Process Report: Implementation of the Comprehensive Primary Care and Community Team (CPCT) Programme in Waitaha and South Canterbury

Executive Summary

Purpose

This report evaluates the implementation process of the Comprehensive Primary Care and Community Team (CPCT) programme in Waitaha |Canterbury and South Canterbury. It identifies what worked well, the challenges faced, areas for improvement, and participants' reflections on what they would have done differently.

A comprehensive evaluation framework was approved by the CPCT Partner Leads[1] group in November 2024. This report relates to Part One: The Process Evaluation which involved completing semi-structured interviews with key implementation stakeholders.

Evaluation Methodology

An independent evaluator conducted the interviews face-to-face with 15 stakeholders, including people from the Pacific Directorate team, Te Aka Whai Ora Hauora Relationship Manager, Project Integration Lead, PHO, Māori and Pacific providers and general practice staff. The interviews focused learning on the following aspects of implementing CPCT: initial engagement, co-design, decisions on the additional roles to be employed, recruitment, communication, support, and changes from the original intent. The interviews were analysed to identify themes.

Background

The CPCT programme, established by Te Whatu Ora in 2023, aims to improve equitable access to primary and community care for priority populations, including Māori, Pacific, rural residents, and Tangata Whaikaha | People with disabilities. The programme was introduced during significant changes in the health system, including the establishment of Te Whatu Ora and Te Aka Whai Ora and the ongoing and significant restructuring since.

The CPCT programme provides additional workforce to primary and community care through funding for additional roles.

[1] Partner Leads Group membership: PHO CEOs or representatives, PHO Clinical Leads, Te Aka Whai Ora Māori Relationships Managers, Te Whatu Ora Pacific Health Team, Te Whatu Ora Commissioning, Project Integration Lead, Independent Chair and Communications support also in attendance.

Te Whatu Ora providing funding (via the PHOs) for additional clinical roles in primary and community care, with the following recommended: clinical care co-ordinators, physiotherapists, pharmacists and/or extended care paramedics (in rural areas).

Te Aka Whai Ora providing funding via Māori and Pacific providers for the employment of Kaiāwhina. All roles to work as an integrated part of primary care in a partnership model aimed at improving access to general practice and improved health literacy and outcomes for the priority population groups.

Key Findings

What Worked Well

- **Leadership and Support**: The Partner Leads Group was crucial for decision-making and leadership. The Project Integration Lead was highly praised for her support, communication, and relationship-building.
- **Relationship Building**: Strong relationships were built between practices and Māori/Pacific providers, which are expected to continue beyond the funding period.
- **Workforce Development**: Funding for Kaiāwhina roles was beneficial, and peer supervision and targeted education were implemented.
- **Positive Outcomes**: Practices embraced the CPCT programme, leading to increased patient engagement and positive impacts on patients' holistic health and wellbeing.

Challenges

- **Funding and Sustainability**: The funding mechanism was complex and unsustainable, with concerns about the programme's future after funding stops. PHOs were not adequately funded for their involvement. The funding for Kaiāwhina was insufficient with Kaiāwhina spread too thinly, often across large geographic areas.
- **Implementation Issues**: The implementation was fragmented, with inconsistencies across the motu and clusters. The national design did not always meet local needs.
- **Cultural Safety and Trust**: Cultural safety issues and lack of trust proved significantly challenging at times.
- **Communication and Coordination**: Inconsistent communication and coordination among stakeholders sometimes led to confusion and delays.
- **Role and Representation**: There was a lack of clarity about the Kaiāwhina role, including their FTE and responsibilities.
- **Reporting:** The Hauora Māori and Pacific Health Teams at Te Aka Whai Ora / Whatu Ora had little visibility of reporting by the providers**.**

What Could Have Been Done Differently

- **Better Planning and Clarity**: More thoughtful national planning and use of funding, with clearer job descriptions for some roles and expectations. Better alignment of clusters according to need, and inclusion of key practices.
- **Sustained Funding**: Sustained funding to ensure the programme could be implemented effectively and achieve its goals.

- **Co-Design and Engagement**: Greater emphasis on co-design with consumers and stakeholders from the start. More consistent engagement and communication with all stakeholders.
- **National Support**: Additional national guidance and oversight of the programme.

Overall, the CPCT programme implementation met Te Whatu Ora's intent, albeit more slowly than expected. There are concerns about the sustainability of the programme beyond June 2025, however many interview participants were confident that many of the relationships developed through the programme would continue beyond this date.

The report highlights the importance of leadership, relationship-building, and workforce development at a local level. It also identifies challenges created by the national development of the programme that included a lack of consultation locally, insufficient funding for roles that support multiple practices and "clumsy" funding mechanisms; a delayed and challenging implementation, issues of cultural safety, communication, and lack of clarity for some roles, including the Kaiāwhina.

Interviewees' recommendations for future implementations include:

- Improved national planning with local co-design.
- Enhanced identification of relevant practices with high numbers of the priority populations.
- Realistic timeframes for implementation.
- Sustained funding to provide support for the practices.

Evaluation Framework

Purpose

This report is for Part One of the evaluation framework (see Appendix 1) which was approved by the Comprehensive Primary and Community Care Teams Partner Leads Group.

