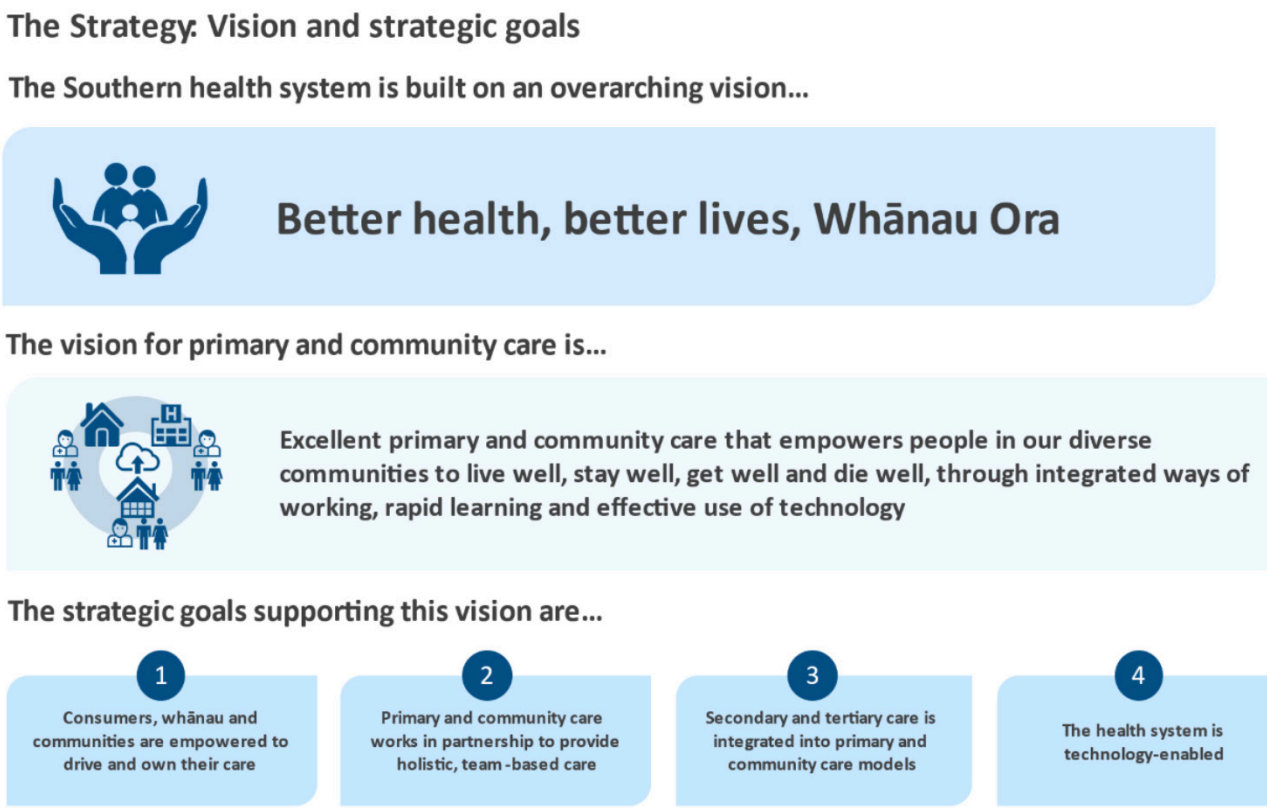

Figure 2. The PCCS Strategy Vision and Strategic Goals

WHAT IS THE EVALUATION?

There was no in-built evaluation plan in the PCCS. This evaluation work came out of a proposal from Alliance South and the Centre for Health Systems and Technology (CheST) to evaluate the implementation of the Southern Primary and Community Care Strategy (PCCS) and build evaluation capacity within the Southern Health System. Alliance South was an alliance between SDHB and WellSouth, while CheST represented the University of Otago and its established wider networks with Otago Polytechnic and Southern Institute of Technology. This work was funded by a three-year grant from Health Research South, itself a research partnership between the Otago Medical School and SDHB.

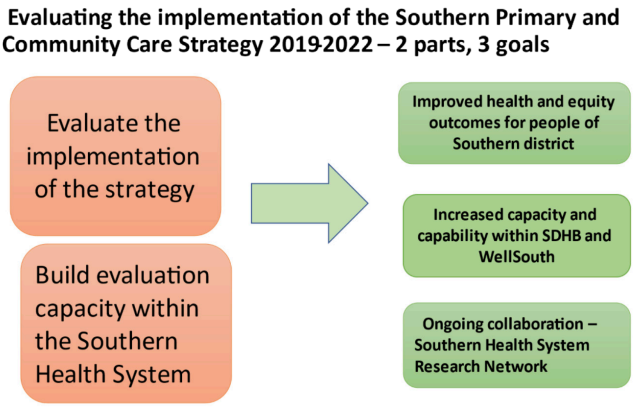

Figure 3. The aims of the Evaluation of the Implementation of the Southern Primary and Community Care Strategy

THE APPROACH TAKEN

Project Aims

This work did not evaluate all aspects of the Strategy implementation but aimed to identify potential facilitators and barriers experienced during the implementation period through focusing on a key group of projects reflecting the headline actions in the Strategy.

The evaluation plan's overall aim was to seek answers to the following questions:

- Does the implementation of the PCCS achieve its own goals of empowering consumers, whānau and communities; providing holistic team-based care; integrating care models across primary, community, secondary and tertiary care; and creating a technology-enabled health system?
- Does the implementation of the PCCS lead to improved outcomes (health outcomes, equity for Māori, service utilisation, system sustainability and user/consumer/patient and staff experiences) for the Southern health system?
- Do each of the headline actions in the strategy (listed below) contribute to improved health care processes and outcomes, including equity for Māori, for patients and their whānau and achieving the PCCS aims?
- Is each health care delivery initiative implemented as intended, and are there any barriers or facilitators to their implementation or unintended consequences, including for Māori, as a result of their implementation?

Overall project structure

Key Headline Actions were identified as the topics for detailed case studies of model changes to ongoing services:

1. Consumer Led Integrated Care (CLIC)

This general practice-based programme was aimed at patients with long term conditions, providing care plans that are individually tailored to the needs of a specific individual. A comprehensive health assessment was undertaken and then decisions made about the assistance each patient may need to manage their own needs, including the development of individual care plans.

2. Health Care Homes

Health Care Homes was a structured programme that aimed to re-engineer how general practices deliver their services. The programme incorporates four elements: urgent and unplanned care, proactive care, routine and preventive care and business efficiency.

3. Home Team

This was a change to the model of care of older patients in the hospital setting and patient support in their homes as they were discharged from hospital. This involved the merging of some existing services. This new model allowed patients to leave hospital earlier and to get ongoing support and care at home as they continued to recover by integrating a number of services (nurses, physiotherapists, occupational therapists, social workers, and rehabilitation assistants).

4. Community Health Hubs

Community Health Hubs were an integral part of the design of the PCCS. A hub would provide many different services working collectively to care for a patient and their whānau. This work investigated the early stages of the development of an urban hub in Dunedin City.

5. Locality Networks

Locality networks were a main feature of the PCCS, and were to be established in different areas, to plan and deliver care closer to where people live, work and play. This work evaluated the formation of the Central Lakes Locality Network.

Three further projects considered cross-cutting themes:

6. The Impact of the PCCS from a Māori perspective

This study aimed to explore the impact of the PCCS on equity within the Southern Health System from a Māori perspective. This was undertaken through ascertaining the views of Māori expert key informants and health providers within the Southern Health System.

7. Engagement with Consumers

This work critically evaluated the community engagement undertaken in the development, implementation, and ongoing functioning of the Southern Health System Primary and Community Care Strategy and included the Primary Maternity Strategy.

8. Implementation Evaluation

This high-level investigation of the implementation of the PCCS aimed to identify facilitators and/or barriers to its successful implementation as perceived at a governance level. The original plan to undertake an outcome evaluation of patient experience, staff experience and equity focused outcome measures was not completed due and the intervening COVID-19 pandemic and attribution concerns, so the process evaluation was the main focus.

An identified academic lead and service provider lead partnered with researchers to conduct the research projects over 3 years from 2019. Business analyst, quality improvement and administration support was provided by SDHB and WellSouth, with support from the academic partners. A steering group was appointed to oversee the evaluation work, with membership representing:

- An SDHB senior leader.
- A WellSouth senior implementation leader.
- A senior Polytechnic (Otago Polytechnic or Southern Institute of Technology) academic lead.
- A CheST senior academic lead.
- A Māori representative.
- A Community representative.
- The Principal Investigator on the Project, also initially Alliance South's Alliance Leadership Team chair.

Figure 4 Original Evaluation Plan Strategic Goals

METHODS

The different projects used mostly qualitative methodologies including:

- semi-structured interviews
- focus groups
- document analysis
- literature reviews.

The combination of the different options above varied between projects. Interviews were carried out both in-person and via Zoom. Some recordings of interviews were transcribed verbatim before analysis and others were analysed utilising a rapid analysis process[3]. Some projects utilised the built-in dictation facility in Zoom. The Consolidated Framework for Implementation Research (CFIR) [4] was used for analysing findings in the majority of projects.

IMPORTANT CONTEXTUAL FACTORS IN THE EVALUATION

COVID-19

This work was just getting started in earnest when COVID-19 arrived in New Zealand and the effects started to be felt by the population and the health system across the country. To respond to the challenges the COVID-19 pandemic posed, all sectors of the health community, both the hospital and the primary care environment were required to devote significant resources to the battle. The shift in focus to fighting COVID-19 had both positive and negative effects on the strategy implementation. Staff focus was shifted to COVID-19 and how to work in new ways in this new environment, therefore many other projects stalled or were put to one side for a time.

However, the development and use of telehealth for providing alternatives to in-person care to reduce the spread of the virus very quickly became business as usual. The lack of face-to-face contact was limiting at times but the use of technologies like Zoom, and Microsoft Teams made some work easier by reducing travel. In addition, the impact of having to work as 'one system' to keep our communities safe, often accelerated the development of trusting relationships between people in different parts of the local health system.

Health system reform

In March 2021, the government announced substantial changes to the health system and the planned creation of Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora). This resulted in a shift in focus and a level of uncertainty about the direction of travel in the future, including a lack of certainty and job security for staff at many levels.

Challenges of leadership

Early in 2021, the Alliance Leadership Team (ALT) was put into abeyance. This committee represented both the primary and secondary sector and was originally tasked with overseeing the implementation of the Strategy. The absence of this group left the steering group overseeing the evaluation projects without the valuable leadership of the ALT. A previously reworked schema for all the projects provided a valuable resource to keep the work happening during this time.

The eight projects undertaken as part of this evaluation of the PCCS are presented in the following sections.

The Projects and their findings

Client Led Integrated Care programme (CLIC)

Figure 5 Client-led Integrated Care - CLIC – logo

AIM

To investigate if personalised care plans within the Southern District's Client Led Integrated Care (CLIC) programme support acceptable and effective long term conditions care, enhance the patient care experience, and improve the patients' ability to self-manage their condition.

INTRODUCTION

This research project is an evaluation of the CLIC model of long-term conditions care which was implemented in general practices in the Southern district from 2018. This report represents **provisional findings and interpretations** which will be described more fully in the lead authors PhD which will be submitted in 2023.

In 2018 WellSouth established a new long-term conditions programme entitled Client Led Integrated Care. This is a model of care which utilises interprofessional teams of health professionals with the vision of providing patient centred primary care to reduce secondary healthcare utilisation and encourage self-management in long-term conditions. Although many health organisations in Aotearoa, New Zealand use care planning as part of their response to the growing numbers of people with long-term conditions, the evidence supporting its effectiveness is mixed. There is little understanding of the health benefits to be derived from care planning or whether this system is equitable for all members of the general practice population.

METHODS

This research project investigated the effectiveness of CLIC by using case study methodology. Four general practices participated in the research between 2019 and 2022. These practices were situated in both rural and urban areas across the district and were selected for the research by a process of maximum variation. Participant observation and interviews with patients, health professionals and administration staff were undertaken in two separate visits to each practice around 18 months to two years apart from late 2019 to early 2022.

This research was undertaken during a period of great upheaval both in Aotearoa, New Zealand and globally. The COVID-19 pandemic caused significant disruption for general practice and practice populations. Those practices who had established CLIC into their practice generally managed to carry on with the programme, while another case study practice who was struggling to embed CLIC into their practice in 2019 put the programme on hold until 2021. The pandemic also served to highlight the inequities in our society with access to health care services, testing for COVID-19 and vaccination systems all emphasising that those least well served by our health system suffered the most during the pandemic.

