SYNERGIA

EVALUATION OF WHAKAKOTAHI

A report for the Health Quality & Safety Commission

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29th June 2020

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Contents

ACKNOWLEDGEMENTS 4

1. EXECUTIVE SUMMARY 5

Introduction 5
Evaluation approach 5
Engagement and partnership in primary care 6
Quality improvement capability through Whakakotahi 6
Health outcomes, consumer engagement and integration 7
Contribution of Whakakotahi to equity 7
Strategic contribution of Whakakotahi 8
Key considerations 8

2. INTRODUCTION 10

2.1 Whakakotahi, the programme 10
2.2 Report structure 13

3. EVALUATION APPROACH 14

3.1 Evaluation questions 16
3.2 Data sources used in this report 17

4. THE STORY OF WHAKAKOTAHI 18

4.1 Tranche 1 20
4.2 Tranche 2 20
4.3 Tranche 3 21

5. CONTRIBUTION TO EFFECTIVE ENGAGEMENT AND PARTNERSHIPS IN PRIMARY CARE 23

5.1 Increased engagement with primary care 23
5.2 Broadening engagement with primary care 25
5.3 Maintaining relationships with primary care 26
5.4 Benefit for the Commission 28

6. CONTRIBUTION TO QUALITY IMPROVEMENT AND HEALTH OUTCOMES 29

6.1 Whakakotahi has increased quality improvement capability 29

6.2 Whakakotahi's contribution to improving health outcomes 32
6.3 Whakakotahi and consumer engagement 35
6.4 Integration within Whakakotahi 37

7. CONTRIBUTION OF WHAKAKOTAHI TO EQUITY 39

7.1 Whakakotahi increased its focus on health equity 39
7.2 Collaboration with PHARMAC placed emphasis on medicines access equity 40
7.3 Stakeholder's perspectives on the contribution to equity 41
7.4 Contributing to equity through quality improvement 47

8. STRATEGIC CONTRIBUTION OF WHAKAKOTAHI 48

8.1 Collaboration and partnerships were key strategic contributions of Whakakotahi 48

9. OVERVIEW AND KEY CONSIDERATIONS 50

9.1 Key considerations 51

APPENDIX 1: PHARMAC DRIVER DIAGRAM 53

ACKNOWLEDGEMENTS

Synergia would like to acknowledge the support of the key stakeholders that took part in this evaluation. We would particularly like to thank the Whakakotahi project teams for engaging with Synergia throughout the three years of Whakakotahi to support this evaluation. We would also like to acknowledge the key stakeholders at the Commission, Te Pātaka Whaioranga PHARMAC and the wider primary care sector for their time, insights and expertise, particularly in contributing to this final evaluation report.

We also like to thank the programme team, led by Carmela Petagna and Jane Cullen from the Health Quality & Safety Commission, and partner Sandy Bhawan from PHARMAC. Your ongoing engagement and support of the evaluation process over the last three years has been appreciated.

The expertise and experiences of all the stakeholders, through many forms of data collection, have enabled the evaluation to provide a great insight into the contribution of Whakakotahi as a quality improvement programme and provide useful insights and considerations for the future iterations of this successful programme.

1. EXECUTIVE SUMMARY

Introduction

Whakakotahi is one of the Health Quality & Safety Commission's (the Commission's) key initiatives in its Primary Care programme. The initiative aims to increase quality improvement capability in primary care.

Whakakotahi has three key aims:

1. **Increase engagement between the Commission and the primary care sector.**
2. **Increase quality improvement capability of those involved.**
3. **Contribute towards improved processes leading to improved health outcomes, by focussing on the principles of equity, consumer engagement and integration of services.**

Whakakotahi has now come to a close in its current phase, with the third and final Tranche of project teams completing the programme in March 2020. Over the next year, the Commission is looking to reflect on the key learnings from Whakakotahi to inform future directions for the next iteration of the programme, whatever form that may take.

This report presents a summary of the learnings from Whakakotahi, drawing on previous reports and including feedback from all three Tranches. This report is intended to provide insights, considerations and summaries of the Whakakotahi programme to support the ongoing work of the Commission in primary care.

Evaluation approach

A formative evaluation of Whakakotahi was conducted. At this final stage, the evaluation aims to provide summative feedback on the programme.

The evaluation is designed to provide feedback on five key areas:

1. **Contribution to effective and increased engagement of the primary care sector.**
2. **Contribution to effective working partnerships between the primary care participants and the Commission.**
3. **Increased quality improvement capability among Whakakotahi participants.**
4. **Improvements in health outcomes and potential contribution to longer term outcomes of equity, integration and consumer engagement in participating settings**
5. **Understanding Whakakotahi through the Commission's evaluation framework.**

It is important to note that previous reports have focused solely on the first three areas, with some limited insights into the fourth area. This report aims to contribute to understanding what we can about all five key areas.

A mixed methods approach has been used and draws from quantitative (survey) and qualitative (interview) data collected by both the Commission and Synergia.

Engagement and partnership in primary care

Whakakotahi has enabled the Commission to build strong relationships with many organisations in primary care across New Zealand. In the context of this report, the term 'primary care' is used as an inclusive phrase that consists of general practice, pharmacy, non-government organisations and any other community organisations working with patients to improve their health and wellbeing. These relationships are robust and built on solid foundations through the level of support and effort the Commission invests into participating project teams. Many of these relationships are sustained after Whakakotahi has finished, with the Commission's quality improvement advisor as a point of contact, which has enabled mutually beneficial sharing of learnings and insights.

The addition of partner organisations such as Te Tihi o Ruahine Whānau Ora Alliance (Te Tihi) and PHARMAC in later phases of Whakakotahi have enabled the Commission to expand the reach of Whakakotahi and engage with a broader range of primary care organisations. The partnership with Te Tihi supported the Commission to engage with Māori and Pacific primary care organisations in a more meaningful, respectful and culturally safe way, as well as supporting these organisations to share their own knowledge and kaupapa back with the Commission.

The partnership with PHARMAC fast-tracked the Commission's engagement with pharmacies and pharmacy-collaboratives with the addition of the medicine access equity focus. This was important and contributed to increased integration between pharmacy, general practice and non-government organisations in tranche 3.

Key benefits for the Commission:

- **Understanding primary care at the community level.**
- **Raising the profile of the Commission in the primary care sector.**
- **Building sustainable relationships with primary care providers and primary care sector organisations.**
- **Building partnerships with Māori provider Te Tihi and another Crown agency, PHARMAC**

Quality improvement capability through Whakakotahi

There is **clear evidence for improved quality improvement capability in Whakakotahi participants**, with team members actively noting increases in their knowledge and awareness of quality improvement tools, processes and methodologies.

There has been **limited identified spread of these capabilities beyond the teams** and organisations directly involved in Whakakotahi and their networks, though wider engagement into the primary care sector may support a slow burning change in increasing capabilities.

There is also some indication that aspects of the quality improvement learnings are sustained post-Whakakotahi, however this is not confirmed to be systematic across all those involved in the programme. There is space for the Commission to explore how best to support sustained learnings and use of the quality improvement methodologies in primary care and a scalable approach for doing so.

Health outcomes, consumer engagement and integration

There is limited clinical data to accurately ascertain the impact of Whakakotahi on health outcomes, however anecdotally **project teams perceive their projects to have had positive impacts for patients involved**. Quality improvement data was used to track health outcomes throughout Whakakotahi, and this demonstrated some slight improvements for patients across the varying project areas.