The report explores the effectiveness of the implementation of CPCT in Canterbury | Waitaha and South Canterbury. It covers what can be learnt from the approach taken - what worked well, what the challenges were, areas for improvement and what the participants would have done differently if the process was repeated.

Part Two of the evaluation framework explores the outputs and outcomes for those involved, including for patients / whānau, the additional staff employed with CPCT funds, general practice and providers, through quantitative data analysis, interviews and patient / whānau surveys.

Evaluation Methodology

Pegasus contracted an independent evaluator to complete this work on behalf of CPCT Partners in Canterbury and South Canterbury. The evaluation framework was developed and approved by the Partner Leads Group.

Part One of the evaluation gathered qualitative data through face-to-face semi-structured interviews.

An interview guide was developed that included questions to explore what had worked well, what could have been improved (challenges) and what participants would do differently if repeating the process. The following key aspects of the implementation t were covered in the interviews:

- Initial engagement
- Co-design
- Decisions about roles
- Recruitment process
- Communication and support
- Information provided
- Changes between original intent and what was implemented

Between December 2024 and February 2025 fifteen (15) interviews were conducted with the following stakeholders:

- Pacific Directorate team members (4)
- Te Aka Whai Ora Hauora Manager
- Project Integration Lead
- Project Clinical Lead
- System Designer Te Whatu Ora Waitaha Living Well/Commissioning
- Two Hauora Māori provider leads
- A Pacific provider (Kaiāwhina)
- Three Waitaha PHO leads and the South Canterbury PHO lead
- Four Practice Managers

The evaluator interviewed the participants individually, except for the Pacific Directorate team. The interviews averaged approximately 40-50 minutes. The interviews were recorded through Teams (with the transcription option utilised) and the evaluator took notes. A summary of the interviews was shared with the interviewees to check for accuracy and to provide an opportunity for additional information to be shared.

The interviews were analysed using Microsoft's AI tool, Co-pilot to establish themes.

Report Structure

The report is structured to outline the:

- Rationale and context for the national CPCT programme rollout
- Implementation process locally (Canterbury and South Canterbury)
- Findings from the interviews with key stakeholders
- Summary discussion.

Comprehensive Primary Care and Community Teams (CPCT) Background

Comprehensive Primary Care and Community Teams (CPCT) is a national programme established by Te Whatu Ora and Te Aka Whai Ora in 2023 to improve equitable access to primary and community care and the health and wellbeing of priority populations - Māori, Pacific, people that live rurally and Tangata Whaikaha People with disabilities. It is a partnership model designed to ensure roles such as the Kaiāwhina are embedded in general practice and provide a holistic co-ordinated and collaborative approach to care and delivered in a way to improve access and health outcomes for the target groups.

The development of this programme began when the health system was experiencing considerable change, including the introduction of the Te Pae Ora Act (2022), which dissolved District Health Boards and created Te Whatu Ora (Health NZ) and the Māori Health entity Te Aka Whai Ora, and a new Public Health service. A key feature of the Pae Ora Act was to introduce localities as a mechanism to support integrated care and enable services to be planned to address the needs of people within the locality; this would ensure a local approach to planning and delivering health services. Localities were piloted in several regions across Aotearoa | New Zealand although not in Waitaha or South Canterbury.

A change of government in 2023 resulted in further restructuring of the health system, which is ongoing and has resulted in significant changes in personnel at the national and local level. It is suggested this level of flux in the system made it more challenging to introduce large change management projects, like CPCT.

National Introduction of CPCTs

The CPCT programme was introduced across the motu from mid-late 2023 to provide workforce support at a local level to clusters of practices in primary care. This was in the form of funding for additional workforce FTE from Te Whatu Ora and Te Aka Whai Ora. The key objectives of CPCT were to:

- Introduce additional clinical roles into general practice
- Establish Kaiāwhina roles via Hauora Māori and Pacific providers to provide additional support for patients, whānau and the practices
- Increase equitable access to services that enhance the health and wellbeing of people / whānau
- Strengthen collaborative ways of working
- Advance seamless experiences of care
- Support the sustainability of primary care

National Funding Mechanism

Workforce resources

The investment of national funding for Te Aka Whai Ora to employ Kaiāwhina started from August 2023. Discussions between Te Whata Ora and the PHOs about the CPCT programme and the

additional clinical roles started in from October 2023. (Note: In November 2023, the regions were advised that the funding would cease on 30 June 2025.)

Nationally it was recommendation funding for additional clinical roles was for the employment of:

- Care Co-ordinators
- Pharmacists
- Physiotherapist
- Extended Care Paramedic in rural areas

A process was established to use the funding for employing roles beyond those listed.

Clusters

Practices were clustered "to achieve a functional amount of FTE resource and combine the efforts of practices and Hauora Māori and Pacific providers that deliver services to the same communities" (Ref: Te Whatu Ora - Waitaha Service Specification with PHOs).

The communities / practices included in the CPCT programme were identified nationally, based on the number of people / whānau enrolled in the practice that were of Māori, Pacific ethnicity, or considered rural[2], rather than the % of these groups.

PHOs were not included in the design of the funding mechanism due to the expectation that localities would be implemented in the regions ahead of the roll out of CPCT.