FINDINGS

The findings from the present research suggest:-

- That people with multimorbidity want continuity of care, and relationships with their health care professionals which are based on trust
- In a changing health landscape, there is an increasingly diverse population who may need individualised and culturally competent care

- Health professionals are required to be adequately educated in working inter-professionally and with a complex population who may have multiple health and social needs
- Financial barriers to accessing primary care are significant for this section of the population in Aotearoa, New Zealand.

RECOMMENDATIONS TO PROVIDE THIS

- Healthcare in primary settings may need to move away from a biomedical model and be adaptable to different ways of connecting with people
- Good leadership and excellent communication are key factors, with whole of practice buy-in and champions to drive the programme (the importance of bringing people along with you)
- Education – having sustainable and ongoing education programmes for all staff
- Technology – this needs to be established before a programme rolls out. Practices quickly lose interest if they are having IT problems or issues with reconciliation, risk identification, or if they feel the wrong patients are being stratified into the programme
- Health organisations need to recognise the challenges of complexity and employ capabilities thinking to be able to provide appropriate resources to provide accessible care which allows people to be cared for in the way that works best for them and their whānau
- Understanding that culture change for both practices and patients is a long game. It takes time for people to implement a change of model, particularly one that means existing care models must change e.g., from acute 15-minute patient turnover to comprehensive assessment with a holistic and long-term focus.

Prepared by Anna Askerud, supported by Chrys Jaye, Fiona Doolan-Noble & Eileen McKinlay.

WHAT DID THE STRATEGY SAY?

Goal 1 of the Strategy – to empower patients to drive and own their own care.

The development of 'shared care plans and care co-ordination for people with more complex needs'

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

Those practices within this research who were involved and consulted in the testing phases of CLIC, most of whom had an established long term conditions model of care in their practice, were able to initially incorporate CLIC into their practice and have since evolved CLIC into a model of care which generally works for their practice. Those practices reviewed in this research who were required to move to the CLIC model of care as the programme was rolled out to all 83 general practices within the PHO struggled with a lack of buy-in. The 'why' of CLIC was poorly communicated and understood by some practice staff and patients. The pandemic affected the implementation of CLIC significantly with practices slowing down or halting CLIC completely. The research suggests that, although successful for some people, CLIC may not be reaching the more vulnerable people in the population.

Health Care Homes implementation in the Southern district

Figure 6 Health Care Home Logo

AIM

To explore the facilitators and barriers to implementation of the Health Care Home (HCH) model and its perceived effect on the southern health system.

BACKGROUND

Health Care Home (HCH) represents a re-engineering of how general practices deliver their services in New Zealand (NZ) and has arisen in response to the ageing population, ageing General Practitioner (GP) workforce, shortage of general practitioners, and increase demand for hospital services in NZ. It is being rolled out across NZ and the model of care requirements for HCH have been set out by the NZ Health Care Home Collaborative. The core elements of HCH across individual practices are provision of timely urgent or unplanned care, proactive care, routine and preventive care, and business efficiency.

METHODS

Interviews were conducted with staff from SEVEN GP practices. The practices varied by geographical location, population characteristics and practice size. The range of participants included staff in different roles: GP/Practice Owner, General Manager, Nurse Manager, Nurse Practitioner, Business Manager, and Financial Manager (n=15). A rapid thematic analysis informed by the Consolidated Framework for Implementation Science (CFIR) was conducted.

FINDINGS

Overall, the implementation experience of HCH by practices was positive. It appears that there was a general view among each practice team of the need to change, to work smarter and in a structured way to ensure the future viability and sustainability of the practices.

It appears that prior to HCH implementation journey, some practices had a reasonable clinical capacity, but some struggled with major workload issues. A few of the practices had tried to implement some changes before formally adopting the HCH model.

Different elements were introduced in practices as part of HCH intervention: designated acute slots, GP triage, care planning and need assessment, provision of HCA, morning huddle, patient's portal, upskilling of staff, the delegation of responsibility across team members, and lean processes.

Positive impact of Covid

An unexpected, but positive, impact of Covid-19 was the sudden and dramatic uptake of telehealth models by all the remaining practices that had not begun the implementation of the HCH model and the bedding in of these practices for those who were some way along their planned implementation. Telephone triage, telephone or video consultations became an essential method of working to reduce the number of face-to-face consultations and protect both patients and staff.

Key findings

- The HCH model had well designed core components, but more attention is needed to the how the programme was implemented locally to tailor the programme elements for the local context
- Strong leadership in practices with organisational commitment is critical in driving change
- There was confusion and resistance from staff during the initial stage of HCH implementation and patients had little awareness of the change made to the practices
- Too many changes in the first year were overwhelming to staff and practices
- Whole of practice engagement was crucial
- The use of external change agents - WellSouth's HCH implementation team was very helpful and important
- Practices struggled to engage with Māori patients.

Potential solutions

- Adapt interventions to enhance their fit with the context
- Ensure a leadership who leads change by encouraging and engaging team members to accommodate change
- Ensure access to knowledge and information to both staff and patients around changes made in the system
- Implement changes in stages
- Engage team members right from the beginning to get buy-in from the team
- Ensure ongoing practical support from the implementation team to address ongoing issues in the HCH practices
- Give greater focus on equity with specific initiatives, more resources, different strategies, and models of engagement.

CONCLUSION

Overall, the HCH model had positive effects by helping general practices to think and act differently and proactively to provide services. It helped to increase access and convenience to patients, staff teamwork and communication and practice efficiency. This increased efficiency, improved working life of staff and increased patient experience. That said, there were a number of issues which needed attention such a role clarity of new staff, training and education to both staff and patients regarding introduction of the new way of working and technology, simplification of some tools and need for flexibility to implement HCH components in a way that suits individual circumstances. Existing and future HCH practices need to consider these factors when implementing changes. It is imperative to tailor the HCH model to local needs and individual general practices for successful implementation.

Carried out by Dr Gagan Gurung, supported by Professor Tim Stokes, Stuart Barson.

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

From the strategy the aim was to 'Develop HCH to enhance access to primary care...'

"The HCH model of care design to reduce barriers to equity of access by, (for example) targeting high risk populations, including Māori, through stratification and stepped care."

"Our health workforce is working as 'one team', within an integrated system of care, centred on the HCH, and with delivery through team-based care (including health and broader social service representation."

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

It does not appear to have achieved the increased level of integrated care aimed for in the strategy, however the programme has resulted in many positives for the medical practices and patients.

There was one unexpected effect during the introduction of HCHs; the arrival of COVID-19. This accelerated the roll out of HCH to all practices as telehealth became an essential component of providing non-contact care during a pandemic.

As an addendum, the national approach to HCH implementation has recently been significantly reoriented to recognise the principles of Te Tiriti o Waitangi and the importance of equity in the design and structure of the programme. [5]

Home Team Development and Implementation

Figure 7 Detail taken from the Southern Primary and Community Care Strategy

AIM

To identify facilitators and barriers to the successful implementation of Home Team and perceived benefits of the programme.

BACKGROUND

The Home Team is a team of nurses, physiotherapists, occupational therapists, rehabilitation assistants and social workers based in Dunedin and Invercargill hospitals. They work with older people to maintain and regain their independence, support their discharge from hospital to home and work with patients to avoid future hospitalisation.

They can provide equipment, assess patients, link people to other services, provide home care and fill in gaps until other services arrive.

METHODS

Semi-structured interviews were conducted with 23 service providers (Home Team - 9 and other providers -14) and 7 elderly people who used Home Team Care. A rapid thematic analysis informed by Donabedian's structure-process-outcome framework was conducted.

KEY FINDINGS

- There was confusion and resistance from staff during the initial stage of Home Team implementation, and patients had little awareness of the practice changes.
- There was inadequate initial preparation and a rush in implementation.
- There was a lack of skill mix in the team.
- There were not enough cars and computers for the team.
- There was no detailed performance measurement framework for the programme.
- Interdisciplinary work was still a work in progress. More skills sharing and delegating tasks was needed.
- Use of different needs assessment tools by various service providers who were providing care to the same patients.
- There were no formal referral guidelines.
- There was confusion about who the Home Team was because many community service providers provide home care.

POTENTIAL SOLUTIONS

- Ensure more allied staff are involved so that there is a good balance of allied and nursing staff to strengthen the inter-professional focus.
- Ensure access to knowledge and information for both staff and patients regarding changes made in the system.
- Ensure provision of enough cars and computers to the team (resources).
- Implement changes in stages.
- Develop and measure key performance indicators to track progress and achievement.
- Ensure up-take of the Calderdale Framework [6] to support and develop the unregulated allied health workforce, working under supervision from allied health professionals.
- Improve coordination and communication across different service providers by using the same tools and sharing information via an electronic system.
- A flexible referral guideline is recommended.
- Ensure there is patient education about how the Home Team can help.

Prepared by Dr Gagan Gurung, supported by Professor Pauline Norris & Mr Glenn Symon.

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

"Two 'proof of concept' service models will be advanced to test and demonstrate more integrated ways of working across services and settings, (one being):

An integrated rapid response and enablement team, bringing together primary care, community nursing, allied health, and secondary care specialists, with a focus on the frail elderly."

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

The Home Team at the time of the evaluation had not met its full potential as described in the Strategy.

Community Health Hubs

AIM

This project investigated the early planning phase of development of an urban hub in Dunedin City.

INTRODUCTION

The development and design of a Community Health Hub (CHH) was outlined in the Primary and Community Care Strategy, and its associated plan. A hub was described as

"The potential physical infrastructure required to enable integrated ways of working within locality networks, with modification of the scale and scope of the hub determined by population size and existing infrastructure" [2]

Hubs were viewed as a way of providing integrated healthcare models tailored to the needs of individual communities and moving services closer to patients' homes. This was one of the essential facets of the plan to provide a sustainable healthcare delivery model for the people of the Southern region.

Figure 8 HCH Community Health Hub model and relationship with locality networks

The development of the New Dunedin Hospital design gave the process additional impetus to establish a Dunedin Hub. The design of the New Dunedin Hospital relies on some existing services that are currently within the hospital being moved into primary care. Some or all of these 'out of scope' services could be relocated into a community hub.

Hubs could contain a variety of co-located services including but not limited to:

- Core primary care (Health Care Home expanded primary care team)
- Enhanced urgent care
- On-site pharmacy
- Diagnostics
- Space for hospital specialists
- Space for minor procedures

These co-located services utilising multidisciplinary teams would provide mobile services (e.g., community nursing home visits) and in-clinic services (e.g. rehabilitation) and could include urgent care. The Strategy envisaged that the development of Hubs in different areas would be undertaken by the corresponding Locality Network, once the Locality Network had been established.
As it transpired, plans relating to the development of a Dunedin hub were advanced before a Dunedin Locality Network was established.

METHODS

An investigation into the design and introduction of an urban Community Health Hub to be located in Dunedin was carried out in early 2021. The data collection was completed just prior to the second COVID-19 lockdown and the announcement from the government of the substantial changes to the health system, including the creation of Health New Zealand and the Māori Health Authority.

Data from this project was collected via semi-structured interviews. Those interviewed included staff from both executive and clinical roles, from both hospital and primary care settings and also included the consumer perspective. A rapid thematic analysis informed by the Consolidated Framework for Implementation Science (CFIR) [4] was conducted.

FINDINGS

Defining a new model of care

There was found to be no clear agreement on exactly what a Hub would look like, and which services would be contained within a Hub. Different groups involved had their own preferences for what services should be included in a Hub and how they should be provided.

There was consistent agreement that it needed to be broader than just health services, and there needed to be social components in the overall design. The model of care needed to consider not just the individual patients but the wider environment and additional factors that contribute to a patients' and their whānau's overall health and wellbeing. This included providing a truly integrated primary care service with pathways that connect patients to the hospital setting when needed.

Interviewees acknowledged that Māori were not well served by the current healthcare model and a move to a more whānau-based model was needed.

To further the development of hubs required an integrated health system, the backbone of which would be the underlying technology. It was seen as essential to be able to share and co-ordinate a patient and their whānau's care. This required a stable IT system to facilitate the sharing of patient information and care plans between all those involved in providing care - the hospital services, community and GP services and any allied and social services required by the patient and their whānau. Without the ability to share information to provide co-ordinated patient centred care, the Hubs would not work as intended.

POTENTIAL SOLUTIONS

The following barriers and facilitators for successful establishment of a community health hub were identified:

Barriers:

- Lack of trust between groups, for example, between, general practice and hospital providers where there were existing 'prickly' relationships.
- Lack of an IT system to share information between primary and secondary care and communication between providers.
- The need for sustainable funding models to make it happen and to continue once in place.
- Resources - time is needed to develop new ways of doing things, which required additional staff with the time and ability to make it happen.
- Lack of staff training to learn new essential skills.