Whakakotahi resulted in some positive examples of consumer engagement in primary care – a space where consumer engagement has not traditionally been done systematically. Some teams have built great, solid relationships with consumers through their projects and the focused decision to engage with consumers, though these examples within Whakakotahi are in the minority.

There was also a lack of understanding among the primary care teams as to what is meant by consumer engagement and co-design within the Whakakotahi context. The programme intended to encourage experience-based co-design, with direct consumer involvement in all aspects of the project.

Whakakotahi may not have made the contribution to consumer engagement that was originally anticipated; however, this experience has garnered some considerable learnings for the Commission in terms of the challenges and context of this space within primary care. **There may be further work for the Commission to explore co-design and consumer engagement in primary care in the future.**

Whakakotahi has made some contribution towards improving integration in primary care, however this is also not systematic across all project teams involved. The added partnership with PHARMAC went some way to support and encourage horizontal integration between general practice and pharmacy.

Contribution of Whakakotahi to equity

Whakakotahi has increased its focus and emphasis on equity over the years. In its first year, Whakakotahi was critiqued for its inflexibility on the quality improvement science and Western models it employed. The Commission took this critique on board and adapted the model to allow for more flexibility in the process and also sought to engage Māori expertise and cultural advice and support through Te Tihi. In later years, the more flexible and agile approaches to quality improvement interpretation and application have been commended by all project teams, notably those who come from Māori health providers.

The later collaboration and partnership with PHARMAC supported an additional focus on medicine access equity, an area that aims to ensure access to medicines are equitable, with a particular focus on Māori.

It is acknowledged that Whakakotahi is part of a broader system and will never be able to have a significant impact alone on health equity – it requires a systemic approach across the sector to achieve equity and equitable outcomes and a need to work at both a systems and programme level. **Whakakotahi as a programme learnt and responded to criticism and worked hard to improve its understanding and contribution to equity over the course of this first phase.** It has also supported the Commission to

highlight areas of inequity within primary care and provide a guide for how to better support primary care in the sector's goal to achieve equity.

Strategic contribution of Whakakotahi

The Commission is also interested in understanding the strategic fit of Whakakotahi. There are several ways in which this programme aligns with the Commission's strategic priorities, but also lines up with the strategic goals of the wider health sector as well.

Whakakotahi contributes to the Commission's strategic priorities through:

- creating **collaborative partnerships** between the Commission and primary care, particularly providers serving priority population groups
- creating opportunities for **interagency collaboration** with other national agencies
- providing **training and education in quality improvement** tools and methods
- supporting **sector-led quality improvement initiatives** chosen by the project teams
- developing a base of **primary care improvement science knowledge** (both within primary care and the Commission).

Key considerations

In the future, the Commission will explore what the next iteration of Whakakotahi may look like. The evaluation of Whakakotahi has identified the following key considerations to support this thinking:

- **Capability development:** Primary care needs to be supported with the management of quality improvement data.
- **Support with co-design:** If patient co-design is an ongoing goal of Whakakotahi, there needs to be more support and/or emphasis placed on this aspect of the programme.
- **Interagency and community partnership and collaboration:** Continue to collaborate with other national and community organisations to share insights and learn from one another. A cohesive response to building quality improvement capability, improving health outcomes and achieving equity is required to successfully sustain desired outcomes.
- **Further enhancing the focus on equity:** Continue to support the integration of te ao Māori and quality improvement approaches to ensure relevance and value for Māori providers. Focusing on a few topic areas with identified health inequities for example gout, asthma or diabetes may increase the impact on equity.
- **Scale:** The current model of support needs to be adapted to work at scale. There is value in exploring the potential for collaboration with quality improvement advisors at district health boards (DHBs) and primary health organisations (PHOs) to extend the reach of Whakakotahi.
- **Sustainability of capability development:** Strategies to sustain and spread the quality improvement capability developed in project team members would add further value.

- **Sustainability of the quality improvement ideas:** Focusing on a few areas may enhance the sustainability of the quality improvement ideas, as a few core ideas would be easier to share and support regionally and nationally.
- **Building an evidence base:** To substantiate stakeholders' views and experiences of Whakakotahi, it would be useful to draw on system level data. Focusing on some core topic areas would enhance the feasibility of outcome data collection for the programme.

A number of these considerations highlight the value of focusing on a few core areas, while this makes sense for the reasons outlined above, it is important that these topics are co-defined with the sector to ensure that Whakakotahi remains relevant to local providers and the needs of the populations they serve.

Whakakotahi has evolved since its initial inception and progressed towards a well-defined, robust quality improvement programme for primary care. It is largely achieving its intended outcomes, and there have been some great learnings from this exploratory programme. The Commission should be proud of the work that has gone into developing this programme and be excited for where these learnings could take them.

2. INTRODUCTION

The Commission is responsible for monitoring and improving the quality and safety of health and disability services in New Zealand and promoting a culture of continuous quality improvement across the whole sector. Prior to Whakakotahi, the Commission led a range of programmes supporting the development of quality improvement capability within the health sector and many of these gains were made within secondary care. At this time, the Commission did not have a high profile in primary care and wanted to learn where it was best placed to add value to the primary care sector quality improvement culture.

The Commission's 2015/16 Statement of Performance Expectations demonstrated their intentions to increase their focus on primary care, aged residential care and disability services. A primary care work programme was soon initiated and the Primary Care Expert Advisory Group (PCEAG) was established in 2016. The PCEAG provided advice to the Commission which informed the establishment and design of Whakakotahi – the primary care quality improvement challenge.

In early 2017, Synergia submitted a successful proposal in response to a request for proposal process to the Commission to conduct a formative and summative evaluation of Whakakotahi. The Commission identified the need for an evaluation to provide formative feedback to inform the development of Whakakotahi and understand whether the programme was meeting its objectives.

2.1 Whakakotahi, the programme

Whakakotahi is te reo for "to be as one", and this name was developed by the Commission's primary care expert advisory group (PCEAG), with strong Māori input, to refer to the Commission's primary care improvement challenge. The Commission launched Whakakotahi to the primary care sector with an expression of interest process in April 2016. Whakakotahi was a three-year, small-scale programme that began in 2017. It was designed with the advice of the PCEAG made up of primary care sector leaders and included consumers and those representing a Māori perspective.

The Commission's Health Quality Intelligence team had previously engaged in the primary care space through their work on the Atlas of Healthcare Variation, and the national primary care patient experience survey; Whakakotahi marked a new space for the Commission working directly with primary care.

The overarching vision of Whakakotahi has been to increase quality improvement capability in the primary care sector through the following objectives:

- Create collaborative partnerships between the Commission and primary care, particularly providers serving priority population groups.
- Provide training and education in quality improvement tools and methods.
- Support sector-led quality improvement initiatives chosen by the project teams.
- Develop a base of primary care improvement science knowledge (both within primary care and the Commission).

The emphasis for Whakakotahi changed in the final year to reflect an overarching vision to improve health outcomes with a focus on Māori health gains, equity and patient experience in primary care.

While the vision of the programme changed throughout the three years, the key principles of equity, integration and consumer engagement remained.

Each year primary care teams from general practice, pharmacy and Māori health providers have submitted expressions of interest (EOIs) for quality improvement projects that they have prioritised for their population. These EOIs indicate that they were interested in implementing and partnering with the Commission on specific projects, while also learning about quality improvement to better serve the needs of their local populations. Applicants were able to select any topic area that was important and relevant to them, which saw a broad range of projects entered for consideration.

Whakakotahi has seen a total of 18 teams participate since 2017, a summary of project focus areas is listed in Table 1.