The Kaiāwhina roles with Māori Health and Pacific Providers were to be an integrated part of the general practice team to provide a more comprehensive and "wrap-around" service to patients and address barriers to access.

CPCT Operating Framework

A lengthy framework document was provided by Te Whatu Ora to guide implementation with many aspirations for the service.

Reporting

Te Whatu Ora's reporting requirements included implementation status with progress based on the Operating Framework, exemplars based on patient and CPCT staff's experience and quantitative data on the number of Māori, Pacific and Total Unique Service Users and Contacts involved in the programme, and Multidisciplinary meetings, (see Appendix 2). Reports sent to Te Whatu Ora reporting. These were copied into the Te Whatu Ora Waitaha and South Canterbury staff involved in this work.

Te Aka Whai Ora's reporting system was based around the individual Māori and Pacific providers reporting to Te Aka Whai Ora's national office, rather than the commissioning managers.

[2] Enrolled in a practice that was deemed rural in the PHO Servies Agreement.

Localisation of the CPCT programme

It is worth noting that this model was a significant change from the existing system and required a different way of working for many practices and Māori and Pacific providers, including having non-clinical staff within practices.

Te Aka Whai Ora Waitaha and the Pacific Health Team Waitaha contracted with Māori and Pacific providers to employ Kaiāwhina after discussions between August and November. These roles were in place November 2023 as Te Aka Whai Ora distributed funding earlier than Te Whatu Ora – Waitaha and South Canterbury.

Te Whatu Ora - Waitaha and South Canterbury Commissioning teams were tasked with starting implementation on 1 October 2023. The Te Aka Whai Ora - Waitaha commissioning team requested that the implementation not start until a project leader was appointed.

1.5FTE funding was provided for the Project Integration Lead role. The Project Integration Lead was employed at 0.5FTE and supported by a person from the Pegasus Project Management Office at 0.5 FTE for the first seven months. This supporting role took a lead in setting up the reporting framework within the PMS systems, amongst other tasks.

A further 05FTE was originally agreed to sit with Waitaha Primary Health PHO, however, they were unable to recruit to the role. It was therefore agreed this funding would be used to support the work on the implementation including administration support and contacting for the evaluation.

The Primary Health Organisations were approached by Te Whatu Ora – Waitaha Commissioning Team in October 2023 to assist with implementing the CPCT programme. Discussions were held about how to cluster the practices. There was no additional funding available to PHOs for administration of the programme.

	FTE funded
Waitaha	13.71
South Canterbury	2.52
Pacific Kaiāwhina	2
Māori Kaiāwhina	5

Te Whatu Ora – Waitaha and stakeholders agreed that Pegasus would be the lead organisation, holding the contract for the Project Integration Leads to guide and support the implementation across Waitaha and South Canterbury.

Initial engagement and co-design process in Waitaha

The Project Integration Lead started the initial engagement and co-design process with the key stakeholders. A process for this engagement and co-design was agreed by the Partner Leads in February 2024 and included:

- Bringing the practices and providers within the clusters together
- Understanding the needs of the priority populations within the cluster

- The process of collectively agreeing the best use of the resources – clinical roles and who should employ them.
- Agreeing how to make referrals, how to get the model of where and who are the priority populations and other details
- Some clusters decided to undertake co-design at the practice level.

Contracting

CPCT FTE Funding for the additional clinical roles es was provided to the relevant PHOs. Following the codesign within each cluster, PHOs either contracted practices to employ the additional clinical roles, or a provider, as was the case in South Canterbury. In a limited number of instances, a PHOs employed the clinical roles on behalf of the practices, where this was more practical.

The Te Aka Whai Ora funding distribution was agreed via a number of hui with the South Island and Waitaha Hauora Māori providers. Letters of engagement and Kaiāwhina and workforce development agreements with Māori and Pacific Health providers were put in place in November 2023.

The CPCT Integration funds provided to Pegasus as lead PHO were also applied to communications, venue hire, and food associated with cluster and practice meetings.

Cluster Implementation Status

The individual clusters progressed through implementation over time as the capacity of the Project Integration resources allowed. Clusters were used in part to maximise the utilisation of relatively small amounts of FTE linked to individual practices. See Appendix 3 for information about the clusters, including where they are located, which resources have been employed and status of implementation process.

Implementation support mechanisms

Partners-Lead Group

Establishment of a CPCT Governance Group was required by Te Whatu Ora, however, Te Aka Whai Ora were not supportive of this group being established. After discussion, a Partner Leads Group (with no formal Terms of Reference) was agreed to as an alternative mechanism for leadership and decision-making.

Guidelines

As the implementation progressed, guidelines and checklists were developed to support practices to implement the new way of working.

Regular review and refinement

Following the implementation of the additional roles and agreement on how work in an integrated way, the Project Integration Lead progressed ongoing reviews (starting with one in the first 6-8 weeks) with each practice and providers, to further enhance the integration of services and address any emerging issues. Further ongoing reviews were prioritised to those practices and providers that would benefit for additional support.