Facilitators that would enable successful implementation of a hub included:

- Committed leadership.
- Oversight - a group to manage and develop hubs was needed.
- Communication - needed IT in place to share information (technologically enabled) and the development of strong relationships between individuals and providers.
- New workforce skills - upskilling of current staff and training of new staff, identifying the necessary skills and competencies required.
- Making it happen - detailed plans, consultation with all parties and a change management process.
- Relationships - the building of strong and lasting relationships between groups and individuals involved in the care of the patient.
- Development of a funding model that is flexible to accommodate new models of care and service delivery.

Produced by Dr Patti Napier supported by Dr Carol Atmore & Ms Lisa Gestro.

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

Hub definition from the Strategy

'The potential physical infrastructure required to enable integrated ways of working within locality networks, with modification of the scale and scope of the hub determined by population size and existing infrastructure.'

The needs of the design of the hubs would be overseen by the locality networks.

DID IT ACHIEVE WHAT WAS EXPECTED/PLANNED?

Currently there is no locality network in place in Dunedin to carry out the role of identifying the needs of the population and the corresponding services to be included in the hub overall as outlined in the Strategy.

There still appears to be no true consensus of the core services that should be contained within a hub. However, there is greater agreement that the model of care needs to be wider than just health services as outlined in the strategy.

At the time of writing, after a stalled process, the work on a CHH in Dunedin was moving forward. Several factors have delayed development, with redeployment of key staff to the fight against COVID-19 having a significant impact alongside the challenges experienced in private-public partnerships.

Locality Networks

AIM

To investigate the development, implementation, and establishment of a locality network within the Southern region.

INTRODUCTION

The Primary and Community Care Strategy (PCCS) outlined the establishment of locality networks as one of its core models of care changes, alongside the development of enabling infrastructure and support, to achieve the aim of the strategy.

This evaluation considers the development, implementation, and early establishment of the Central Lakes Locality Network (CLLN), the first to be established in the Southern region, under the aegis of Alliance South.

This research aimed to:

- Establish if the locality network model was fit for purpose.
- Determine if it had the potential to deliver on the stated outcomes (plan and deliver care closer to where people live, work, and play and use risk stratification to identify people who will benefit most from integrated care, using a stepped care approach).
- Describe the strengths and weaknesses of the model at the point in time of the evaluation.

These questions are important to understand as claims of effectiveness of networks tends to be theoretical or conceptual as opposed to being grounded in experience.

METHODS

This evaluation consisted of an overview of published literature, document review related to the CLLN, and semi-structured interviews of stakeholders and members of the CLLN.

The overview of published literature (research studies and reports) exploring locality networks, or place-based working in health care. The document review of existing documents related to the development, implementation, and establishment of the CLLN. These included hard and electronic copies of reports, meeting minutes, terms of reference and expressions of interest.

Interviews with stakeholders (senior health care leaders and managers at both SDHB and WellSouth) and members of the CLLN to understand their experiences and views on the development, implementation, and establishment of the CLLN. These took place in early 2021 when the CLLN had been active for nearly eighteen months.

Data were analysed, informed by Cunningham et al's Evaluation Framework for Clinical and Health Networks.[7]

Figure 9 PCCS Action Plan schema for Locality Networks

FINDINGS

- The network did not reflect the vision of the Strategy. This inability to translate the vision into reality had several drivers, including uncertainty around the role and function of the network from the senior management of the partner organisations to Alliance South (SDHB and WellSouth) and network members. This resulted in a sense of confusion, impacting the relationship between the network and Alliance South, giving rise to friction and frustration.
- The decision to move away from the description of a network outlined in the PCCS led to the circulation of an expressions of interest that did not target the individuals required to form a network as described in the strategy.
- While the network was clear on its role as an advisory group to the Alliance, key stakeholders within Alliance South described being unclear about what it was they wanted of the network. Furthermore, expectations articulated in the terms of reference, such as liaising with the local communities to identify issues and gaps in services, were discouraged by key stakeholders within the Alliance. This was due in part to concerns of the additional workload that were likely to be generated.
- Constructive relationship building was challenging, especially between the Chair of the network and key stakeholders in Alliance South, ultimately impacting on the work of the network.
- Most of the literature and the Health and Disability System Review: Proposals for Reform refer to networks of providers. In contrast, while some within the CLLN worked for different providers, it was made clear to members that they were not there to represent their organisations, and this was seen as realistic on the ground.
- The network was never resourced adequately across multiple domains – financial, information/data, administratively and time.
- Where the network was supported with a clear mandate from the Alliance for involvement and given project management resource, they were successful in developing primary maternity solutions.
- The makeup of the group and the Alliance's 'hot-potatoes' drove the focus of the work. As a consequence, work addressing the stated equity priorities related to Māori, those living in socioeconomic disadvantage, and rural and remote communities, had barely commenced at the time of this evaluation.
- Lack of clarity across the different phases of development drove a sense of confusion which impacted the relationship between the network and Alliance South resulting in tension and frustration for both entities.

POTENTIAL SOLUTIONS

The following supportive factors for locality network success have been identified:

- Shared purpose and identity within the network.
- Strong relationships of trust, reciprocity, and mutual interest within the network.

The barriers to network success included:

- The lack of clarity at the Alliance South level regarding what they wanted of the network.
- Excessive control of the work agenda by Alliance South.
- Over-reliance on Alliance South for data and information, in part driven by a lack of resourcing of the network.

For future locality network establishment and implementation to be successful, developing trust will be key, both within the network and between the network and the organisations that create it. This needs to be supported by clear expectations of the network's purpose, workplan and expected outcomes. The locality network then needs to be adequately resourced by those commissioning its work to allow the network to achieve its purpose within realistic time frames.

Prepared by Dr Fiona Doolan-Noble supported by Professor Robin Gauld and Dr Carol Atmore

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

Locality networks were envisaged to 'better co-ordinate care' and are defined in the strategy as 'The strategic and operational network of providers and services required to provide timely, responsive care to defined populations based on agreed minimum levels of care, with some local variation for particular health needs and service context.'

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

The members of the network put in considerable effort to understand the role of the network. However, the development of the CLLN lacked clear direction as to whether it was to advise on the desired services or be involved in providing them.

The use of a project manager in place for one project made a significant difference on the success of one workstream but had the effect of making committee members question who was in charge.

The Impact of the PCCS from a Māori perspective

AIM

To explore the impact of the PCCS on health equity within the Southern Health System, from a Māori perspective. To explore what impact the PCCS is having on equity for Māori, identify facilitators and barriers to improved equity for Māori, identify key opportunities for improved equity for Māori and explore how key opportunities for improved equity for Māori might be advanced into the health system reforms.

METHODS

In-depth qualitative interviews were carried out. These were Māori led and underpinned by Kaupapa Māori principles. The interviewees were Māori staff working in key Māori health related roles, or as primary healthcare providers in the Southern Health System.

PRELIMINARY FINDINGS

- Those interviewed felt they were yet to see the Strategy provide improvements in health equity for Māori.
- The change process was seen as a top down one. There needed to be an increase in the community voice.
- The Strategy putting forward a new model of care was not communicated or distributed well.
- The new model of care needs to be a more integrated and seamless model of care.

PRELIMINARY RECOMMENDATIONS

Several factors were identified at this point. These factors were seen to move the health system forward to improved health equity.

- Community voice - this is needed to provide direction. This includes talking to the people in the community, development of a whānau voice and that this voice needs to be heard at all levels but driven from the community upwards.
- Culturally safe systems, structures, and policies - this will make the journey smoother and allow change to happen faster. There needs to be a shift in the system, the system values need to align with the needs of the community.
- Seamless and synergistic care - to allow whānau to access care as a single process whether in primary, secondary or tertiary levels, to improve integration of services. Change the model of care so that it is seen as one system. Make it about whānau and the patients' journey.
- Treaty principles - will provide power to the process. The principles of Te Tiriti o Waitangi of partnership, options, active protection, tino rangatiratanga and equity will drive the journey to improve health outcomes for Māori.

Prepared by Dr Karyn McLennan, Professor Emma Wyeth, and Peter Ellison

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

"Consumers, whānau and communities are empowered to drive and own their care"

"We will be able to say - Primary and community care responds effectively to the needs of Māori"

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

The Strategy documents do not appear to consider equity in any great detail. However, in the changing world of health, this awareness and recognition is moving forward. This awareness and recognition is moving forward.

Consumer Engagement

AIM

To critically evaluate the community engagement undertaken in the development, implementation, and ongoing functioning of the South Health System Primary and Community Care Strategy and the Primary Maternity Strategy.

METHODS

A scoping review mapping out what is currently known. Document analysis, group interview with Community Health Council and key informant interviews completed the work.

A Health Quality and Safety Commission Guide for District Health Boards re continuum of community engagement into health services was used as a guide for this piece of work. This guide outlines a spectrum of engagement from just general information through to empowerment. This covered the range from simply informing the community regarding change to giving communities the power to make decisions regarding change.

FINDINGS

Engagement of Māori - demonstrated partial engagement with the existence of the Southern Iwi Governance Committee. Some of the barriers to empowering engagement to the expected level were identified as lack of Te Reo translation, time of day for meetings, no early or sustained partnership with Iwi and Māori, lack of culturally appropriate communication and engagement, and over reliance on the Iwi Governance Committee. This all resulted in a lack of partnership.

Community engagement on rural maternity services - community was more involved in the consultation process with the ability to identify and overcome some barriers and the acknowledgement of the willingness to engage in a genuine conversation. Some of the barriers to collaborative engagement aimed for were identified as lack of focus on engaging with Māori women and the need to rebuild trust after the community backlash.

Themes identified were:

Barriers - It was seen by many that development occurred behind closed doors and when feedback was called for it was on a prepared document and that feedback may or may not be listened to. It was felt that Iwi consultation was lacking.

Communication - need for clear plain English in both discussions and documents.

Engagement with Māori - lacked visits to local marae to consult and was seen by many as too little too late.

During the Maternity services project - the project was responding to local community backlash to changes. Therefore, it took time to rebuild trust and move forward, but eventually the community felt listened to.

RECOMMENDATIONS

- Building community engagement and partnership, having people involved from the inception to evaluation. Māori and Iwi should be engaged early, inclusively and broadly for large scale health changes.
- Honouring Te Tiriti o Waitangi obligations through engagement.
- Innovation, accessibility, and engagement, be innovative to increase the accessibility for those people with disabilities.
- Use and maintain meaningful relationships and networks, tapping into the connections that currently exist.

To have the most impact - ensure that the time and resources are allocated to engagement to allow it to happen as planned.

Prepared by Robbie Manning, Supported by Professor Emma Wyeth, Professor Sarah Derrett, and Peter Ellison.

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

From the Strategy 'Consumers will be involved in the design and review of primary and community health services.'

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

There was some consumer engagement around the Strategy however those interviewed expressed concern that the consultation came too little too late. Later, the level of engagement increased significantly during the response to the proposed changes to maternity services in Central Otago.

Implementation of the Strategy from a governance level

AIM

To explore the process of implementation of the primary and community care strategy through Alliance governance in the Southern health system.

METHODS

Qualitative semi-structured interviews were conducted with 11 key informants (Alliance Leadership Team members and Senior Health professionals) who were involved in developing and/or implementing the strategy. A rapid thematic analysis, informed by implementation science theory, using the Consolidated Framework for Implementation Research [4] was conducted.

NB. During the evaluation period, wide-ranging New Zealand health sector reforms were announced. With alliances, partnerships and networks increasingly held up as models for integration, this evaluation identifies important lessons for policymakers, managers, and service providers both in Aotearoa New Zealand and internationally.

FINDINGS

The large number of strategy action plans and interdependencies of activities made the implementation of the Strategy complex. Communication and relationships between individuals and organisations were identified as important factors for joint and integrated working. Key elements for implementation were not adequately addressed to better align the interests of health providers, and there were multiple competing priorities for the project leaders. Gaps in the implementation process included no detailed implementation plan, ambitious targets, weak execution of the plan, the lack of a clear performance monitoring framework and a weak feedback mechanism.

Key Findings	Potential Solutions
– The structure put in place (alliance) itself doesn't bring joint working. Relationship building is key.	– Invest in nurturing and maintaining relationships between individuals and institutions.
– Expectation to deliver new models of care without provision of dedicated resources doesn't work.	– Ensure availability of adequate resourcing and develop agreement regarding the distribution of available resources.
– A committed leadership to resourcing and joint working is important.	– Ensure leadership who leads change by sharing common vision and goals, develop team work based on trust, relationship and open communication.
– It is hard for project leaders to lead the strategic work on top of their day job	– Ensure a dedicated change agent to map out the implementation.
– Lack of detailed plan (clarity around roles and responsibilities and scope) and interdependencies were stumbling blocks for the strategy implementation.	– Acknowledge the complexity. – Develop a detailed and achievable implementation plan with a single project management approach. – Ensure robust staff and stakeholder engagement.
– Robust feedback mechanism is needed for quality of implementation and promote shared learning.	– Develop an overall quality improvement approach for the whole strategy and performance measurement framework to track the progress of strategy's objective.
– Composition of the ALT didn't truly reflect the partnership with Māori.	– Ensure greater representation of Māori at the governance level.