Table 1: Project focus areas

2017	2018	2019
Three projects: • Diabetes • Gout • Post-stent follow-up	Six projects: • Diabetes (2) • Child asthma • Access to health services for Māori • Skin infections for the Tuvaluan population • New patient enrolment in a Very Low-Cost Access practice	Nine projects: • Diabetes (3) • Child eczema (2) • Access to rural medicines • Gout • Physical health for opioid substitution patients • Use of inhalers for asthmatics in prison

Figure 1 on the following page depicts the logic model for Whakakotahi. This was developed at the very beginning of the programme in 2016. It reflects the early thinking around Whakakotahi as a programme and its intended outcomes.

Figure 1: Whakakotahi logic model

Programme goal: To increase quality improvement capability in primary care by more than 20% (as measured by the average score of the tools, methods and techniques self-assessment) which will contribute towards the long term aims of improving health outcomes, equity, consumer engagement and integration.

Context and need	Resources and activities	Outputs	Short term outcomes	Long term outcomes
• It is accepted that successful primary care is key to the future health of the population, reducing inequities and escalating costs. • Most NZers (95%) are enrolled with a primary health provider. • The Commission is responsible for health care improvement across the whole sector and intends to increase its focus on primary care and community services, aged residential care and disability services.	• EOI process and selection of local primary care initiatives using prioritisation criteria developed by the PCEAG. Applicants can submit their own initiatives that are important to them and their enrolled populations but must be aligned to one or more of the priority areas: equity, consumer engagement, integration. • Reimbursement for participating projects of staff time of up to $6000 excluding GST plus any travel and accommodation costs. • A project manager and quality improvement advisor will work with the individual initiative teams to support as needed. This will include site visits, regular meetings, quality improvement advice and facilitation. • Three learning sessions for participating initiative teams for each tranche to facilitate quality improvement capability building, sharing of information and learning, and the formation of natural networks.	• Staff in participating projects have attended Whakakotahi QI learning sessions. • Participating practices have implemented their own QI initiative and tested changes. • Identification of any initiatives with validity and transferability suitable for wider spread. • Primary care QI process case studies. • Communications, tools and resources on how to implement QI initiatives across the primary care sector.	Outcomes for participating projects: • Stronger connections with the Commission. • Stronger relationships and possible partnerships between primary care and the Commission. • Increase in QI expertise and capability. • Improved patient outcomes and experience related to specific improvement initiatives. • Initial benefits towards intended QI goals in the areas of health outcomes, equity, consumer engagement, and integration. Outcomes for the Commission: • Collaborative partnerships with participating primary care teams. • Increased understanding of primary health care sector and QI in this context.	• Stronger connections and engagement between the Commission and the primary care sector. • Stronger engagement and connections across primary care. • Increased primary care sector QI leadership capability and knowledge. • Improved quality of primary health care. • Improved health outcomes, equity, consumer engagement and integration in primary care. • Improved performance against key metrics including contributory and system level measures.

This report is the final and consolidated report in a series of reports that have detailed the progress of Whakakotahi across its three years of implementation. It is designed to summarise key insights through the formative evaluation and provide some insights into key considerations for the future.

Previous evaluation reports are available on the Commission's website,[1] and include:

- Whakakotahi evaluation: Progress report on phase 1 initiatives (November 2017)
- Whakakotahi evaluation: Preliminary findings report (October 2018)
- Whakakotahi evaluation: Progress report on Tranche 2 initiatives (December 2018)
- Whakakotahi evaluation: Progress report on Tranche 3 initiatives (January 2020).

2.2 Report structure

Following this introduction, this report will describe the evaluation approach. This will describe how this evaluation was conducted, highlighting the evaluation questions and the data sources used in this report.

Following this, the report will include a brief summary of the story of Whakakotahi, which will explore the three years, or tranches, of the programme and note any key changes, improvements and partnerships that formed over the course. From there, this report is structured according to the key areas of the evaluation. These include engagement with primary care; outcomes for quality improvement; health outcomes, integration and consumer engagement; and equity.

The report will also detail the strategic contribution of Whakakotahi and conclude with key considerations in planning the Commission's future direction to support primary care in New Zealand.

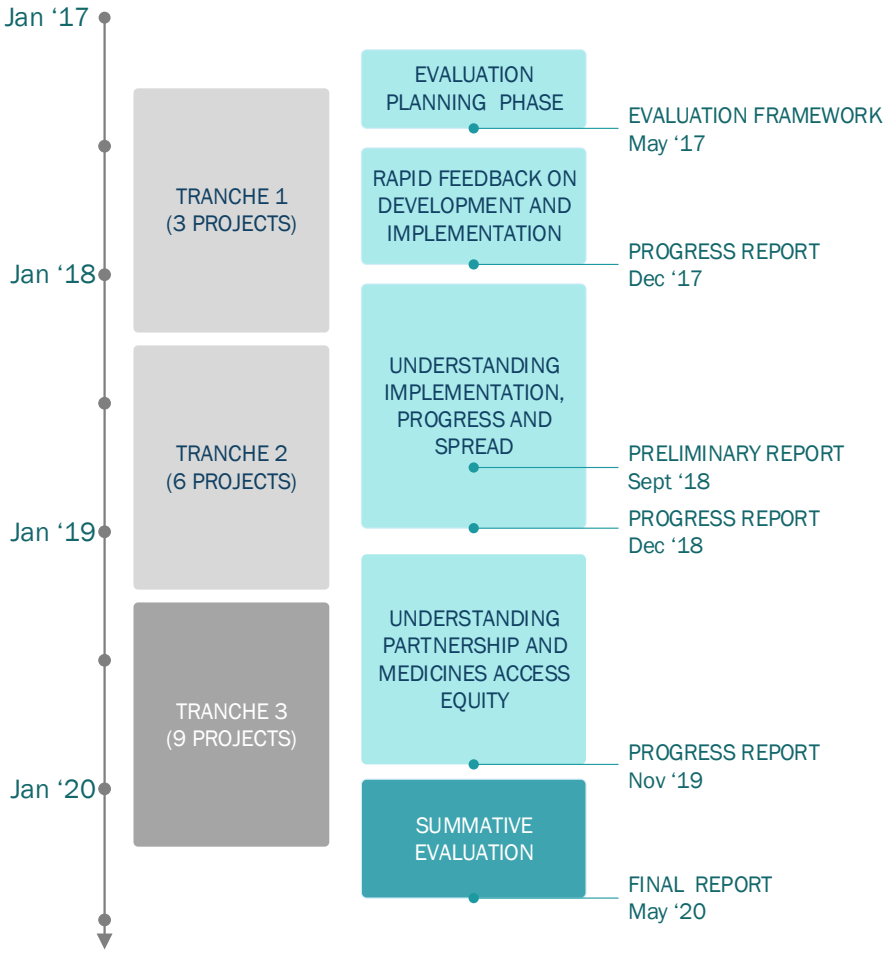
[1] https://www.hqsc.govt.nz/our-programmes/primary-care/publications-and-resources/publication/3892/

3. EVALUATION APPROACH

The evaluation of Whakakotahi was a formative evaluation that walked alongside the Whakakotahi programme when it began in 2017. The formative evaluation was designed so that early insights and key learnings could be fed back to the Commission to inform changes and improvements in the programme as it progressed.

This report marks the final stage of the evaluation with a summative lens to reflect on the learnings and achievements of the Commission's Whakakotahi programme. Figure 2 displays the full phases of the evaluation with a timeline, indicating the present position in the darker shades.

Figure 2: Current phase of the evaluation



An overview of the evaluation including objectives and methods is presented on the following page in Figure 3.