South Canterbury implementation process

The South Canterbury Commissioning team were first to start engagement, holding co-design meetings with the local Māori provider and the CPCT cluster practices. This was ahead of the Project Implementation Lead being employed. The Commissioning Team contracted the Hauora Māori provider to manage the cluster funding and progress the employment of the additional clinical roles in collaboration with the practices.

Engagement and co-design went well, and the Project Integration Lead understood that implementation was progressing and near completion. However, this has not been the case, with implementation across a number of the practices / communities not completed. Additional work was undertaken by the Project Implementation Lead, Te Whatu Ora and South Canterbury PHO between December 2024 and February 2025 to reset the implementation of CPCT as able for the six months January to June 2025.

Workforce Development Funding

Pegasus Health holds the Workforce Development Funding on behalf of the PHOs. A comprehensive plan of how these funds would be utilised was agreed by the Partner Leads. This includes providing peer support and education, for all roles new to general practice including for Kaiāwhina, improving access through enhancing the Front Desk and First Contact staff to work in a culturally safe manner, supporting Equity Champions within each general practice and developing videos and offering workshops to support primary and community care providers to improve access for people with disabilities.

Interview Findings

What worked well

Leadership and Support

All participants from Waitaha |Canterbury noted that the Project Integration Lead worked hard to implement the programme, with the majority of participants praising her commitment and dedication, support, relationship building capacity, solution-based focus, and adaptability within the constraints of the contract. “She provided excellent support, communication and follow up.” One provider, however, felt that communication could have been improved – “I would have liked to have heard from (the Project integration Lead) more often, not just when there was a risk. “Some felt the amount of communication was overwhelming and sometimes irrelevant.”

Ongoing support for the programme from Te Whatu Ora – Waitaha was extremely helpful for the Project Integration Lead. Most of the Hauora Māori Providers felt well supported by Te Aka Whai Ora, however one respondent noted that there could have been stronger leadership and communication from Te Aka Whai Ora.

The Partner Leads Group has been crucial for decision-making & leadership.

The Project Integration Lead’s regular check-ins (reviews) with practices and partner providers have provided an opportunity for relationship building and day-to-day issue resolution, such as lack of

referrals. This check-in mechanism will also be important for sustainable communication when the funding ceases.

Some respondents noted that the Project Integration lead was "spread very thin".

Relationship Building

Relationships have been built between practices and Māori/Pacific providers, particularly in urban areas where these relationships may not have previously existed. Many feel that these relationships are likely to continue when the funding ceases in June 2025. Several practices noted that they have "good" or "wonderful" relationships with the partner providers.

Pacific providers have found it invaluable to be more involved with general practice and provide support and information about their services to both the practice team and their Pacific patients.

"Building strong relationships between providers, practices and stakeholders was crucial."

"The programme strengthened connections between Māori and Pacific providers and the practices."

Commitment to the programme

With Te Whatu Ora's announcement in November 2023 that the funding would cease in June 2025, there was concern this would decrease participation in the programme, however, as one PHO Programme Leader noted "People were able to see past the funding stopping."

"Practices embraced the CPCT programme and integrated it into their existing models of care".

Several practices noted the intent of the programme was good. One commenting: "It was such a wonderful opportunity – not often this amount of money comes into general practice for Māori and Pasifika." "The integration of pharmacists and care co-ordinators into the practice has been positive, with significant contributions to patient care and support for clinicians."

Positive Outcomes

There have been positive outcomes for patients, whānau, practices, Hauora Māori and Pacific providers, as identified in the large number of exemplars in the quarterly narrative reporting, particularly where patients' holistic health has improved.

"We've seen increased engagement and positive impacts on patients."

Workforce Development

Hauora Māori providers noted that workforce development funding for Kaiāwhina involved in CPCT, and in like roles across the Māori Health workforce has been very beneficial, including the training sessions designed by the Māori Health providers and including staff from Pacific providers.

Individual practitioners

In some areas, the model is working exceptionally well. Contributing to this is the drive of the individual practitioners, e.g. a rural pharmacist is "making a real difference".

PHO involvement

Considering the PHOs were not funded to support their practices, their commitment and willingness are appreciated by the Project Integration Lead – "they've done a significant amount of work and been very supportive in making CPCT happen".

Incidental sharing of information

The Integration Project Lead noted that several times she has been able to share useful information across the practices, e.g. the rural classification tool to support practices to more accurately identify the target population.

What could have been improved (challenges)

CPCT Te Whatu Ora national development process

Lack of consultation during development

Many felt the overall aim of the programme was sound - "it's a great idea", however, most participants mentioned Te Whatu Ora's initial development of the programme lacked consultation with key local stakeholders and consumers.

Funding Mechanisms

The funding mechanism was seen by all as unnecessarily complex and "clumsy". "More thoughtful planning and use of funding, with clearer job descriptions and expectations" would have been beneficial.

Te Aka Whai Ora funded the Kaiāwhina roles through the Hauora Māori and Pacific providers considerably earlier than the PHOs, meaning the Kaiāwhina were available to provide their services often well before the clusters were implemented, e.g. the East cluster is just starting the implementation process now, more than 12 months after the partner providers received their funding. This disconnect was challenging for all involved.