Figure 10 Key Lessons

Summary of key findings

- The structure put in place (here, the Alliance) itself doesn't bring joint working. Relationship building is key.
- The composition of the ALT didn't truly reflect the partnership with Māori.
- A leadership committed to resourcing and working jointly is important.
- An expectation to deliver new models of care without provision of dedicated resources doesn't work.
- It is hard for project leaders to lead the strategic work on top of their day job.
- Lack of detailed plans (clarity around roles and responsibilities and scope) and interdependencies were stumbling blocks for the strategy implementation.
- Robust feedback mechanisms are needed for quality of implementation and to promote shared learning.

POTENTIAL SOLUTIONS

- Invest in nurturing and maintaining relationships between individuals and institutions.
- Ensure greater representation of Māori at the governance level.
- Ensure the leadership who leads the change shares a common vision and goals, and develops teamwork based on trust, relationships, and open communication.
- Ensure availability of adequate resourcing and develop agreement regarding the distribution of available resources.
- Ensure there is dedicated change agent capacity to map out the implementation. Acknowledge the complexity. Develop a detailed and achievable implementation plan using a project management approach.
- Ensure robust staff and stakeholder engagement.
- Develop an overall quality improvement approach for the whole strategy and performance measurement framework to track the progress of strategy's objective.

Prepared by Dr Gagan Gurung, supported by Professor Tim Stokes and Associate Professor Chrys Jaye

WHAT DID THE STRATEGY SAY WOULD HAPPEN?

The PCCS four main goals were: -

1. Consumers, whānau, and communities are empowered to drive and own their own care.
2. Primary and community care works in partnership to provide holistic team-based care.
3. Secondary and tertiary care is integrated into primary and community care models.
4. The health system is technologically enabled.

DID IT ACHIEVE WHAT WAS EXPECTED/ PLANNED?

Some successes were achieved in particular areas, but these were not universal.

Building evaluation capacity within the Southern Health System

This was achieved through several mechanisms. The Academic - Service provider lead partnerships Many projects had no evaluation planned or integrated into the project itself at inception. One of the key aims of the research project was to build evaluation capacity within the Southern Health system, both in the hospital and primary setting.

This was achieved through several mechanisms. The Academic - Service provider lead partnerships that oversaw each of the projects developed productive and trusting relationships. Similarly, the Steering Group for the evaluation project comprised academic, community and health provider members who worked together to oversee the implementation of the research projects. Embedding the research team within SDHB (for the Strategy Evaluation Lead) and the University (for the Research Fellow) developed linkages across organisations.

The Strategy Evaluation Lead appointed for the duration of the research project joined the Quality Improvement Team based within the SDHB and participated in the regular meetings with this team to understand the QI projects being undertaken. During this time the Improvement Movement within SDHB was established, utilising an on-line QI training course open to all staff working within the hospital.

This Institute of Health Improvement programme allows staff in the health workforce to understand and implement small changes that benefit the staff and individuals and whānau who are engaging with the system thereby improving quality of care and supply. In mid-2021 this training programme was expanded out to include some staff based in primary care.

For front line staff evaluation can be a very new concept. The Health Care Home programme showed examples in the primary setting of using data to lead to changes in practice. Staff have seen the benefits of understanding the potential of what the numbers can tell them and where evaluation of this data may be advantageous.

Within the funding provided for this evaluation, the following roles were provided and/or supported:

- Evaluation and coordination lead.
- Research Fellows and Associate Research Fellows.
- PhD student.
- Masters student.

Figure 11 The Concept - Building evaluation capacity within the Southern Health System

ONGOING COLLABORATION THROUGH A RESEARCH NETWORK

One of the outputs of this evaluation research project was to establish on ongoing research network between academia and service providers in the district. In an aligned but separately funded project, the Southern Primary Health Care Research Network has been established, funded by the Division of Health Sciences at the University of Otago, in collaboration with WellSouth Primary Health Network. It is hoped that this will lead to ongoing research collaboration in the district that aligns with the aims and aspirations of the Pae Ora health reforms.

EVALUATION OUTPUTS

The research conducted during this period was shared with a wide audience through a number of mechanisms.

1. Progress reports as work progressed - reports were made to the Alliance South Leadership Team and latterly to the SDHB Community and Public Health Advisory Committee and the WellSouth Board.
2. Presentations from individual projects have been given within the University of Otago departments (Otago Business School, School of Pharmacy, Department of General Practice and Rural Health). Presentations of progress and outputs have been made to the Community Health Council.
3. Publications arising from this work are listed below, with others in the pipeline:

    a. Gurung G, Atmore C, Gauld R, Stokes T. Integrated ambulatory care in the New Zealand Health System: a scoping review. Journal of Integrated Care. 2020 May 20.

    b. Askerud A, Jaye C, McKinlay E, Doolan-Noble F. What is the Answer to the Challenge of Multimorbidity in New Zealand? J Prim Health Care. 2020 Jun; 12(2):118-121. Doi: 10.1071/HC20028. PMID: 32594978.

    c. Askerud A, Jaye C, Doolan-Noble F, McKinlay E. (2021) What Do They Get Out of It? Considering a partnership model in health service research. Primary Health Care Research & Development 22(e14): 1–4. Doi: 10.1017/S1463423621000141

    d. Gurung G, Barson S, Haughey M, Stokes T. Health Care Home Implementation in Otago and Southland: a qualitative evaluation. Journal of Primary Health Care 2022; 14(2): 130–137. Doi:10.1071/HC22032

    e. Manning, R. (2022). Community Engagement for the Southern Health System's Primary and Community Care Strategy: A Case Study Approach (Thesis, Master of Public Health). University of Otago. Retrieved from http://hdl.handle.net/10523/13644

    f. Gurung G, Jaye C, Gauld R, Stokes T. Lessons learnt from the implementation of new models of care delivery through alliance governance in the Southern health region of New Zealand: a qualitative study. BMJ open. 2022 Oct 1;12(10):e065635.

4. Three colloquiums were held (April 21, May 22 and September 22). These were open to a wide audience and were attended by both SDHB and WellSouth executives and staff, primary health care providers University of Otago staff and students, Otago Polytechnic staff and students, research staff and members of the public who had been involved in the PCCS development. The reports from the first two colloquiums are included in Appendix 1 and 2.

Discussion

COMMON THEMES

The following common characteristics were identified as beneficial to successful implementation across the projects evaluated:

- Equity focus
- Relationships
- Dedicated staff to focus on the change process
- Training and education at all levels
- Time to undertake change
- IT and technology
- Funding
- Evaluation

Common themes across six of the projects were identified by the research team. These themes were identified in different projects either as facilitators or barriers, as many facilitators became barriers if they were lacking from the implementation. These are identified in Table 1 below.

	Home Team	Health Care Home	Locality Network	Community Hub	CLIC	Overall Implementation
Process Factors						
Established Design	-	✓	X	X	✓	✓
Clear aim and/or Goals	✓	✓	X	X	X	✓
Example of integrate Care	✓	-	-	✓	-	X
Leadersip or Champions	✓	✓	X	X	-	X
Resources						
Dedicated staff to focus on development	✓	✓	X	X	✓	X
Training and education	✓	✓	X	X	✓	X
Time set aside to undertake change	X	X	X	X	X	X
IT and Technology	X	X	-	X	-	-
Funding	✓	✓	X	X	X	-
Additional						
Relationships	✓	-	X	-	X	X
Equity	X	✓	✓	✓	X	-

Key: + facilitator of project success; x barrier to project success; ? unclear of impact

Figure 12 Facilitators and barriers to success across six of the projects.

In addition, partnership with Māori and community engagement in the process of change early on and consistently throughout the projects was lacking but seen as crucial for success.

There is lots of research investigating implementation practices which provides details of facilitators and barriers to successful implementation.[8] These include:

- Equity
- Leadership
- Clear goals and implementation plan
- Building relationships
- Resources
    - Time
    - Dedicated Staff
    - Funding
    - Technology

We saw a disconnect between theory and practice, and these learnings were not applied universally in all projects. Those projects that incorporated these learnings, (consciously or unconsciously) performed well and those that didn't had significant issues. In our evaluation, the successful projects benefited from:

- a dedicated project manager or supervisor providing leadership and guidance.
- resourcing that included additional funding and time for staff to undertake the necessary changes.
- the building of strong relationships between those involved.

DID THE IMPLEMENTATION OF THE PRIMARY AND COMMUNITY CARE STRATEGY ACHIEVE WHAT WAS PLANNED AND HOPED FOR?

From the perspective of achieving health equity for Māori, it appears that the Strategy implementation has yet to provide tangible improvements. Iwi involvement in design was insufficient.

For both Māori and other community members, the change process was seen as top down, with poor communication of the new ways of working being described, with limited opportunities for genuine input. There needed to be an increase in the community voice. The new model of care needed to be more integrated and seamless from the whānau user perspective.

The PCCS planned for complex change. Many of these projects are still works in progress. Some projects did experience some degrees of success. The Home Team demonstrated a level of team- based care and the HCH made significant progress with the introduction of the telehealth model. Other projects did not work as designed, for example the Locality Network and the introduction of Community Health Hub is still just getting underway.

Looking across all the projects, the common themes about what facilitated and were barriers to successful implementation have been identified here. The lack of success in the implementation of the Strategy was not the fault of staff not working hard, but rather lack of attention to the known enablers to successful implementation of change.

RECOMMENDATIONS FOR THE FUTURE

The learnings from this evaluation are worthy of reflecting on for those undertaking future large- scale change within a health system and are outlined here.

Partnership with Māori

- Embed Te Tiriti o Waitangi principles to provide power to the process. The principles of partnership, options, active protection, tino rangatiratanga and equity will drive the journey to improve health outcomes for Māori.
- Give voice to whānau to provide direction. This includes talking to the people in the community, development of a whānau voice and that this voice needs to be heard at all levels but driven from the community upwards.
- Embed culturally safe systems, structures, and policies - this will make the journey smoother and allow change to happen faster. There needs to be a shift in the system, the system values need to align with the needs of the community.
- Change the model of care so that whānau access care as a single process whether in primary, secondary or tertiary levels, through improved integration of services.

Community Engagement

- Build community engagement and partnership, having people involved from the inception to evaluation. Māori and Iwi should be engaged early, inclusively, and broadly for large scale health changes.
- Honour Te Tiriti o Waitangi obligations through engagement.
- Be innovative in approaches used to increase the accessibility to the engagement process for those people with disabilities.
- Use and maintain meaningful relationships and networks, tapping into the connections that currently exist.

Leadership

- Ensure those who lead the change share a common vision and goals and work together as a team. They must be committed to collaboratively apply their resources and work effort. This teamwork needs to be based on trust, strong relationships, and open communication.

Relationship Building

- Invest in nurturing and maintaining relationships at all levels between individuals and institutions. Strengthen and develop strong relationships with a high degree of trust.

Clear Goals, Plans and Direction

- Develop a detailed and achievable implementation plan using project management approaches.
- Ensure robust staff and stakeholder engagement and buy-in.
- Develop an overall quality improvement approach for the whole strategy and performance measurement framework to track the progress against strategic objectives.

Dedicated Resources

- Ensure availability of adequate resourcing and develop agreement regarding the distribution of available resources, including:
    - Time - including dedicated staff to get work underway. It is hard for project leaders and other staff to work on additional changes on top of their day job. Ensure there is a dedicated change agent to map out the implementation.
    - Education and training - having sustainable and ongoing education programmes for all staff, about the project from the early stages and ensure all staff can upskill where appropriate for new models of care.
    - Funding - development of funding that is flexible to accommodate new models of care and service delivery.
    - Technology - changes to how technology is used need to be established before a programme rolls out. Staff and patients quickly lose interest if they are having IT problems or issues. To provide integrated care requires the ability to share information between providers (a technologically enabled system).

Evaluation

- Build in evaluation of change at project inception, and adequately resource robust processes to identify if equitable improvements were achieved. Have realistic timelines to assess the impact of change.

Conclusion

The implementation of the PCCS in the Southern district was a complex process across a large number of moving parts. Lack of attention to the known facilitators of successful change led to modest system improvements. Remedies to these issues are likely to form the basis for future successful implementation of ongoing change in our local, regional, and national health system. Given the next phase of health reform coming, this evaluation report is timely and should be heeded by the current and new leaders aiming to achieve Pae Ora in the Southern District. These lessons are also relevant to other local health systems across Aotearoa, and more widely when local context is taken into account.