Figure 3: Evaluation overview

Evaluation aim:
To conduct a formative and summative, process and outcome evaluation of Whakakotahi – Primary Care Quality Improvement Challenge

Process objectives:

- Evaluate the implementation of the Whakakotahi initiative
- Evaluate the implementation of participating primary care quality improvement projects
- Identify key barriers, enablers and success factors for the implementation of Whakakotahi
- Identify key barriers, enablers and success factors for the implementation of participating primary care quality improvement projects
- Identify areas for modifications or improvements to Whakakotahi and the implementation of other quality improvement programmes
- Share learnings for doing quality improvement projects in primary care

Outcome objectives:

- Evaluate the effectiveness of Whakakotahi in achieving its intended objectives
- Evaluate the effectiveness of the participating primary care quality improvement projects in achieving their intended objectives
- Identify any unintended outcomes of Whakakotahi
- Identify if Whakakotahi is providing value for money
- Identify considerations for the sustainability and scalability of Whakakotahi

Process criteria:

- Whakakotahi and participating site context
- Effective collaboration between the primary care sector and the Commission
- Implementation of Whakakotahi programme and activities
- Shared learnings and resources with the wider primary care sector

Outcome criteria:

- Contribution to effective and increased engagement of the primary care sector (across the sector and with the Commission)
- Increased quality improvement capability among Whakakotahi participants
- Increased use and spread of quality improvement methodologies in primary care
- Improvements in health outcomes and potential contribution to longer term outcomes of equity, integration and consumer engagement in participating projects

Phase	Design and context	Rapid feedback on development and implementation	Understanding implementation, progress and spread	Summative evaluation
Methods	Evaluation planning workshop Document review Evaluation framework	Document review Learning session and QI data monitoring (Commission) Key stakeholder interviews Site visits	Learning session and QI data monitoring (Commission) Key stakeholder interviews Site visits Online survey	Learning session and QI data monitoring (Commission) Key stakeholder interviews Site visits Online survey Mixed methods data integration

3.1 Evaluation questions

The key evaluation questions were developed in collaboration with the Commission at the start of the evaluation. The questions are centred around the five key areas. The table below identifies these questions.

Table 2: Key areas and evaluation questions

Key area	Evaluation question
1. Contribution to effective and increased engagement of the primary care sector.	• How has the primary care sector been engaged in Whakakotahi? • How effective has this approach been? • How has the engagement approach and activities supported equitable awareness and engagement across the primary care sector? • How widely across the primary care sector are people aware of Whakakotahi? • How could this approach be improved?
2. Contribution to effective collaboration between the primary care sector and the Commission.	• How has the Commission's ability to work with primary care improved? • How have the Commission and the primary care sector worked together? • Who has been involved from the sector and from the Commission? • How effective has this collaboration been? • How could this approach be improved?
3. Increased quality improvement capability among Whakakotahi participants.	• To what extent has the project supported an increase in QI capability among participants? • How equitably have the QI capability changes been distributed across the primary care sector? • What activities have supported this increase in capability? • Which of these activities, if any, appear to be the most successful? • What are the existing barriers to developing QI capability? • What else would support improvements in QI capability? • How does the Whakakotahi programme align to and/or complement the Quality Improvement Facilitator (QIF) course?
4. Improvements in health outcomes and potential contribution to longer term outcomes of equity, integration and consumer engagement in participating practices.	• What changes in health outcomes, causing improvement or unintended consequences, have been supported by Whakakotahi? • How has Whakakotahi supported an improved team culture, for example, ability to talk about QI issues? • How have the participating projects spread QI capability or QI project benefits outside of the project team? • What is the practice's contribution (potential and actual overtime) to equity, integration and consumer engagement?

5. Understanding Whakakotahi through the Commission's evaluation framework.	• In what ways has Whakakotahi contributed to the Commission's overarching evaluation framework components of value-for-money, benefits realised and the strategic fit for the Commission?

It is important to note that previous evaluation progress reports have primarily been focused on the first three evaluation areas.

3.2 Data sources used in this report

This report pulls together a number of information sources to inform the findings identified. These include:

- Previous evaluation reports to the Commission, including three progress reports and one preliminary findings report.
- Commission collected learning session survey data.
- Project team survey data.
- Evaluation interviews with past project teams.
- Commission collected consumer engagement data and associated documents.
- Commission collected outcome data from project teams.
- Interviews with key stakeholders from the Commission, PHARMAC, and other primary care stakeholders.

4. THE STORY OF WHAKAKOTAHI

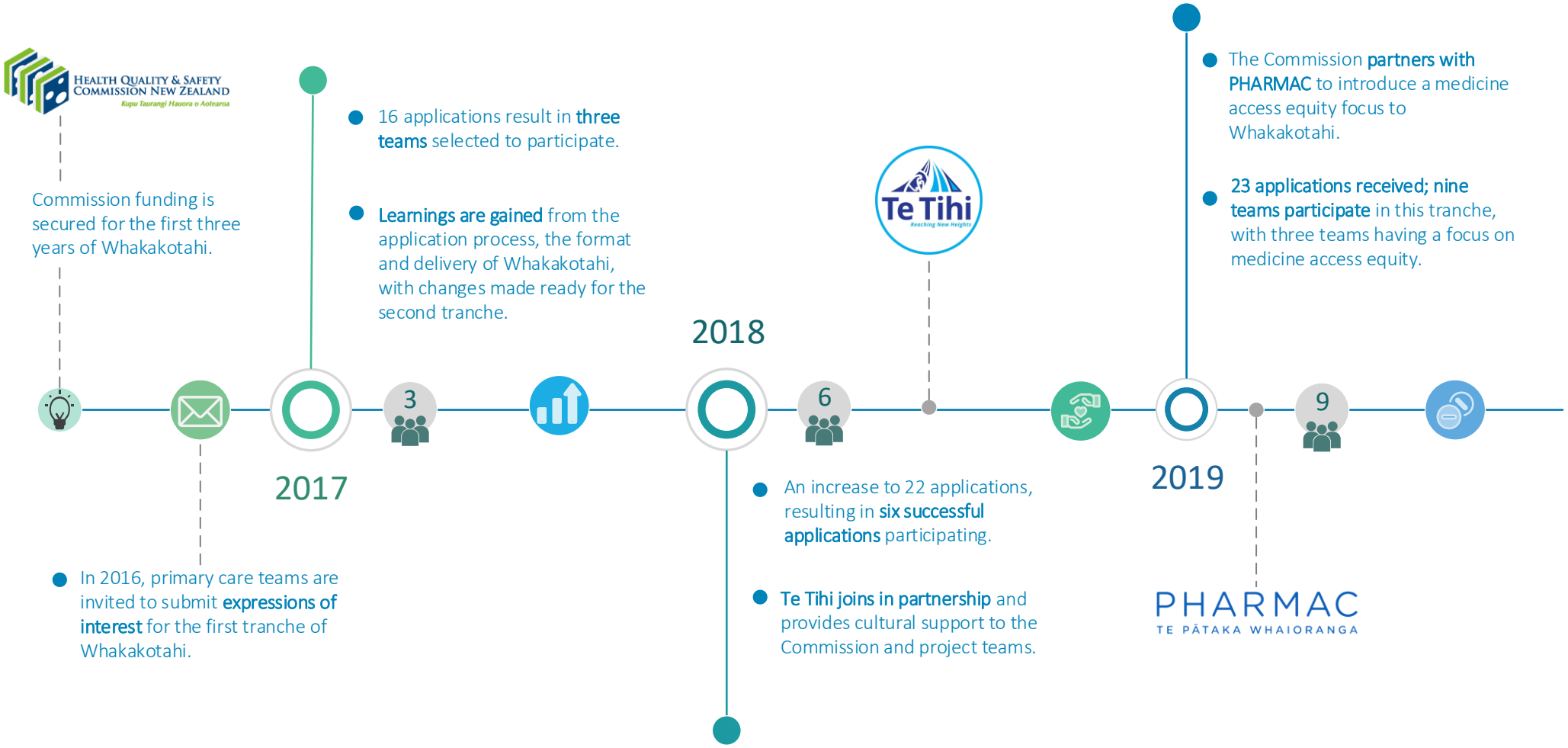
The story of Whakakotahi summarises the journey of the programme across its three tranches. The learnings, changes and key outcomes for each of the three tranches are summarised in this section. Previous progress and summary reports for the evaluation of Whakakotahi have been drawn upon in this section.