Practice inclusion methodology

The practices and clusters were decided based on total numbers of people enrolled the practices that were Māori and Pacific and rural, rather than their percentage of the practice population. The interviewees talked about the impact of this in terms of:

- Key rural practices, e.g. Ashburton, being excluded because of small numbers of enrolled population (and therefore small numbers of Māori or Pacific) at a practice level
- Large practices being included who did not have relatively high proportion of Māori, or Pacific people enrolled, but because of the size of the practice had a high number of these population groups. These practices already employed the proposed additional roles, e.g. pharmacist already working across two of the large practices
- Smaller and rural practices received limited resource. In rural areas where this was combined across the cluster to achieve a reasonable amount of FTE, a person in the role had to travel long distances.
- For smaller urban practices, the different operating and ownership models influenced the ability to combine resources.

- Some rural practices were included in the same cluster yet there were significant distances (up to 70km) between practices, and they operate very differently.

Lack of flexibility for use of additional roles

The roles set by Te Whatu Ora left a feeling of "trying to fit roles into practices when they needed something else for this group of patients".

Implementation timeframe

The timeframe within which Te Whatu Ora expected the programme to be up and running (clusters funded from October 2023 and implementation by February 2024), meant there was no time for meaningful discussion with the target group of consumers to understand what their needs were and what roles would be most beneficial.

One respondent noted: "It appeared that the National Team thought this service could be rolled out quickly, however Waitaha chose to go through a proper co-design process which has meant better outcomes and engagement."

Many identified that it would have been beneficial for the contract's timeframe to have been sufficient to acknowledge the time it takes to build relationships and integrate a new way of providing service. This was particularly so in an environment of busy general practices and partner providers, and where the implementation stakeholders felt "done to" rather than included in the development process. "We weren't given all the time we needed to deliver by June 2025."

Inconsistent regional implementation

Several participants noted there have been varying interpretations across the motu of what the funding could be used for, e.g. one cluster in the North Island used the funding to immunise the children located when a hard-to-reach parent was discharged from hospital.

Operational Framework Document

Te Whatu Ora's Operational Framework document was lengthy and "aspirational" with a significant number of expected outcomes which were always going to be challenging to meet in the timeframe, e.g. reducing ED attendances, addressing acute care needs and proactive care of chronic conditions.

Alongside this was the expectation of increased enrolment of the hard-to-reach target groups. In a time where many practices have closed books this "created tension between Kaiāwhina and practices" when Kaiāwhina had identified potential CPCT patients who were then not able to be enrolled. Some practices have developed good systems for ensuring these patients are supported whilst on the enrolment waiting list.

It is worth noting that the CPCT programme was designed at a time when localities were being piloted, with a view to extending them across the motu. Localities could have provided greater support with standard documentation, e.g. general practice implementation guidelines, and relationship building mechanisms for a programme of this size.

Local Implementation Challenges

Implementation timeframe

The Project Integration Lead acknowledged that the time taken to implement the programme has been much longer than wished for by all involved. "They must have been really frustrated. I know I was." "It was an unnecessarily long process but at the same time it was rushed to get everything in place – hurry, hurry because the funding was going to run out."

The following appear to have impacted implementing the programme in a timely way:

- The relatively late employment of a Project Integration Lead
- The challenges for time-poor practice leaders to engage in the lengthy co-design process
- The time it took to build relationships and trust
- The planning required to establish and support clusters, particularly with the 0.5FTE Project Integration Lead resource
- lack of visibility of how Kaiāwhina providers were funded and how the small FTE number could be used most effectively across the clusters.

Commissioning disconnect

There were three commissioning leads and therefore three agreement managers in different teams with little to no visibility early on about what each were doing or the implementation timeframes.

There have also been challenges for the Hauora Māori and Pacific Health Team leads accessing the providers' reporting which goes directly to the national team. This has led to little visibility of the outcomes and therefore the ability for the leads to support the providers as well as possible.

Relationship building

There were initially issues of trust "and sometimes racism" between some of the practices and the Māori providers. Some practices found it difficult to engage with their partner providers. This has been particularly evident in how the Kaiāwhina role was perceived and the need for practices to be seen as culturally safe by and for patients, e.g. reception staff and the environment needing to make the priority populations feel welcome. Some partner providers and general practices found the initial meetings "extremely uncomfortable", and it was suggested an initial "mihi whakatau would have been a great opportunity to establish networks".

Several interviewees identified that more consistent representation from Māori providers at meetings would have reduced confusion about roles and responsibilities. Some mentioned inconsistent communication among stakeholders leading to confusion and delays.

Implementation delays in general practice

The Hauora Māori Team raised concerns about having no project lead which led to agreement that Pegasus Health would employ a project lead. A Partner Leads group was established which gave the stakeholders an agreed approach and relationship establishment. However, it delayed the general practice implementation and while general practice was still working on the co-design process, the Māori and Pacific providers were able to move ahead and recruit more quickly than general practice.

Insufficient Kaiāwhina Resourcing

Many mentioned that the Kaiāwhina funding is insufficient to ensure effective coverage, with the resources split across multiple practices. This is especially true in rural areas with large distances for Kaiāwhina to travel.

Clusters

The idea of some of the practices (particularly rural) being put into clusters became impractical. Practices were too far apart, both geographically and in their way of operating.