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Appendices

Appendix 1. April 2021 Colloquium report

Report from

Evaluation of the Primary and Community Care Strategy Implementation

Mid-Point Progress Colloquium

Held Friday 16th April 2021 9 am – 1 pm
Boardroom, Level Two, Otago Business School, University of Otago, Corner Clyde and Union St, Dunedin

Purpose: To share mid-point feedback on the evaluation of the Primary and Community Care Strategy (PCCS) implementation, learn of progress in other contexts, and discuss where to from here

Executive Summary

N.B. This Colloquium took place immediately prior to the announcement of the health reforms.

The mid-point evaluation of the implementation of the primary and community care strategy (PCCS) identified several common threads:

- Greater focus on equity needed, particularly for Māori, and to partner with Māori as Te Tiriti partners
- Change takes time
- Changes that improved team work, provided wrap around services, (e.g. clinical pharmacists, Health Improvement Practitioners, health coaches, community support workers) and improved integration between primary, community and hospital care were valued
- Clarity of purpose and scope of projects important

There was a general agreement that building research and evaluation capacity within the Southern health system, in partnership with the University of Otago, Otago Polytechnic and Southern Institute of Technology should be pursued, in a 'Ko Awatea of the South' concept. Translating research and evaluation into practice would be key. This could be built around Health Research South, but would need an expanded role beyond locality assessments and funding, and be broader than SDHB and Dunedin School of Medicine, to include the whole Southern health system, and the academic institutions more broadly.

PROGRAMME

8.45 Tea and coffee

Part 1: Progress to date in PCCS Implementation Evaluation Project

9.00 Welcome, outline for the morning - Carol Atmore

9.10 Background to the evaluation of the PCCS - Carol Atmore, Stuart Barson

9.25 Project updates: What have we learnt so far? - The evaluation team

- CLIC
- Health Care Homes
- Home Team
- Community Health Hubs
- Locality Networks

10.40 Morning Tea

Part 2: Experiences from colleagues

11.10 The Stewart Island project. A report on a Community Development Project undertaken by 3rd year Nursing Students - Jean Ross and colleague

11.25 Building research and evaluation capacity within a district health board – Brooke Hayward, Senior Evaluation Officer, Ko Awatea

11.45 Creation of a knowledge broker role to support translation of research into projects and programmes. Ko Awatea experience - Maria Larcombe

Part 3: So what, and where next?

12.00 Group discussion led by expert panel (Professor Peter Crampton, Professor Jo Baxter, Gail Thompson, Gilbert Taurua)

How will these findings impact on the ongoing implementation of the PCCS and maximise equity? How can we increase Southern Health System research and evaluation capacity?

12.55-1.00 Closing remarks

Summary

This was an opportunity to share with a wider audience the findings from some of the projects that are included in the evaluation of the implementation of the Primary and Community Care Strategy. The formal part of the morning was made up of presentations from four of the individual projects being undertaken as part of the evaluation. Three of the reporting projects are midway through and one (a shorter project) is nearly completed. These projects were augmented with presentations on the experiences from one of the Otago Polytechnic 3rd year nursing students' projects and staff from Ko Awatea based at Counties Manukau DHB. This made up the formal part of the morning.

The morning concluded with a panel discussion, involving invited experts, that looked at the work that had been presented on the day and explored the direction to take from here.

The presentations were attended by both Southern DHB and WellSouth executives and staff, University of Otago staff and students, members of the public who had been involved in the PCCS development and research staff.

There was general support for exploring what would be required to establish a 'Ko Awatea of the South'.

Introduction from Dr Carol Atmore

Carol Atmore is the Academic Lead for the Implementation Evaluation project and presented background to the Primary and Community Care Strategy.

The PCCS has been a long time in the making and has involved numerous groups and individuals. It had it's roots in the 2017-2027 NZ Health Research Strategy. Vision for the Strategy: - *"Excellent primary and community care that empowers people in our diverse communities to live well, stay well, get well and die well, through integrated ways of working, rapid learning and effective use of technology."*

The four strategic goals of the PCCS are:

1. Consumers, whānau and communities are empowered to drive and own their care and wellbeing
2. Primary and community care works in partnership to provide holistic, team-based care
3. Secondary and tertiary care is integrated into primary and community care models
4. The health system is technology-enabled

The Evaluation

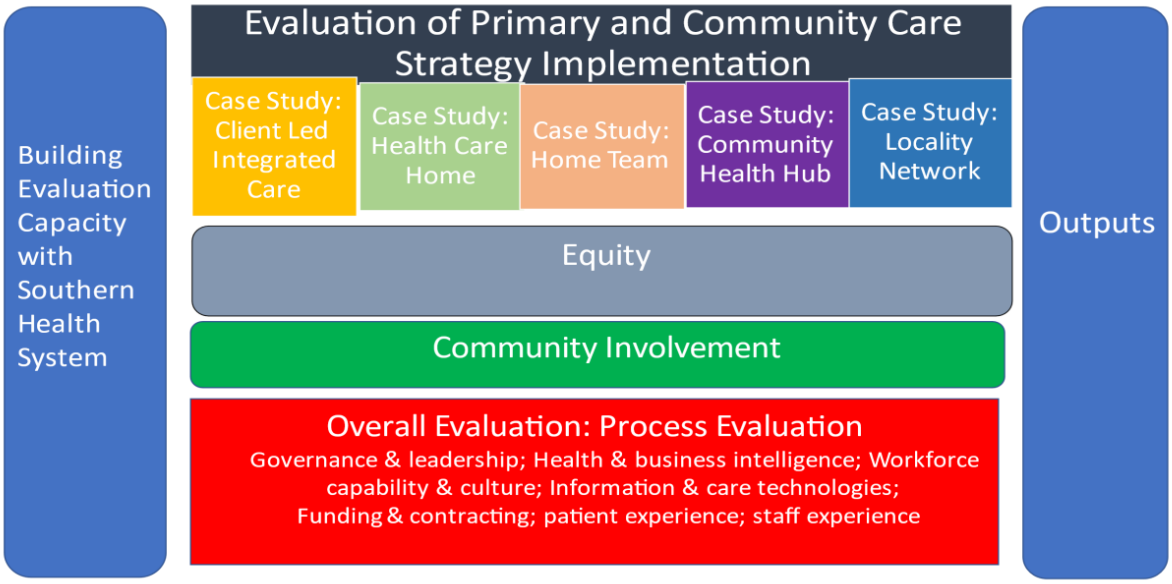
Evaluating the implementation of the Southern Primary and Community Care Strategy 2019-2022 – has 2 parts and 3 goals

Part 1:- Evaluate the implementation of the PCCS
Goal: - Improved health and equity outcomes for people of Southern district

Part 2: - Build evaluation capacity within the Southern Health System
Goal:-Increased capacity and capability within SDHB and WellSouth

Goal:-Ongoing collaboration – Southern Health System Research Network

This evaluation research is funded by Health Research South and consists of eight related projects as outlined below.



The presentations reported on the work from FOUR of the projects so far.

Research projects

1. CLIC = Consumer Led Integrated Care

Presented by :Anna Askerud.

Academic lead and support: Associate Professor Chrystal Jaye, Dr Fiona Doolan-Noble, and Associate Professor Eileen McKinlay.

Service provider lead - Wendy Findlay, Wellsouth: Primary Health Network

The research question:- Do personalised care plans within the Southern District's (CLIC) programme support acceptable and effective long-term conditions care, enhance the patient care experience and improve the patients' ability to self-manage their condition?

Anna interviewed patients, Registered nurses in GP practices and GPs.

Learnings so far.

Logistical difficulties - from a practice organisation perspective – onerous administration of CLIC, three care plans, IT hiccups, reconciliation for payment. Has taken time for practices to restructure and develop CLIC to work with their community. Practices feel that they didn't get enough support or guidance around this. Slowly developing a workable programme but this has taken time.

Time – the CHA takes a long time to complete and some patients are unable to finish it. Practices developing a Quick CLIC. Can follow up over the phone.

Patient ID and stratification - some feel that CLIC is targeted at those who are most invested in their own health. Cultural safety of this programme queried.

Education and Support - many nurses feel they do not have the right set of skills to successfully manage this programme.

Primary/Secondary integration - GP's are sceptical whether secondary care is reviewing the care plans.

Level 3 patients – frail elderly – little evidence of case management at this level.

Level 1 patients – previously were on Care Plus where they usually received four subsidised appointments per year. If patients come out at level one then do not quality for any financial or support.

Support services are slowly coming online and are hugely beneficial – clinical pharmacists, HIP's, health coaches, community support. These roles support the nurses and provides a referral pathway where needed.

2. Health care Homes

Presented by: Stuart Barson, WellSouth PHO and Gagan Gurung, University of Otago

Academic Support: Tim Stokes, University of Otago

Service provider lead: Marc Haughey, WellSouth PHO

Health Care Homes: is a structured programme that aims to re-engineer how general practices deliver their services. The programme incorporates four elements: urgent and unplanned care, proactive care, routine and preventive care and business efficiency.

Research Questions: Has the HCH initiative been implemented as intended? What are the impacts and benefits of HCH? What are the facilitators and/or barriers to HCH implementation?

Learning so far

There were positive view on most of the programmes changes: GP triage, daily huddles, patient portal, lean process. Also positive views of the tools that support the changes and good support from WellSouth/HCH implementation team. Every practice is different therefore flexibility around service elements is important. The existing primary care funding model a barrier to fully realise HCH concept

Two key areas of learnings:

1. Perceived benefits
    - Helped to think differently about how practice provide services
    - Provided a structure to streamline services
    - Greatest benefits to patients – choice, convenience, access, improved patient journey
    - Improved team-work and problem solving, coordination and communication
    - Increased efficiency e.g. free up nurses and Drs time, smarter service.
2. Change management
    - Too many changes in a short period can be overwhelming
    - Staff initial resistance with changes
    - Initial period of HCH funding support very helpful
    - Whole team engagement from the beginning important
    - Positive organisation culture
    - Organisation champions

Equity

- Practices reported struggling to engage with Māori patients and acknowledged that a different model of engagement necessary. However, they reported that HCH helped to make practical efforts in this area.
- Work is continuing to focus on how to make practice culturally welcoming and it was recommended that it was important to measure efforts made by practices on equity not only outcomes

Covid derailed some of the HCH progress, but gave an opportunity to move forward quickly with some of the applications e.g. telephone triage and telehealth

Recommendations.

- More focus on lean and change management

- Flexibility about adaptation of tools
- Consideration of financial implications and opportunity cost of implemented changes
- Patient education
- DHB has to dialogue with practices and take actions to devolve more services from secondary to primary care
- Continued support of HCH implementation team to liaise HCH with DHB and support ongoing implementation issues

3. Home Team

Presented by: Gagan Gurung, University of Otago

Academic Support: Pauline Norris, University of Otago

Service provider lead: Glenn Symon, SDHB

Home Team is: - A team of nurses, physiotherapists, occupational therapists, rehabilitations assistants and social workers based in Dunedin and Invercargill. They work with older people to maintain and regain their independence, support their discharge from hospital to home and work with patients to avoid hospitalisation.

They can provide equipment, assess patients, link people to other services, provide home care and fill in gaps until other services arrive

Research questions. Has the Home Team initiative been implemented as intended? What are the views and experiences of people using Home Team services/ families and carers? What are the views and experiences of Home Team and other stakeholders about the impact the service is making? What are the facilitators and/or barriers to implementing the Home Team initiative?

Preliminary work

- The home collaborative group involving many different disciplines
- Collaborative research between the University and DHB has an advantages with sharing skills and challenges with communication
- Learning to work within resource constraints for the research
- Home Team identity has proved interesting as other staff and patients don't recognise the name
- Challenges of interviewing this patient group due to age, hearing, cognitive impairment.

Equity focus

- Trying to include Māori and Pacific patients and whānau
- There will be more questions about equity in second interviews with team
- Ensuring our projects dovetails with a larger project on equity

4. Locality Network

Presented by: Dr Fiona Doolan-Noble

Academic Support: Dr Carol Atmore, University of Otago and Professor Robin Gauld, University of Otago

Research Question: To determine how effective the implementation of and establishment of the Central Lakes Locality Network leadership group has been.

This is the second iteration of the central lakes network, the first developed some what organically and this one was set up by the Alliance South Leadership Team.

Preliminary findings:-

Tension emerged in all interviews.

- It appeared that there was an element of disconnect between the Alliance and CLLN in terms of values and basic assumptions.
- Tension existed between the Alliance and the network because of the lack of clarity from the Alliance around how the network was to operate versus how network members felt they could contribute more meaningfully to their locality.
- Members of the network felt that they were identifying issues relevant to their locality but were not supported by the Alliance to move on these.
- A lesser tension was around the way the network meetings were run.

There are three networks in the Central Lakes Locality: CLLN, a mental health network and a COVID response group.

> ➨ *"Something speaks to the fact that we haven't got it right, when these other groups feel the need to exist*". Stakeholder 2.