From the outset, primary care was an area where there had been little exploration and involvement from the Commission. Primary care is a complex environment and few relationships had been established in this sector. The Commission went through a process of engagement and consultation with key sector stakeholders; the goal was to understand how the Commission could work in primary care in a way that was meaningful and responsive to the sector. The Commission also had a drive to become known in this environment, build relationships and establish a credible presence and reputation within primary care.

> *"The intent was for a small amount of resource to support a huge and disparate sector; but to seed some areas that could become models for better outcomes for patients."*
>
> Commission stakeholder

The Whakakotahi journey has been exploratory, with many learnings and adaptations made along the way. The timeline on the following page shows the progress in the Whakakotahi programme over time, including the number of teams, and the development of key partnerships.

Figure 4: Timeline of Whakakotahi



4.1 Tranche 1

The first tranche of Whakakotahi attracted 16 applications from primary care teams. Three of these were selected to participate in the programme. The application process generated some considerable learnings; respondents respected the process and how it encouraged deeper thinking about their project, and what aspects of quality improvement methodology would support their success. The process also brought some challenges, as it required a large time investment to complete to a high standard.

This tranche of Whakakotahi generated a number of key insights and learnings for Whakakotahi:

- **Refinement of application process and improvement of the experience of engagement for primary care.** This involved improving the EOI template, providing earlier mentoring and support for teams developing their proposals, and reviewing the original requirement for PHO involvement.
- **Changing engagement methods with teams.** Tranche 1 teams identified that there were many different engagement methods used that resulted in repetition and sometimes confusion. It was recommended that this be streamlined to allow for greater flexibility in the processes used to engage with the Commission.
- **Clarity around expectations of involvement.** Tranche 1 teams reported that prior to Whakakotahi they did not understand the level of work and time required to participate and run a successful quality improvement project. It was recommended that the Commission clarify expectations and time commitments required.
- **The need to understand the context.** Tranche 1 was a great opportunity for Whakakotahi to learn the importance of understanding the context that the teams were working in, and the need to understand this early in the process.

Overall, it was reported that **tranche 1 of Whakakotahi was well implemented in the early stages and was making good progress against its intended goals**. Whakakotahi was seen as supporting the Commission's engagement with the primary care sector and there was evidence of the programme improving quality improvement capability for those involved.

4.2 Tranche 2

The second year of Whakakotahi attracted 22 applications from the primary care sector, with six teams selected to participate. It was partway through this Tranche that the Commission engaged Te Tihi as a partner to support cultural engagement with teams.

Considerations and learnings at this point of Whakakotahi were less related to the delivery of the programme: the focus was on how the Commission could continue to leverage the value of Whakakotahi.

- **Improved experience of engagement for teams.** The Commission modified the frequency and methods of reporting for tranche 2, which resulted in easier reporting and communication with the Commission.
- **Allowing flexible journeys to success.** Recognising and valuing the capabilities of teams that may have been outside the traditional notions of quality improvement methodologies was something that the Commission acknowledged in tranche 2 as key to partnering in primary care.

- **Leveraging off QI capability already developed through Whakakotahi.** Recommendations were made for the Commission to explore how to support further growth of capability in primary care; supporting the development of networks, connections and development of QI skills.
- **Greater focus on equity and what role Whakakotahi plays within the system.** There was recognition of the respectful way the Commission engaged with teams in Whakakotahi, and it was identified that the capacity of providers in high needs areas should be considered and supported to contribute to addressing equity at a system level.

It was reported that overall, tranche 2 of Whakakotahi was well received by the project teams involved. There was evidence that the learnings from the first year improved ongoing implementation of the programme. Whakakotahi continued to achieve against its intended goals with an increase in the number of teams participating.

4.3 Tranche 3

Tranche 3 of Whakakotahi involved a new partnership with PHARMAC. This partnership was established through a series of mutual connections and shared networks. The previous PHARMAC manager for Access Equity previously held a role at the Commission and was aware of Whakakotahi when it first began. This is in addition to the current manager for Access Equity having participated in the first tranche of Whakakotahi as a project team member, at the time being employed by a local provider.

This PHARMAC partnership supported three additional projects in the third tranche of Whakakotahi, which focused on medicine access equity. The partnership involved a memorandum of understanding between the two organisations which included a financial contribution towards the programme delivery and supported extra PHARMAC resource to support the application / selection process and provide guidance to the medicine access equity teams throughout the programme.

This resulted in a total of nine teams participating in the final year of Whakakotahi in its current format. At the time of Tranche 3, Whakakotahi was fairly well established as a programme and there were few formative changes to make. Key considerations from Tranche 3 centred around the learnings from inter agency collaboration and partnership, and the focus on medicine access equity.

- **Mutual benefit when agencies partner.** The partnership was beneficial for both the Commission and PHARMAC, with increased knowledge and awareness about what both agencies do. Collaboration of this nature also allowed for shared resources and support.
- **Matured view on equity.** In its third year, Whakakotahi had matured the way it viewed and measured equity and shifted to actively identifying what contribution the projects and programme as a whole could make towards equity.
- **Building sustainable capacity for QI in primary care.** A significant reflection on the third year of Whakakotahi was centred around the sustainability of capacity and capability that had been created. Considerations were put forward about the role of Whakakotahi and the Commission in facilitating QI networks in primary care, and how to integrate QI capability building into existing, well-established priorities for primary care such as Cornerstone (the Royal New Zealand College of General Practitioners (RCNZGP) accreditation programme).

A previous evaluation progress report identified that at the close of tranche 3, Whakakotahi continued to work towards the original intended goals while acknowledging that these goals may have changed and been refined over the years.

5. CONTRIBUTION TO EFFECTIVE ENGAGEMENT AND PARTNERSHIPS IN PRIMARY CARE

This section looks at the first two key evaluation areas: **contribution to effective and increased engagement with the primary care sector,** and **contribution to effective collaboration between the primary care sector and the Commission.**

One of the key aims of Whakakotahi has been to increase the engagement between the Commission and the primary care sector. Through Whakakotahi, the Commission attempted to improve its reach, connections, networks and understanding of the primary care sector; a space it had not previously done much work in. Whakakotahi was exploratory and attempted to connect the Commission with primary care in a reciprocal way. The Commission was to support primary care in building capability and capacity for quality improvement, sharing skills, methods and techniques, while also learning the challenges, barriers, and context of primary care at the community level.