Privacy issues

The issue of privacy is challenging as the Privacy Commissioner has instructed that referrals cannot be made to external / non-clinical providers without the patient's consent. This can make it difficult to refer to Kaiāwhina.

Lack of ongoing support and resourcing

Some practices noted that they received initial funding to ensure participation, but ongoing funding, resource allocation and support for the roles have been challenging.

Reporting / data collection

Many noted that the data collection and reporting could be improved. There is an inherent difficulty in measuring anything other than outputs which do not equate to outcomes. "There's difficulty in measuring impacts beyond basis statistics."

Recruitment challenges

Practices mentioned the challenges recruiting to some of the roles, particularly in rural areas.

Primary Health Organisations

PHOs were not included initially in the programme design because it was anticipated localities would be in place when the service was developed nationally. Once it was agreed they would be involved, PHOs were not funded to administer contracts or employ the additional roles where necessary. Despite these constraints, the PHOs were praised for they work they put in to make the programme successful.

South Canterbury issues

South Canterbury's Commissioning Team funded the local Hauora Māori provider to manage the funding. The lack of national guidance was a big issue, particularly the lack of a Memorandum of Understanding (MoU) template to guide overhead allocation between the contracted provider and practices which led to the breakdown between the Hauora Māori partner and the Waimate practices. A template had been repeatedly required.

Also, contracting directly with the practice for their employment of the additional roles e.g., the clinical pharmacist was successful, compared to the care co-ordinator being employed by the Hauora Māori provider. Alignment with priorities and integration within the primary care team were compromised.

It was felt that the lack of a PHO in South Canterbury providing oversight, stretched Commissioning resources and those of the Project Integration Lead, including the Project Integration Lead prioritising effort to the delayed Waitaha implementation, contributed to the issues that arose.

What would interviewees have done differently if repeating the process

The bulk of interviewees comments were mostly related to how the CPCT programme was developed nationally, including:

- More thoughtful national planning, including greater emphasis on co-design with local providers and consumers to establish the need and the resources required.
- Acknowledgement by Te Whatu Ora that relationships take time to build trust and work collaboratively, including the operational issues associated with including new roles which may not be clinical within general practice, e.g. Kaiāwhina, care co-ordinators.
- More effective use of funding – some felt it should have been given directly to the partners and practices to establish the local need and most effective use of the resources.
- A different model (% of target populations) used at a national level to decide on the resources required, e.g. providing data about unenrolled and unengaged patients and making the programme more outcomes-driven than outputs-driven.
- Enhanced national support to the regions, e.g. encouraging sharing of information about contracting, providing useful reporting mechanisms. "They are open to interpretation which leads to less ability to utilise the data for future planning."
- Sustainable funding to ensure the programme could be implemented effectively and achieve its goals.
- Nationally led support and information sharing opportunities, additional guidance and templates to support the practices, rather than each region needing to develop their own.
- Engagement with community providers and practices first to establish what is going to work for the target groups.
- Privacy issues needed to be thought through carefully.
- Start the service by getting an initial version up and running and learn from this and "evolve as it goes".
- Employ non-clinical Care Co-ordinators within practices to bridge patient support.
- Employ a regional manager or more FTE to manage implementation and support.

There were mixed thoughts about whether the original intent of the programme had been met. Some felt that it was "set up to fail" having been developed in isolation of the regions; others believed that it had improved relationships between primary care and Hauora Māori and Pacific providers. As a result, they believe those relationships will continue beyond the funding end date. The introduction of a more holistic approach to care in the primary care setting has been beneficial.

Summary

Overall, the CPCT programme implementation met Te Whatu Ora's intent, albeit more slowly than expected. There are concerns about the sustainability of the programme beyond June 2025, however

many interview participants were confident that many of the relationships developed through the programme would continue beyond this date.

The report highlights the importance of leadership, relationship-building, and workforce development at a local level, while identifying challenges created by the national development of the programme, including lack of consultation locally, insufficient funding for roles that support multiple practices and "clumsy" funding mechanisms, delayed and challenging implementation, cultural safety, communication, and lack of role clarity.

Interviewees' recommendations for future implementations would include:

- Improved national planning with local co-design
- Enhanced identification of relevant practices with high numbers of the target populations
- Realistic timeframes for implementation
- Sustained funding.

Appendices

Appendix One – CPCT Evaluation Framework

FOR CONSIDERATION	
TITLE	DRAFT FRAMEWORK FOR LOCAL EVALUATION OF THE CPCT PROGRAMME IN WAITAHA & SOUTH CANTERBURY
PREPARED BY	Gill Coe
DATE	8TH November 2024
RECOMENDATION	• Note Te Whatu Ora Quarterly Reporting requirements • Comment on proposed framework for evaluating CPCT in Waitaha and South Canterbury

1. SUMMARY

This paper provides an update on progress with the use of these workforce development funds included in the CPCT agreement. It also proposes that a rest of the use of these funds occurs and asks attendees to comment on suggested use of these funds and the approach taken.

2. BACKGROUND

The CPCT agreements with Te Whatu Ora require quarterly reporting as detailed in Appendix One. This includes

- Qualitative reporting on service provision, service highlights and any emerging risks or concerns. These incudes a request for six monthly exemplars
- Quantitative reporting on
    - FTE of recruited roles
    - Numbers of unique service users and contacts by ethnicity

The most recent reports (Q1 2024/25) on agreements between the PHO and Te Whatu Ora are included on the agenda for noting.