Equity

- In terms of addressing equity for Māori this was overshadowed by the focus on geographical and financial equity.
- Geographical and financial equity was significantly influenced by the make up of the group. As a consequence the differences between the 2 rural hospitals either side of the gorge dominated a lot of discussions.

Make up of the network

- In terms of engagement, the recruitment process was viewed sceptically by many as far a representation, however individuals believed there was a good skill mix within the CLLN.

Strong personalities

- There are strong personalities involved in leadership at the local health system level and within the network which has impacted on the success of the network.

Lack of clarity

- There were mixed interpretations about what a locality network was but all believed it had a purpose in improving the health and wellbeing of individuals and communities within the locality.
- The Primary and Community Strategy laid out a vision for the Locality Networks (p26 of the related Action Plan).

  "*Now somewhere between strategy and setting it up it seemed to have morphed*". Stakeholder1

- Addressing issues worked best when there was a clear focus on problem, and when a partnership approach was taken by the DHB and the network, for example the maternity services review.

Recommendations

- This study provides insights into the key elements when establishing future networks and progressing CLLN.
- The perception of local people as to the relative advantage of establishing this second network versus maintaining the initial network was low.
- The mandate for the group was not well thought out and poorly communicated. Therefore, there is a need for clarity of purpose, for example, is it is an advisory or a doing group.
- How to effectively engage with and address the issue of equity for Māori.
- Agreement on resources required to fulfil purpose.
- Matching the skills and knowledge around the table with what will be required going forward in terms of the strategy and implementing the Health and Disability Services Review recommendations.

Other presentations

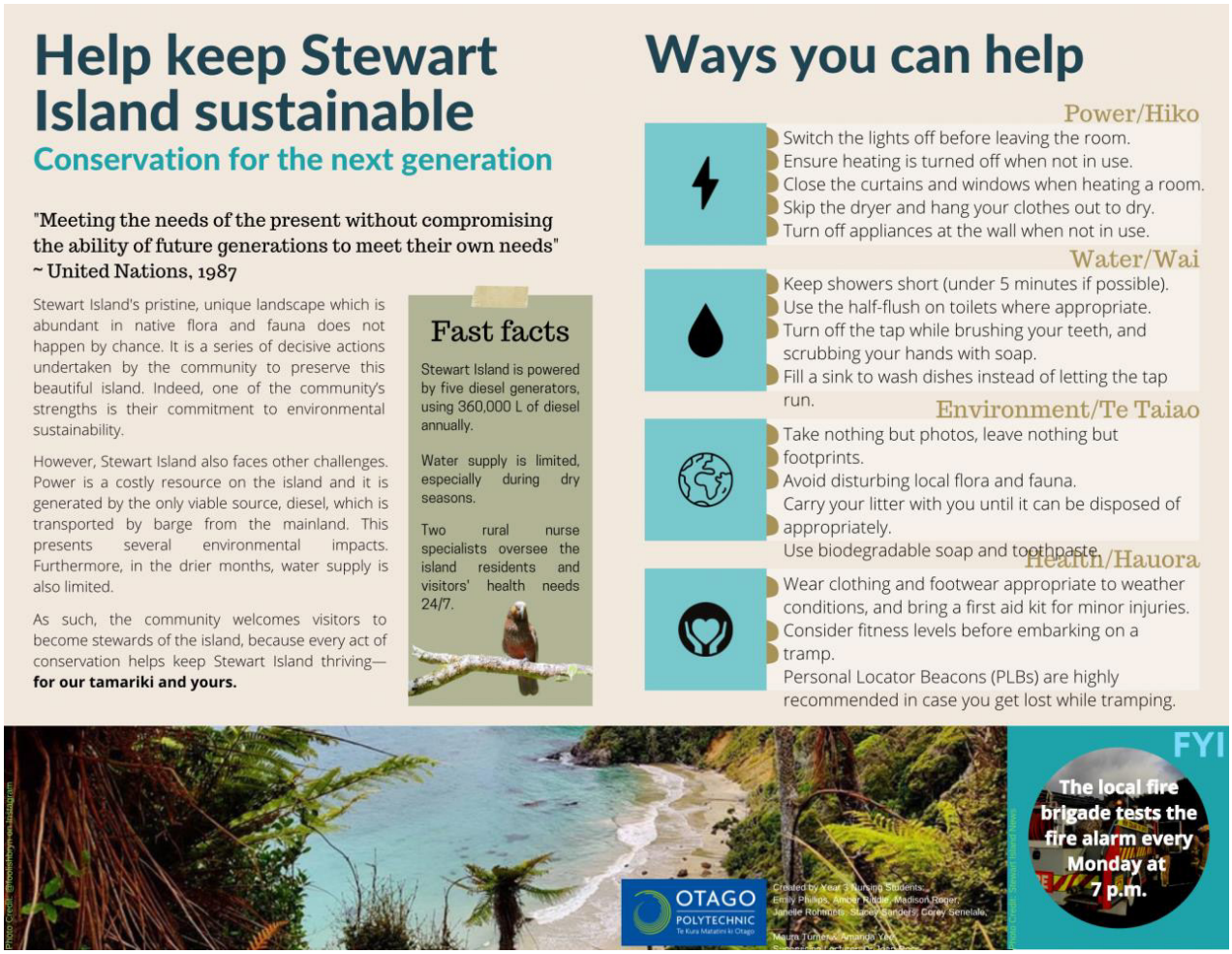
1) Nursing project, Otago Polytechnic, Stewart Island project

Presented by Dr Jean Ross, Otago Polytechnic

Third year nursing students working as a group, undertake a research project working with a local community. It has a public health view and covers a wide variety of topics.

Aim: To uncover health care needs and health disparities, Maori and non - Maori while working alongside and with community members that make a difference to health care and reduces health disparities. These projects need to be sustainable once the team leave.

A project undertaken in Stewart Island project was reported on and as part of the project the students produced an information pamphlet for visitors to encourage the conservation of scarce resources like power and water.



2) Ko Awatea

Presented by Brooke Hayward, Senior Evaluation Officer, Ko Awatea

A second focus of the larger research project that this evaluation is part of looks to increase the evaluation and research capacity with in the DHB and WellSouth. Ko Awatea provide evaluation and research support within the Counties Manukau DHB alongside fostering a culture of improvement.

" Ko Awatea's purpose is to enable and support individuals and teams within CM Health to continuously improve the service and care we deliver to our patients, whaanau and Counties Manukau community"

Systems thinking and approaches apply here to build a culture of evaluation.

1. Resources:
   time and funding are key barrier to clinician led research and evaluation. (this clinician led work facilitates change being put into practice)
2. Workforce: skills and capability
   There is immense potential with the staff given their local knowledge, lived experience and on the job learning. Everything they carry with them as institutional knowledge is important to research.
3. Relationships:
   Important to build relationships with tertiary partners, services and divisions to foster wider research. The relationships are key to promoting the service. Also, frontline staff and key contact relationships are essential as it is them who are needed to facilitate collection of data. Putting evaluation findings into practice relies on relationships as well.
4. Knowledge and data:
   Knowledge and data to support informed decision-making, with evidence, is something that is quite widely accepted. This is needed to grow our team and ensure visibility of the work, build a robust business case for resource, demonstrate our value to the wider organisation
5. Leadership

Critical to setting expectations around evaluation, role modelling and culture development. Also, essential to facilitate the ability to have discussions about racism (a term that can be difficult to talk about) and addressing the equity issues. Supportive leadership is necessary to advocate for change, evaluation can disrupt the status quo and this can be challenging for researchers.

3) Creation of a knowledge broker role to support translation of research into projects and programmes. Ko Awatea experience.

Presented by Maria Larcombe

Maria outlined her previous role at Ko Awatea and gave details about the concept of evidence informed decision making.

Evidence Informed Decision making is " evidence from published or unpublish literature, normally accessed from a database or a journal It is a deliberative process that provides guidance for decision making and using best research evidence."

Evidence based vs evidence informed, this is different in that evidence informed "recognises that research evidence is rarely complete enough to be used as it is so instead the conclusions have to be modified for the local context"

For Ko Awatea projects, a team (and a budget) is brought together, this will include clinical staff, research support (librarian, knowledge broker, evaluator), analytical assistance and an overall project manager. A project is identified, planned and carried out.

There are many challenges in the translation of research into practice. One of the solutions used here was the role of the knowledge broker. This role facilitates the exchange of information between researchers and end users. The knowledge broker is part of the project teams; provides education on research evidence integration, evidence reviews, a model for EIDM and increasing ties with academia.

Panel discussion

The panel consisted of Professor Peter Crampton, Professor Jo Baxter, Gail Thompson, (SDHB) Gilbert Taurua (SDHB) and Brooke Hayward (Ko Awatea). Nb. This meeting took place the week before the announcement of the restructure of the New Zealand health system.

Gilbert:

- the primary and hospital settings are inter-related and what happens in primary care impacts what happens in hospital and visa versa
- equity is a complex concept
- there are complex challenges including Māori in research as it is a small community with a small number of individuals
- to make changes there are still courageous conversations to come

Gail:

- important to make sure there is 'right fit' with service provision
- Currently we are good at keeping people moving through the system, rather than looking at what people want and how we can work differently.
- Start capturing data and use for continued improvement to achieve desired outcomes
- We sometimes miss the time for reflection/evaluation of whether the project/improvement has actually improved outcomes
- Increasing capacity and ability to achieve this is essential

Jo:

- This group of projects have several advantages. It is beneficial to get together and learn what other research is going on so we avoid missing some important knowledge. This group of projects is fortunate in that regard as there is value in thinking about them all together, in terms of the landscape – what are the pieces of PCC that exist?; the ecosystem – how do they all inter-relate and interact?; and optimising the ecosystem – is almost a project in itself
- Equity- intention and attention. The system has been seriously missing the needs of Māori. In the past there has been identification that there are poor outcomes for Māori but it has been seen as 'unfortunate' and no real change has happened. This can be awkward to address.
- Need to change the framing of the issue and change the narrative. Use words like unjust and racist and roll up our sleeves and do something.
- Important to design projects with Māori in mind especially when it is identified as not working for Māori. Need to be evidence based with evidence to benefit Māori included in the design.
- Moving forward there is an obligation to do something about equity for Māori as Treaty partners, to ensure they are treated as partners
- Suggested reading - https://www.health.govt.nz/our-work/populations/maori-health/whakamaua-maori-health-action-plan-2020-2025

Peter:

- Need to note that political and policy context has changed immensely over the time of these projects. This has an impact on emphasis and priorities. Particularly the incorporation of Treaty perspectives into research

- Next week's health announcement will have an impact. And will intersect with ideas given today and equity issues
- Building capacity and evaluation capacity. It would be good to have a Ko Awatea type group in the South as it brings significant intellectual capital
- Health Research South would need to be reimagined to become a Ko Awatea model.
- Building capacity is about building relationships, the question is what it would look like and what relationships to build
    - Within the university, the polytechnic and other tertiary institutions
    - within the DHB (Ko Awatea like)
    - with other groups external to these areas, i.e. Iwi

Brooke:

- Deadlines and timeline pressures from organisations can be challenging to getting research and evaluation completed. Need to slow down to do research well.
- Still room for improvement at Ko Awatea and learnings so far would mean developing it differently if starting over again. We could learn from this.
- We have the advantage of being able to work together and create a clearer marriage between the team that deliver the care and interact directly with patients and those doing the evaluations. This is a great facilitator for translational change, combining evaluation, evidence and practice
- Addition of consumer perspective is a strength of these projects and it will be interesting to see how these are incorporated into practice especially around cultural safety

General discussion:

- Rapid evaluation techniques not highly valued in the university environment.
- Could fund a Ko Awatea like organisation by moving funds from external consultants to a research group
- Currently the strategic refresh of the health system is being designed by Synergia (consultants). This presents the issues of not being transparent or having robust processes and is not accountable.
- Ko Awatea is funded by the DHB. This is not protected funding and could be pulled at any time. They work in a constant environment of potentially being dissolved at any time as they are non-essential and not frontline care and may be seen as expendable. An environment of needing to prove their value all the time.
- The evaluation of PCCS is a combination of funding that employs research staff (Health Research South grant) and 'in kind' time and some resources from both University, WellSouth and DHB staff.
- Need to up our game on equity

Recommendations/ where to from here

- Develop a Ko Awatea type service in the south.
- Explore if this could be built around HRS but expanded role beyond locality assessments and funding, and broader than SDHB and Dunedin School of Medicine
- Building capacity within the organisations is essential.
- Needs a long-term view with substantial investment over time to build capacity within the health system

- Needs strong leadership within the organisation to support such a development
- University could support research, however their time should be bought rather than 'in kind'
- Need to investigate how to make it sustainable in the future
- Research and evaluation vs improvement science. The later can be much more useful to the people on the ground. Therefore, need to identify how do we make research translate into practice (it was noted that it can be very hard to change clinicians' behaviours)
- Develop a position paper/summary of the colloquium to initiate a conversation with Health Research South, SDHB and WellSouth, regarding how to progress this kaupapa.