5.1 Increased engagement with primary care

Throughout the three years of Whakakotahi, it is clear that there has been increased engagement with primary care. Over the course of the programme, there have been an increasing number of responses to the EOI process for becoming involved in Whakakotahi, along with increased integration outside of the traditional general practice team. This suggests that word of Whakakotahi and the Commission's interest and work in primary care more broadly has spread over this time. Further, each round of Whakakotahi has increased in the number of primary care teams involved, contributing to the spread of increased engagement (Figure 5). This indicates an increasing interest in Whakakotahi as it became more well-known and recognised at the community level.

Figure 5: Number of applications and participating teams

Tranche 1: Three teams were selected out of 16 applications

Tranche 2: Six teams were selected out of 22 applications

Tranche 3: Nine teams were selected out of 23 applications

For the Commission, this has meant engagement in Whakakotahi with a total of 18 primary care teams throughout the three years, building relationships and networks with 18 different primary care groups across the country. Whakakotahi has provided a platform for the Commission to engage at the community level with primary care and consumers and has led to some long-lasting relationships. These relationships have created all-round benefits for teams participating.

"Getting a foot in the door in primary care in a practical way has been a key benefit of Whakakotahi for us. It has been a way of engaging the sector but also consumers and wider communities. Having a structure there and inviting people in to participate has also given them something to do in terms of a project to sink their teeth into and a framework to work by."

Commission stakeholder

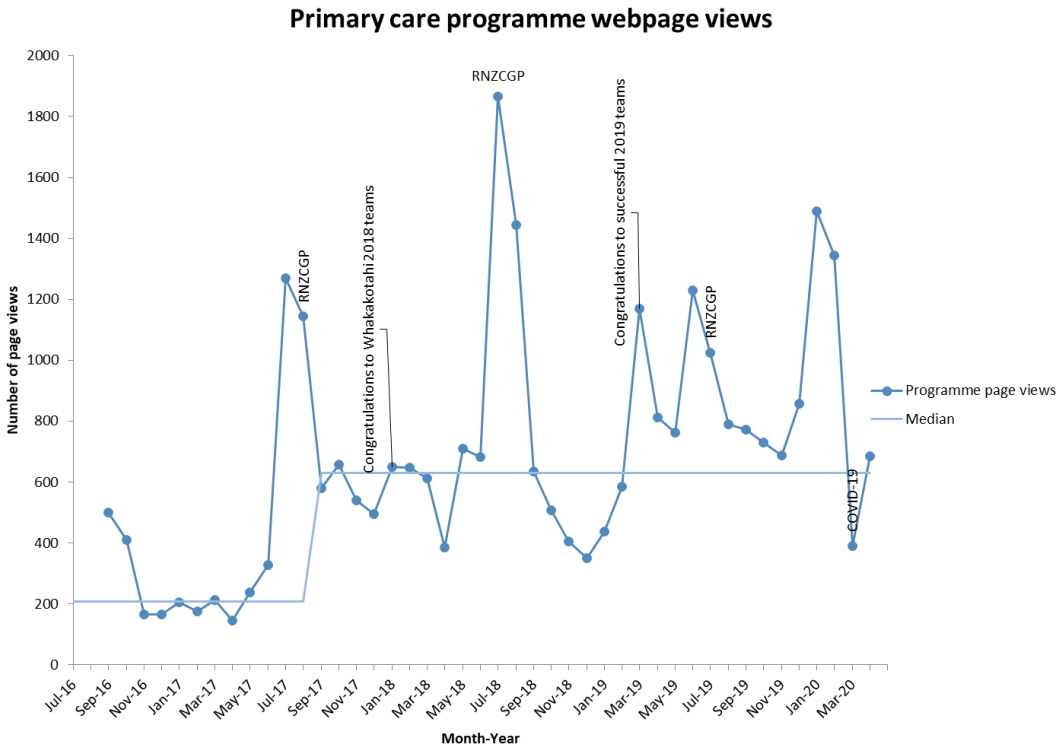
Webpage views for the Commission's primary care programme increased significantly over the course of Whakakotahi. Prior to the programme beginning, in 2016, webpage views averaged at just over 200 views per month, with the average rising more than threefold to 630 views per month for the first quarter of 2020.

There are considerable peaks and troughs in the webpage views, with peaks coinciding with annual conferences (RNZCGP) and Whakakotahi updates after each tranche. There is a notable drop off in early 2020, which coincides with the COVID-19 pandemic.

Figure 6 below details the views.

This is a successful outcome for the Commission, as more people become interested in searching for their work in primary care, learning more about it and becoming aware of what sort of programmes they offer in this space.

Figure 6:Commission Primary care webpage views from 2016 to 2020



5.2 Broadening engagement with primary care

Through the Commission's partnerships with both Te Tihi and PHARMAC, their engagement with different facets of primary care were broadened. The programme encouraged a diverse range of primary care organisations to apply, demonstrating its commitment to driving integration across different primary care teams and this was reflected in increased number of applications received.

The Commission's partnership with PHARMAC demonstrated that the introduction and collaboration with an agency, with a different focus, can encourage and facilitate engagement from different types of respondents. The partnership with PHARMAC became solidified in the third year (2019 calendar year) of Whakakotahi, which resulted in a selection of projects that had a focus on medicine access equity. This additional focus brought with it a wider range of applicants, with more pharmacies and pharmacy collaboratives expressing interest in the programme.

> *"The fact that these two agencies partnered meant that the people who then applied for projects were different to other years, they had a lot more pharmacy collaborative type applications."*
>
> PHARMAC stakeholder

It is important to note that prior to this partnership, Whakakotahi was receiving a number of applications from the pharmacy sector of primary care, and it was noted that the pharmacy environment is well set up for quality improvement activities. However, the introduction of the medicine access equity criteria with PHARMAC supported Whakakotahi in broadening its reach into primary care more purposefully beyond general practice.

The partnership with Te Tihi also supported the Commission to broaden its reach and build relationships with Māori health provider networks and organisations. Te Tihi partnered with the Commission in July 2018 and were involved with the third learning session for the tranche 2 teams. Te Tihi were involved to a greater degree with the application process for the tranche 3 teams and support throughout the 2019 calendar year.

The input of having a Māori provider support the Māori and Pacific applicants was invaluable for Whakakotahi and supported the Commission to be culturally responsive and safe while engaging with Māori health providers. This was also reflected by Māori and Pacific provider participants, who valued the cultural input of Te Tihi on the Commission team.

> *"Having someone who could understand our methods and act as a support to help explain our processes and what we needed to change was really helpful, but the whole team from the Commission were always approachable and let us lead and have ownership."*
>
> Participant

5.2.1 Equity of engagement

During the early phases of Whakakotahi, it was identified that the engagement approach may have been posing some barriers to equitable engagement across the sector. Feedback from teams in tranche 1 of Whakakotahi indicated that a high level of resource was required to respond to the Whakakotahi EOI, which may have posed a challenge for some practices; particularly smaller high needs practices and kaupapa Māori providers.

The Commission has continued to be responsive to engagement and equity concerns and implemented wider and more targeted sharing with kaupapa Māori provider networks and organisations in the later EOI processes. In addition to this, the Commission also entered into a partnership with Te Tihi for support and cultural advice.

> *"Good to support providers to have the confidence in the design of their projects and pull through their cultural concepts and belief systems. The Commission seems to be shifting to really acknowledging the value of these."*
>
> Partner

Throughout the Tranches of Whakakotahi there has been commentary around the equitable reach of the programme. Project teams have questioned the ability of Whakakotahi as a single programme to have equitable engagement as providers and organisations working in the areas of New Zealand with the greatest need for quality improvement may struggle with capacity to engage and participate. While the EOI process was modified and simplified throughout the duration of Whakakotahi, there are still notable barriers to engagement. The writing process of the EOI requires different skill sets and considerable time to formulate and develop projects that would be suitable for quality improvement and participation in Whakakotahi.