2.1. Previous discussion CPCT Partner Leads (May 2024)

Early discussion with CPCT Partner Leads (May 2024) identified value in expanding the evaluation of CPCT beyond what was required contractually. Key points from this discussion are copied below.

<u>Key discussion points on evaluation (May 2024)</u>

- Outcomes of coordination function is difficult to capture and a critical part of the CPCT. This is not represented in Te Whatu Ora reporting requirements.
- There is potentially a lot of work that is not captured as it may only come down to a few referrals, or clinical engagement.

- Noting through the cluster wānanga there is a theme of people are enrolled but not engaged in the general practice. If CPCT results in these people being engaged with the practice that were not before this is important to capture.
- We may see a reduction of engagement as people get more appropriate and timely care
- The current reporting does not capture the work of the Kaiāwhina. Note this is captured through contracts with Hauora Māori and Pacific providers
- There will be gains in relationships and trust between practices ad providers. This will take time.
- Outcomes may differ between practices given variation in where they focus their effort.
- Continue discussion on what we can capture in a quantitative and qualitative measures that bring the idea of trust and relationship to the forefront.

2.2. National Activity

GPNZ have established a TEAMS' forum, for regions to share their approach to reporting and evaluation. Significant variation exists both in how regions have implemented CPCT, capturing data for reporting and evaluation – many not exploring the impact of this work beyond the required reporting. While a national evaluation has not been agreed, any local evaluation can contribute to other voices advocating for continuation of the programme / aspects of the programme.

Direct engagement with Pro Care who have contracted Synergia to undertake an evaluation and Wellsouth has informed a local approach discussed below

3. CURRENT

With implementation of CPCT completed in the majority of practices and clusters, it is timely to revisit measuring the impact of the CPCT programme. Initial thinking on a draft framework for evaluating the CPCT in Waitaha and South Canterbury, is presented below.

4. PROPOSED CPCT EVALUATION FRAMEWORK

This framework proposes the evaluation is undertaken in into two parts –the process taken to implementing the CPCT and understanding to what extent the intended outcomes of the CPCT programme have been achieved.

4.1. Part One: Process Evaluation

This purpose of the process evaluation is to capture how CPCT was implemented and explore the effectiveness and learning of the approach taken - what worked well and where there is room for improvement.

4.1.1. Describe implementation process

Description of what has been implemented and process undertaken to achieve this.

4.1.2. Exploring the effectiveness

It is proposed the 10-15 semi-structured interviews are completed with key stakeholders.

These will include the Project Integration Lead and a person(s) from PHOs, Te Whatu Ora Commissioning, Hauora Māori and Pacific Team members, Māori, Pacific providers, urban and rural practices, and new CPCT staff.

Key questions to explore:

- What worked well
- What could have been improved or was challenging
- What would you change if you were repeating the process

The following areas of the process to implement the CPCT programme included as a focus through the interviews:

- Initial engagement
- Co-design
- Decisions about roles
- Recruitment process
- Communication and support
- Information provided
- Changes between original intent and what was implemented

4.2. Part Two: Outcomes Evaluation

This section will describe the intent of CPCT and use a range of information sources to determine to what extent the intended outcome of CPCT has been achieved. Ideally this provides information on the impact for people / whānau, practices / providers and the health system.

It is proposed the outcomes evaluation is achieved in the following way.

4.2.1. Summarise the original intent

Description of what Te Whatu Ora intended with the programme.

4.2.2. Gather quantitative information on the impact on patients

Survey a sample of participating patients using the Partners in Health Scale to understand the impact on patient health, confidence managing their health, ongoing management, health literacy.

4.2.3. Gather information on changes in the capacity and sustainability of practices

Given the demand on general practice services, it is unlikely any substantial change in metrics like the Third Next Available Appointment (a measure of practice capacity) will occur. It also may be impacted by other factors outside of CPCT. It is therefore suggested that semi-structured interviews, or survey of practices is used to explore any change in capacity from the additional roles.

4.2.4. Coordination of care / comprehensive team approach

Complete three case studies that capture voice of people / whānau and the people involved in their care

Through the interview explore the change and impact of the following:

- Partnership with practices and providers
- Provision of culturally appropriate care
- Shared decision making and empowerment in managing their own health and wellbeing
- Change in practices and providers understanding of patient's health and wellbeing needs

4.2.5. Improved Access – timely care from the right place.

Consider exploring metrics that could indicate a change in the use of ED or Urgent Care Centres for routine care. Suggested this could explore:

- Any change in a CPCT practices number of people that are regular attendees
- Any change in the number of people complex needs now regularly attending practice

Appendix Two – Te Whatu Ora Contract Reporting Framework

Qualitative reporting

Provide a brief narrative report each quarter of service provision, summarising service highlights and noting any emerging risks or concerns.