Report from

Evaluation of the Primary and Community Care Strategy Implementation

Progress Colloquium

Held Tuesday 10th May 2022 1pm – 5 pm
Boardroom, Level Two, Otago Business School, University of Otago, Corner Clyde and Union St, Dunedin

Purpose: To share further findings from the evaluation of the Primary and Community Care Strategy (PCCS) implementation and their relevance for the future.

Executive Summary

This was an opportunity to share further learnings from an additional group of projects included in the evaluation of the implementation of the Primary and Community Care Strategy. The presentations during the afternoon were made up of reports from three of the recently completed individual projects being undertaken as part of the evaluation. These projects included the early stages of the development of an urban community health hub in Dunedin, a consumer engagement project and an implementation project investigating the overall implementation from a high-level perspective. Also included were a scoping project around the development of a sustainable Primary Health Research Network and a report on common themes identified from the evaluation projects.

Implementation benefits from:-

- Clear goals and plans
- Leadership at all levels, champions
- Resources
    - Dedicated staff to focus on change
    - Training and education for all involved
    - Time to undertake change
    - Supportive IT and technology
    - Funding with the ability to be flexible
- Evaluation included at project establishment phase or you don't know if you have achieved what you aim to
- Relationships and trust – the cornerstone of getting things done

The projects that adopted these principles progressed well and those that did not appeared to fall short or stall.

The formation of Health New Zealand and the Māori Health Authority are going to have impacts across the whole system, however the fundamental goals of both equitable access and health outcomes still apply.

The panel of invited experts were asked for comments on what they had heard with a focus on increasing equity and improvements going forward. The need for a shift to a system with a greater Te Tiriti focus was highlighted.

In line with the Covid-19 restrictions in place at the time, this was both a virtual and in-person event. Attendees on site were augmented by those dialling in from Dunedin, Central Otago and as far afield as Wellington.

PROGRAMME

12.45 Tea and coffee

Part 1: Progress to date in PCCS Implementation Evaluation Project

1.0 Welcome, outline for the afternoon (Carol Atmore)
1.15 The current health environment (Robin Gauld)

1.25 Project updates: Presentation from recently completed works
Community Health Hubs (Patti Napier)
Patient Engagement (Robbie Manning)
Implementation evaluation (Gagan Gurung)

2.10 Development of Primary Health Research Network (Abigail Pigden)

Part 2: Putting the work into practice

2.30 A exploration of the recurring themes/learnings from the different projects (Patti Napier)

3.00 Afternoon Tea

Part 3: Is this work still relevant, and where next for equity and service development?

3.20 Group discussion led by expert panel (Professor Sue Crengle, Professor Tim Stokes, Professor John Eastwood and Professor Jo Baxter) chaired by Carol Atmore

How will these findings impact on

- the implementation of the ongoing health priorities?
- maximising equity?
- workforce development?

How can we increase Southern Health System research and evaluation capacity?

4.45 Closing remarks

Summary

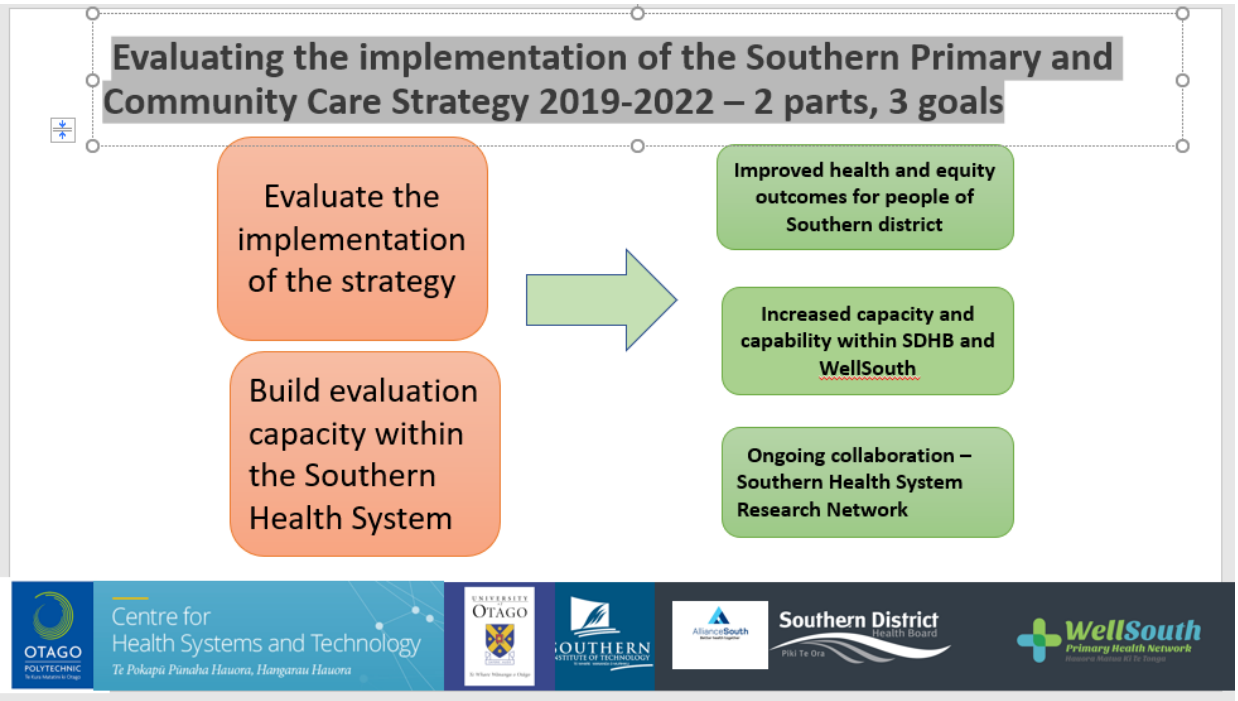
This is the second of three colloquiums. The ongoing evaluation of the implementation of the primary and community care strategy (PCCS) identified several common threads:-

- Repeated the need to increase the focus of the whole system on equity
- There are ongoing challenges with implementation. The successful projects were those that were run applying existing knowledge of barriers and facilitators to implementation, those using this type of knowledge progressed very well, those that did not stalled.
- It is a time for a shift in the power structure of the system, a rise in the voice of the individuals and whanau who are accessing health services. Ensuring they are involved and listened to in all stages of change: from design and planning, through to implementation and evaluation
- Building relationships, trust and communication between all involved is essential
- Re-iterated the problem of translating research into practice. There is a need to improve the dissemination of information to the workforce, in bite size easily digested pieces.
- It was demonstrated over several projects that although there is good information around the facilitators to effective implementation, this was lacking in several of the projects investigated. Partnership with learning institutions can assist in addressing this.
- Re-iterating that change takes time, therefore it is necessary to plan long-term.

The goals of the health system have remained fundamentally unchanged since the 1930s but the current reforms are calling for true partnership with Māori, and the wider community. There were many practical suggestions for improvement and a challenge was issued to those involved in leadership roles (and others) to make a personal effort to become up to speed with understanding Te Tiriti o Waitangi and equity and the need to understand within a NZ context the impacts of colonisation and racism to ensure the needed changes happen.

Introduction to colloquium from Dr Carol Atmore

Dr Atmore gave a summary of the development of the projects over the last 2 ½ years, the work that was presented at the previous colloquium and an introduction of those to be presented this time. The audience were reminded of the dual aims of the project, to evaluate the implementation of the PCCS, and to build ongoing evaluation capacity within the Southern Health System serving Otago and Southland.



The first aim has been addressed with a suite of work containing eight related research projects. These have consisted of five case studies, (Client Led Integrated Care, Health Care Homes, Home Team, Health Care Hubs, Locality Networks) a community involvement project, an equity project and an implementation evaluation project.

The second aim relates to increasing evaluation capacity within the local health system and developing an ongoing Southern Health System Research Network. The goals of this work are to increase the level of evaluation within the system and research informed improvement.

Commentary from Professor Robin Gauld.

Professor Gauld reminded the audience that the goals of healthcare have not changed in over nine decades:-

The Social Security Act (SSA) 1938: core principles for health care included:

- Health care should be a fundamental right; all should have equal rights to health care and to the same standard of treatment
- Services should be universally available
- There should be no access barriers
- The health system should have a preventive not curative focus

Services should be integrated, not fragmented between primary and hospital-based care.

There is nothing new in the basic goals of the New Zealand Health system, however achieving them is still remaining elusive. There are many factors thar have contributed to this situation, some of which stem from decisions made in the very beginning.

The upcoming changes to the health system aim to address these issues by some fundamental changes:-

This includes doing thing differently from in the past and developing a true partnership relationship between the Māori Health Authority and Health NZ. Adding in changes to funding arrangements and integration between hospital-based care and primary care provides the opportunity for whole sector translation.

This will not be without its challenges and there are many questions to be resolved.

- National IT and other systems
- Building ‘operational excellence’
- Developing a ‘learning health system’
- Supporting clinical governance and leadership

Research projects

5. Community Health Hubs –

Presented by Dr Patti Napier

Academic lead and support: Dr Carol Atmore

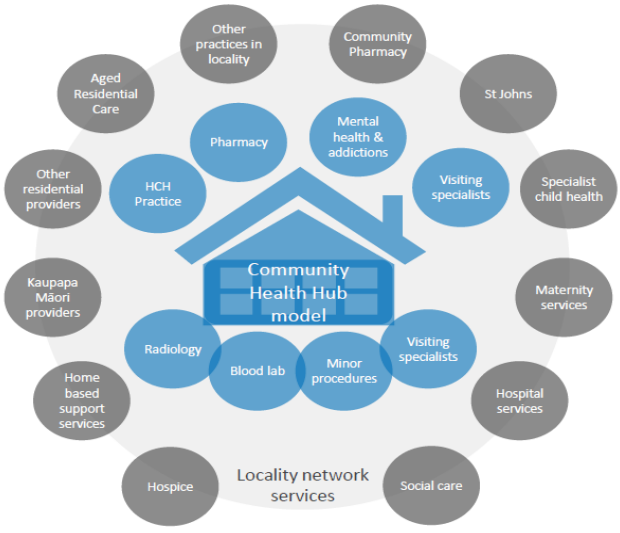
Service provider lead: Lisa Gestro/Clarissa Comerford

This project investigated the early planning phase of development of an urban hub in Dunedin city, using document review and rapid thematic analysis of semi-structured key stakeholder interviews.

Community Health Hubs are one of the cornerstones of the PCCS. They were designed to work in conjunction with Locality Networks and to be tailored to the needs of the local population. Hubs aim to provide services as close to the patients homes as possible.

The PCCS outlines a hub as containing:-

- Core primary care (Health Care Home expanded primary care team)
- Enhanced urgent care
- On-site pharmacy
- Diagnostics
- Space for hospital specialist
- Space for minor procedures
- And relationships with other services



** Community nursing, allied health (e.g., physiotherapy, dieticians, occupational therapy), health promotion, dental*

Findings:

1. There was no consensus of what services should be contained within a hub and whether this should be provided in a single location or by digitally linked services or a mixture of both. Different groups involved have their own preferences for what services should be included in a Hub and how they should be provided
2. Relationships are important, those between staff, patients and services. There are existing prickly relationships that need to be addressed.
3. Resourcing is important; funding, time, staff and technology.
4. There is a need for leadership, governance and clear goals and direction.

Key elements to progress development:

To progress this development and establish greater clarity of what a Hub will look like requires a series of key elements, these include:

- Leadership, there is currently no one in charge.
- Ability to share information between providers (a technologically enabled system).
- Time, including dedicated staff to get hubs set up.
- Development of funding that is flexible to accommodate new models of care and service delivery.
- Creative thinking on the part of staff and a willingness to try something different.
- The building of relationships between groups and individuals involved in the care of the patient.

There is some degree of urgency around getting the hubs into place. The new Dunedin Hospital is under construction and some of its planning involves moving some services out into a Hub. There needs to be hubs in place for this to happen. At the time this work was conducted (Nov 2021) there was no CHH in place in Dunedin but after a stalled process there appears to be progress towards development of an initial hub. Several factors have delayed development, with redeployment of key staff to the fight against COVID-19 having a significant impact.

6. Patient Engagement

Presented by: Robbie Manning

Academic Support: Dr Emma Wyeth and Professor Sarah Derrett, University of Otago

Service provider lead: Peter Ellison, WellSouth.

Aim: To critically evaluate the community engagement undertaken in the development, implementation and ongoing functioning of the South Health System Primary and Community Care Strategy and the Primary Maternity Strategy.