> *"I understand the panel's reasoning for selecting on equity, however equity is typically attached to those places that have a lack of capacity. They have the strength, drive and want, but actually the ability to work at the level Whakakotahi expects, and work in a high needs clinic with low income, does stretch resources way too far."*
>
> Participant

It was noted that there was a need for structural, policy and funding changes to support improved capacity and resource for those with higher needs to be able to engage in programmes such as Whakakotahi.

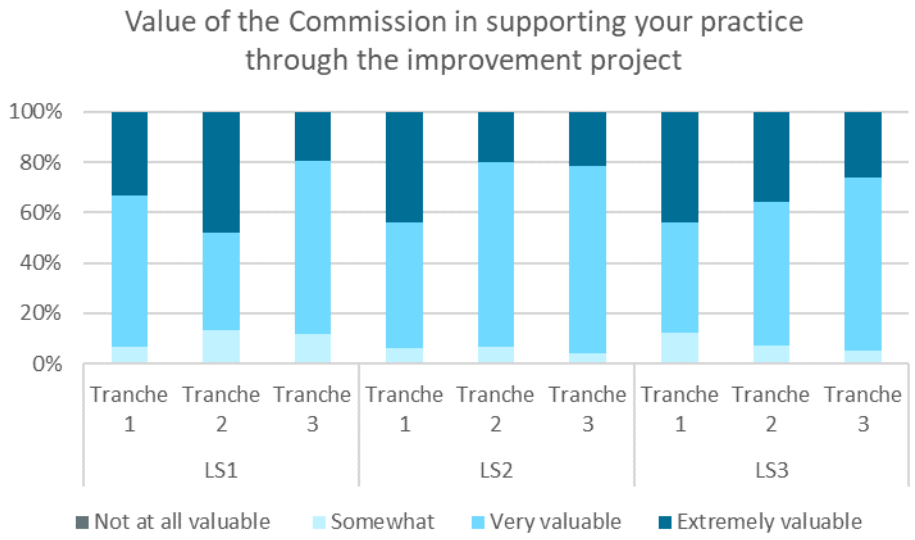
5.3 Maintaining relationships with primary care

Prior to Whakakotahi, the vast majority of teams were not well connected with the Commission and had little insight into the work of the Commission, or the breadth of its primary care programmes. Through Whakakotahi, the nature of the programme and the one-on-one support provided, some strong personal and organisational relationships have been established.

> *"Before Whakakotahi we didn't have anything to do with the Commission and didn't really know what they did or what they could do for us."*
>
> Project team member

It was previously reported that the support from the Commission during Whakakotahi was incredibly valued by participants. Figure 7 below highlights the responses from Whakakotahi participants across all Tranches and their perceived value of the Commission's support during their project at each learning session.

Figure 7: Learning session survey data



The responses were considerably positive, throughout all stages of the project. During evaluation interviews with participants, many noted their desire for their relationships with the Commission to continue post Whakakotahi.

> *"We have enjoyed having the support of the Commission throughout Whakakotahi, and they have been there to help us with things that aren't always within the scope of our project… I would hope that we can continue to have a relationship with them."*
>
> Project team member

Data collection for this report involved revisiting three teams from previous tranches (one from the 2017 tranche and two from the 2018 tranche) to understand what the sustained impacts of participating in Whakakotahi have been. Continued relationships with the Commission were commonly recognised as a positive sustained benefit of participation. The Commission's quality improvement advisor has continued to be in regular contact with some teams and offered support for quality improvement initiatives, as well as conference presentations and workshops. This has been extremely valued by past teams, and results in positive reflections of the Whakakotahi experience and relationship with the Commission.

> *"[The Commission's quality improvement advisor] has always been available to us for support and I know that even now, years after being involved with Whakakotahi, we can give her a call or email for advice. It's been invaluable and so helpful with the work we're trying to do."*
>
> Project team member

5.4 Benefit for the Commission

The three years of Whakakotahi have yielded considerable learnings and benefits for the Commission from increasing their engagement with primary care. It has enabled the Commission to work in partnership with primary care and support quality improvement initiatives at a grassroots community level. This has also resulted in the Commission building some strong relationships with primary care organisations around New Zealand.

Whakakotahi, through this first phase, has been a steep learning curve for the Commission. There have been many challenges in the delivery of Whakakotahi that have been refined and improved over the years, resulting in a well-designed programme to support and engage with primary care in quality improvement at a relatively small scale.

Key benefits for the Commission include the following:

- **Understanding primary care at the community level**. Building relationships with primary care providers and understanding their varied contexts, challenges and needs has been a highlight for the Commission.
- **Raising the profile of the Commission in the primary care sector.** The Commission has been able to increase the knowledge and awareness of their work in primary care through the project teams who have participated.
- **Builing sustainable relationships with primary care providers.** The Commission has maintained connections with some teams past their involvement in Whakakotahi. This has been mutually beneficial and is a credit to the time spent investing in getting to know and understand the local context of different providers.
- **Building collaborative partnerships.** Another key benefit to come out of the engagement with the primary care sector is the partnership the Commission has built with Te Tihi, PHARMAC and other providers. Another mutually beneficial relationship, the Commission has learnt from working alongside the Te Tihi advisors and this supported the cultural safety and responsiveness of Whakakotahi as a programme.

  "They [Te Tihi] really worked alongside us as a part of the team. It built our own capability and understanding and helped us to broker relationships with Māori and Pacific service providers which has been critical to supporting Whakakotahi contribute to achieving equity."

  Commission stakeholder

6. CONTRIBUTION TO QUALITY IMPROVEMENT AND HEALTH OUTCOMES

This section looks at two of the key evaluation areas**: increased quality improvement capability among Whakakotahi participants** and **improvements in health outcomes, integration and consumer engagement in participating teams.**

At its core, Whakakotahi has aimed to bring quality improvement capabilities into primary care. Quality improvement and its associated methodologies have not traditionally formed a significant part of how primary care operates; the intention behind Whakakotahi was to build that capability so that those working in primary care can undertake robust quality improvement initiatives to improve the quality of health services they deliver and improve the experiences of consumers. It is important to understand the local context of primary care; primary care providers are time poor and do not often have resources allocated to quality improvement. Whakakotahi intended to support this through the provision of on-site coaching, experiential learning, and a scholarship for one team member to attend the Ko Awatea QIF course.

There is limited quantitative data to support some of the outcome components of this evaluation, particularly around health outcomes, sustainability and scalability and integration. The evidence is drawn from key stakeholder interviews and past participants of the programme. It is also acknowledged that many of the true outcomes of Whakakotahi are yet to be realised, and it will involve a process for the Commission to continue to learn and develop from the teams that have participated in the programme and look to how this is further translated into supporting primary care at the national, regional and local levels.