Confirmation	Narrative
Implementation progress of Operating Framework	
MOU with partner organisations completed	
IDT systems and processes operational	
Interprofessional training sessions	
Utilisation of workforce development funding across all CPCT members	
Opportunities and challenges with developing the CPCT workforce including recruitment, and retention	
Opportunities and challenges that need to be considered for future service development	
General feedback on impacts	
Six monthly practice change exemplars at a people and whānau level	

Quantitative reporting

Complete the following table for each quarter of service provision:

Funded Role recruited or contracted to	Unit	Māori	Pacific	Other
Care Coordinator	FTE			
Extended Care Paramedic	FTE			

Pharmacist	FTE			
Physiotherapist	FTE			
Total number of unique service users that additional CPCT roles funded under this agreement in the service period have delivered care to.				
Total number of Māori unique service users who accessed services provided by funded additional CPCT roles funded under this Agreement in the service period.				
Total number of Pacific unique service users who accessed services provided by funded additional CPCT roles funded under this Agreement in the service period.				
Total number of contacts provided to service users by additional CPCT roles funded under this Agreement in the service period.				
Total number of contacts provided to Māori service users by additional CPCT roles funded under this Agreement in the service period.				
Total number of contacts provided to Pacific service users by additional CPCT roles funded under this Agreement in the service period.				
Total number of interdisciplinary case meetings for a specific person and their whānau attended by additional CPCT roles funded under this agreement.				
Total number of interdisciplinary case meetings for a Māori person and their whānau attended by additional CPCT roles funded under this agreement.				
Total number of interdisciplinary case meetings for a Pacific person and their family/aiga/famili attended by additional CPCT roles funded under this agreement.				

Appendix 3: Cluster Implementation Status as of February 2025

Waitaha | Canterbury Progress Update

CLUSTER	Practice Prep & Cluster wānanga	Jointly discuss community needs and agree on roles	Complete MOU	Recruitment of roles	Design of integrated service	Commencement date	Roles employed / To Be employed (Indicative FTE only)
Riccarton / Halswell	Completed	Completed	Completed with providers / practices for any final comments	Completed	High level design completed. Final details of implementation underway.	Halswell 21st Aug. Riccarton 5th August. Work completed to involve Kaiāwhina	2 FTE Pharmacist & 0.9 FTE Care Coordinator One Care Coordinator resigned 18th February reducing the total FTE from 3.7 FTE to 2.9 FTE
Rakaia / Methven	Completed	Completed	Completed	Completed	Completed	Rakaia 22nd May Methven 29th May	0.76 FTE total applied to Pharmacist and Care Coordinator roles.
Kaikōura	Completed	Completed	Note: This will not be signed.	Completed	Completed	Kaikoura 6th June	0.43 FTE Pharmacist
Banks Peninsula	Completed for DH Akaroa yet to progress.	Completed	Draft in DH	Completed	Completed	DH -15 July. Akaroa not engaged	0.12 FTE Care coordination function in Diamond Harbour
East Christchurch	Completed	Completed	Drafted for practices / providers to individualise. Working		Completed in majority of practices with final integration of Kaiāwhina	• Whanau Ora 14th Oct. • Piki Te Ora 4th Nov • Te Aranga 9th Dec • Cashel 26th Nov • Linwood 8th Dec	Total of 4.91 FTE. • Pharmacist 2.24 FTE • Physio 1.67 FTE

			through completion of these. completed and signed.		required in three practices.	• New Brighton 20th Jan • Eastcare 20th Jan • Etu Pasifika 8th Dec	• Care Coordinator 1.0 FTE In three practices access to physio services is enabled through copayments to a provider linked to the practice.
Selwyn	Completed	Completed	Drafted For practices / providers to individualise	Completed	Completed in Oxford and Leeston. Integration of Kaiāwhina required in Darfield.	Leeston 9th Sept (Kaiāwhina started 23rd Sept) Oxford 23rd Sept. (Kaiāwhina to start 21st Oct.) Darfield 2nd October (Kaiāwhina yet to start)	Leeston: currently 0.3 FTE pharmacist Oxford: 0.45 FTE pharmacist Darfield: mA pharmacist was contracted to provide 0.2 FTE. For multiple reasons this has not been provide and a reset in underway.
Hurunui	Completed	Completed	Drafted For practices / providers to individualise	Completed	Completed	Cheviot 8th Aug. Amuri 22nd Aug. Hanmer 23rd Aug. Pegasus 26th Aug. Waikari 19th Aug. Amberley 28th Nov.	Pharmacist between 0.8 FTE and 1 FTE Care Coordinator 1 FTE across all the cluster

South Canterbury Progress Update

South Canterbury Practices identified for CPCT implementation	Summary Update
Timaru Medical Centre	Implemented. Pharmacist 0.6 FTE and Care Coordinator 1 FTE
Dr Scott's Practice	Will not be progressing with CPCT implementation due to capacity to progress change
Twizel - High Country Health	Will not be progressing with CPCT implementation due to workforce availability and capacity
Fairlie Medical Centre	Will not be progressing with CPCT implementation due to capacity. Independently looking to involve pharmacist and physio access
Oak House Medical Centre	In process of establishing a 0.2 FTE Care Coordinator role to 30 June 2025
Waimate Medical Centre	Extended Care Paramedic in place.
Four Peaks	In process of establishing a 0.2 FTE Care Coordinator role to 30 June 2025