Methods: a scoping review mapping out what is currently known, document analysis, group interview with Community Health Council and key informant interviews completed the work.

A Health Quality and Safety Commission guide for health board re continuum of community engagement into health service was used as a guide for this piece of work. This guide outlines a spectrum of engagement from just general information through to empowerment. Covering the range of simply informing the community regarding change to giving communities the power to make decisions regarding change.

Themes identified were:

Barriers –It was seen by many that development occurred behind closed doors and when feedback was called for it was on a on a prepared document and that feedback may or may not be listened to. It was felt that Iwi consultation was lacking.

Communication – need for clear plain English in both discussions and documents

Engagement with Māori – lacked visits to local marae to consult and was seen by many as too little too late.

During the Maternity services project: The project was responding to local community backlash to changes. Therefore, it took time to rebuild trust and move forward, but eventually the community felt listened to.

Findings:

Engagement of Māori: Demonstrated partial engagement with the existence of the Southern Iwi Governance Committee. Some of the barriers to empowering engagement to the expected level were identified as: lack of te reo translation, time of day of meetings, no early or sustained partnership with Iwi and Māori, lack of cultural appropriate communication and engagement, over reliance on Iwi Governance Committee. Resulting in lack of partnership.

Community engagement on rural maternity services:: Community was more involved in the consultation process with the ability to identify and overcome some barriers and the acknowledgement of the willingness to engage in a genuine conversation. Some of the barriers to collaborative engagement aimed for were identified as: lack of focus on engaging with Māori women and the need to rebuild trust after the community backlash.

Recommendations:

- Building community engagement partnership, having people involved from the inception to evaluation. Māori and Iwi should be engaged early and inclusively and broadly for large scale health changes.
- Honouring Te Tiriti obligations through engagement,
- Innovation, accessibility and engagement ..be innovative to increase the accessibility for those people with disabilities
- Use and Maintain meaningful relationships and networks, taping into to the connections that currently exist

To have the most impact – ensure that the time and resources are allocated to engagement to allow it to happen as planned.

7. Implementation Evaluation

Presented by: Dr Gagan Gurung

Academic Support: Professor Tim Stokes, University of Otago, Associate Professor Chrys Jaye, University of Otago.

Aim:- to explore how the governance group managed the PCCS implementation in the Southern district and to identify facilitators and/or barriers to its successful implementation as perceived at a governance level.

During the period March 2021 to August 2021 eleven semi-structures interviews with Alliance Leadership Team (ALT) members and the project leads for individual strategy work streams were carried out.

Findings:

The complexity of the implementation context. The sheer magnitude of the action Plan required integration of primary and secondary care alongside an interdependence of different parts of the plan.

Networks and communication. Good relationships between individuals was felt to be essential for joint working, with clear communication of the vision and mission. Existing siloed organisational culture was characterised by low level of trust and poor working relationship.

Implementation readiness. Leadership commitment – need leaders who are able to work together, identify and devote resources and develop trust and confidence, also needed is a shared vision and goal. Leadership stability needed, not frequent changes in key personnel. The need for greater Māori representation at the governance level was identified.

Resources. Projects with dedicated resources and a change team was successful and poor resourcing was the major barrier. However, ALT had no authority and no mandate for decision making and resource allocation. The funding crisis in the health system, with large SDHB deficits limited resourcing.

Relative priority. Key project leaders had to do this ion top of their day job. Covid-19 diverted resources and staff. Some of the strategy misaligned with the interests of some providers creating an incompatibility issue.

Planning and executing

There exists a list of activities to be implemented but detail is lacking on how to implement the strategy. The importance to have a detailed implementation plan was acknowledged and the need for a single project management approach. Execution could have benefitted from greater planning.

Engaging with the community during the development of the strategy received a mixed view. Engaging with multiple stakeholders was seen as challenging but more would have been better.

Reflecting and evaluating. Good reporting to the ALT in terms of update about some programs was lacking and **f**eedback mechanisms could have been more robust. There is a need of a performance measurement framework to measure and track the progress with an overall quality improvement approach in place.

Recommendations

Suggestions for addressing some of these issues are included in the table below.

Key findings	**Potential Solutions**
The structure put in place (alliance) itself doesn't bring joint working. Relationship building is key	Invest in nurturing and maintaining relationships between individuals and institutions
Expectation to deliver new models of care without provision of dedicated resources doesn't work.	Ensure availability of adequate resourcing and develop agreement regarding the distribution of available resources.
A committed leadership to resourcing and joint working is important.	Ensure leadership who leads change by sharing common vision and goals, develop team work based on trust, relationship and open communication.
It is hard for project leaders to lead the strategic work on top of their day job.	Ensure a dedicated change agent to map out the implementation.
Lack of detailed plan (clarity around roles and responsibilities and scope) and interdependencies were stumbling block for the strategy implementation.	Acknowledge the complexity. Develop a detailed and achievable implementation plan with a single project management approach.Ensure robust staff and stakeholder engagement.
Robust feedback mechanism is needed for quality of implementation and promote shared learning.	Develop an overall quality improvement approach for the whole strategy and performance measurement framework to track the progress of strategy's objective.
Composition of the ALT didn't truly reflect the partnership with Māori.	Ensure greater representation of Māori at the governance level.

"it's an ongoing theme in health and in the public sector, which is we've got fantastic ideas and we're good at analysing the problem and we're good at knowing what we need to do, but we're not so good at the implementation piece." (P7)

Development of Primary Health Research Network Presentation

Presented by Dr Abigail Pigden

A qualitative study involving stakeholder and operational interviews and focus group data.

Aim: To scope the critical factors necessary for a **sustainable** primary care research and/or surveillance network in Aotearoa/New Zealand and find answers to the questions:-

- What do people in the primary care space want from a research network?
- What factors lead to a successful and lasting network?
- Should there be a separate sister network for Hauora Māori or an integrated network with a dedicated research stream?

This research is **not** about *establishing* a primary care research network.

Why do we need one?

The New Zealand's health system is changing and to achieve equitable health outcomes for everybody it is necessary to understand the health needs of the population and primary care is uniquely placed to monitor these. Internationally this data is routinely collected through established primary care research and surveillance networks. These networks can explore community-based interventions depending on how they are set up.

There are a variety of configurations for these networks overseas, with a focus on either research or surveillance. An NZ network would rely on **practitioner participation and add value** to the practice and should put **minimal burden** on clinicians. It could provide **useful data-tools and** provide **capacity building** for research for interested practitioners.

Research networks can be closely linked with research institutions like universities who provide the assistance of experienced researchers. with data management, ethics etc

Sustainable funding for a network is critical.

Findings from the SIX domains form questions/prompts for interviews and focus groups.

	Current state	**Future Research Entity**
Structure and Governance	Disconnection/ Poor visibility of what is going on in primary care	Minimum Primary Care Data Set ++ Research network infrastructure Clinicians, Tiriti partners, consumers involved in governance
Practitioner Involvement	Research to Practice and Practice to Research Gap Clinicians are time poor Research perceived as not relevant	Reciprocity Capacity building for research interested GPs Minimal burden for clinicians to participate Research questions must be relevant Research should be translated into useable knowledge
Equity	Hard to benchmark at national level Difficult to evaluate effects of interventions	Equity lens used throughout Enable national benchmarking Enable solution focused research Consumer input from diverse populations
Data management	Large amounts of primary care data "out there" but difficult to access or link together Large variation across regions	More connection for primary care data/research Hesitation around data being taken out of context Privacy and security are critical Data sovereignty needs to be addressed

Funding		At least partly Government funded via the HRC/MoH or HealthNZ Additionally, universities, ACC, Charitable Orgs,

Q: Should Hauora Māori providers be connected to the network or be a sister network? Those Māori clinicians and providers interviewed were split on which would be best but in either case the non-Māori network needs to have a strong equity focus and include Māori partnership at all levels.

Discussion

Respondents demonstrated to a strong desire for improvement in primary care research infrastructure with improving health equity should be the primary goal. The network should involve clinicians and community members and be created in partnership with Māori.

Nb. Carol Atmore added that funding has been received that will allow the establishment of a Primary Care Health Network in Southern, potentially a three-year project.

Common themes workshop

During conversations occurring between researcher on different projects it became apparent that they were finding the same themes appearing in different projects. Therefore, a workshop was held to bring them together to compare findings.

Those involved in SIX of the projects came together and compared notes to identify:-

- common facilitators and barriers across the different projects
- what are the strengths in Southern (what was done well)
- what are the areas for improvement when trying to bring about a system change
- Practical recommendations moving forward

It must be noted that there is a significant amount of research investigating implementation practices and the research provides details of facilitators and barriers to successful implementation. The PCCS Plan included some details for what was planned. **However**, these learnings were not applied universally. Those projects that incorporated these learnings, (consciously or unconsciously) performed well and those that didn't had significant issues.

Successful projects benefited from:

- a dedicated project manager or supervisor providing leadership and guidance,
- resourcing that included funding and time for staff to undertake the necessary changes
- but also from the building of strong relationships between those involved.

These facilitators are all outlined in the literature.

There exists a disconnect between the ideal and the coalface, between the literature and practice. A significant difference between theory and practice.

Nb. This recurring theme was also noted in work carried out by Abigail Pigden described as the research to practice and practice to research gap.

Panel discussion

The panel consisted of Professor Sue Crengle, Professor Jo Baxter, Professor Tim Stokes, Professor John Eastwood, chaired by Dr Carol Atmore.

They were asked to comment on how the presentations' findings impact on the implementation of the ongoing health priorities, maximising equity, and workforce development, as well as how can we increase Southern Health System research and evaluation capacity. Their observations are summarised below:

Professor Sue Crengle.

- there is a need for a shift in model to a whanau focus and whanau voice system.
- There has been an awareness of hauora Māori for decades but now is the time for action.
- Research has shown that hauora Māori providers have been able to deliver almost the same health outcomes as the conventional model while being grossly underfunded.
- Health outcomes are eighty percent determined by social factors therefore there is a need to be working with social authorities to address these needs.
- The potential of the hubs, they need to be transformed into 'localities', into well-resourced and networked community health and primary care providers.
- There needs to be a much broader range of groups/people involved in defining the services.
- This will be achieved by increased engagement with communities. There is a clear expectation in the new model that engagement with the community will be strengthened to ensure that community needs and wants will be heard.
- This transformation means those currently in power need to divest themselves of it.
- The new system will be a one system ideal with Health NZ working closely together, in partnership with the Māori Health Authority and a stronger Te Tiriti focus.
- Relationships are critical to success.
  Need to change to the localities and interface with what the new world will look like and act across the system.

Professor John Eastwood

- Design for hubs – could provide integrated care even if not in the same buildings.
- Appears to be a natural extension of a healthcare home? Is this the right model.
- Lack of leadership/sponsorship resulting in a failure to engage with the players in the system.
- Common thread seen across presentation was relationships, trust and communication, implementation science doesn't always consider relationships
- Teams and teamwork important as is coming together to share ideas (fun days)
- During implementation it is a priority to develop transdisciplinary practice, using staff well e.g. it does not take a nurse to weigh a baby.
- Adapting the workforce for the community needs.
- Patient engagement/consumer engagement should utilise the WHO framework for integrated care, a person-centred approach.
- Important to engage with communities, concern has been expressed that not much occurred during strategy planning, but will occur during reform which is needed
- Suggest caution as changes driven by community may not always address equity, but may assist in starting to get the priorities right to meet the needs of the community..

Professor Tim Stokes

- Challenge to the university to work with the sector to bring about change

- Important for the research to do work in the messy area of implementation in the real world and to work with the local health sector
- Limited capacity of the health system to do health assessment and evaluation that feeds back into the system
- Independent contractors do much evaluation and it is not ideal to helicopter people in and only ask the questions that you want to ask.
- Funding could be part of the system itself in partnership with the university
- Strong partnerships are needed that are not affected by changes in staff
- The NZ Health Research Strategy – encouraged shared research across the sector and at all levels
- Health Care Homes (HCH) was a real success story. The evaluation done by this group was the only independent evaluation ever conducted on HCH
- Going forward – hopes that long term relationships that have developed will endure
- Presentations try and support the feedback in a practical way
- Building relationships, trust and communication (how to do this)
- Need to appoint and support people's appointments within the organisation who have the skills to build relationships
- Challenges - funding with one year funding cycles and competition between organisation for resources

Professor Jo Baxter

- The current system is uncontaminated by Māori voices with the exception of a small number of very hardworking and dedicated individuals trying to create transformation
- Need to commit to the desired outcome with respect to equity and the treaty
- Requires leadership, with confidence and competence to achieve equity
- Challenging for Māori staff to work within a system not designed for Māori
- Those involved in leadership roles need to be up to speed with Te Tiriti and equity and need to understand within a NZ context the impacts of colonisation and racism to ensure the needed changes happen