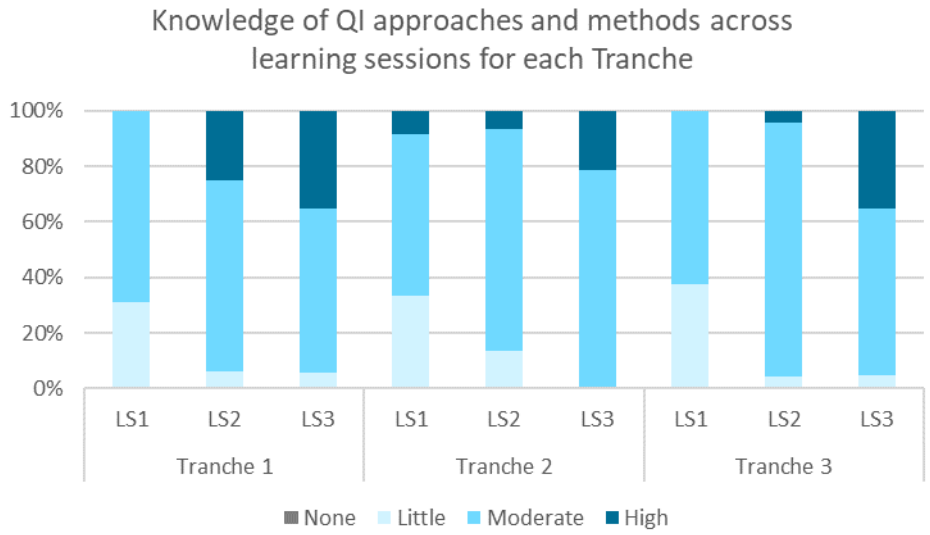
> *"I feel as though the major benefits are yet to be realised… the main purpose was actually to kind of learn from these projects and lift out the findings that we could use to influence systems around us to be changing things, and we are yet to do that."*
>
> Commission stakeholder

6.1 Whakakotahi has increased quality improvement capability

Throughout all three tranches of Whakakotahi, participants have reported an increase in their level of quality improvement capability. Often participants had not previously been exposed to quality improvement methodology and the tools associated with it, and so Whakakotahi provided a unique opportunity to develop these skills in a practical way carrying out a project that was meaningful to their context and community. It was commonly acknowledged by participants that quality improvement tools and methodologies would support better outcomes for their populations, however the context of primary care and in particular, general practice, meant that the time, resources, knowledge, and skills to competently and efficiently utilise quality improvement methods were lacking. Participating in Whakakotahi provided a controlled environment and opportunity to build these skills and capabilities.

Figure 8 displays the self-reported knowledge of quality improvement approaches and methods for all three tranches across their three respective learning sessions. It demonstrates a considerable increase in perceived knowledge as participants move through the Whakakotahi programme.

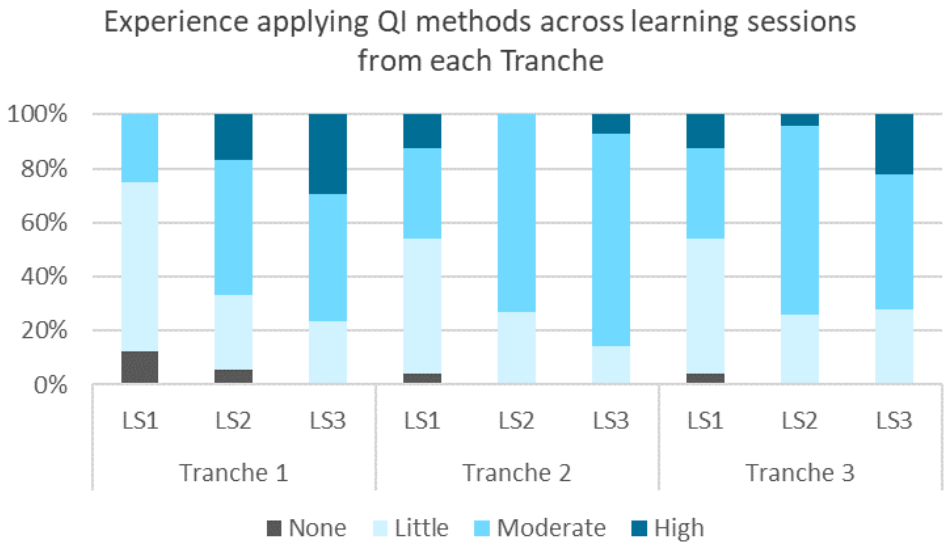
Figure 8: Learning session survey data



Across the duration of Whakakotahi, participants increased their experience with applying quality improvement methods; evaluation site visits over the years supported the idea that capability was increasing, although acknowledged that there may be differences in knowledge gained across team members. It was acknowledged that team leaders were more likely to significantly improve their capability, with supporting members typically gaining more experience and confidence in the use of tools rather than understanding the full quality improvement process. Figure shows learning session survey results across all three tranches and demonstrates that overall, Whakakotahi supported an improvement in capability building.

Teams from past tranches of Whakakotahi indicated that the gains in quality improvement capability do not simply drop off once their Whakakotahi journey comes to an end. While the intensive focus that comes with managing a quality improvement project may have subsided, the tools, terminology and mindset that comes with gaining confidence and experience in applying quality improvement methodologies continues to be evident in their work.

Figure 9: Learning session survey data



> *"There is such great long-term value from Whakakotahi, the real value is the attitude changes around quality and quality improvement. I've noticed it even now, with our COVID-19 response, the phrasing, language and processes that we're going through are inherently quality improvement. And it wouldn't be like this if we hadn't done Whakakotahi."*
>
> Project team member

6.1.1 Sustainability and scalability of capability

One of the key considerations around the model of delivery that Whakakotahi has used is the sustainability and scalability of outcomes. Based on reports throughout the duration of Whakakotahi, at different progress points, the approach that the Commission has taken has worked well in supporting intended outcomes. Consideration should be given to what happens after the Commission and partnering agencies draw back; there remains a trickle of activity and sustained changes in processes and learnings, however there is little evidence to demonstrate that this is as robust or systematic as it was while they are a part of the programme.

> *"To be honest, not much [has been sustained from our Whakakotahi project]. There have been some great tools, ideas and processes that we have kept in our minds and I think that is good, but all the intensive data collection, patient engagement and recruitment stopped. We just couldn't keep it going."*
>
> Project team member

The support from the Commission went away and the dedicated time and focus from the teams faded also, despite the best of intentions. Each of the projects created time for this to happen for a short period of time, so once the presence and encouragement from the Commission is no longer there, it is challenging to maintain motivation against the competing priorities of general practice and primary care.

"There was nothing in our work programme that said this would be the usual way of doing things. So, we weren't able to embed it because the structures just aren't there in primary care to allow it – you take time away from consults and you take away their income."

Commission stakeholder

The Commission is aware of the challenges in supporting sustained learnings and the ability of primary care teams to share those learnings beyond their context. Key stakeholder interviews discussed the next steps for Whakakotahi and an increasing focus on supporting and building sustainable and scalable processes and outcomes were key themes noted.

"If the intention was for these teams to spread that capability, then how can we facilitate that? What sort of levers does the Commission and PHARMAC hold to support that kind of transition?"

PHARMAC stakeholder

Considerations for factors that support the sustainability of outcomes include factors beyond the scope of what Whakakotahi and even the Commission can influence alone. A change in primary care culture, funding and resource to support quality improvement infrastructure and activity would systematise the sustainability of programmes such as this.

It was also noted by a couple of stakeholders that the structure and set-up of pharmacy may be tailored more towards allowing space and capacity for quality improvement. There was recognition that the landscape of primary care and pharmacy in particular is moving towards a more multi-disciplinary model, as pharmacists work more closely with general practice. Whakakotahi could consider pharmacy as a mechanism or 'home' for quality improvement in primary care, to be filtered into general practice. Future engagement could test out these ideas.

6.2 Whakakotahi's contribution to improving health outcomes

Identifying and quantifying the contribution to health outcomes is a challenging process. Project teams track patient outcomes as a part of their quality improvement projects. Quality improvement data was used to track improvements in health outcomes in this way, and the data has highlighted that some small changes and improvements have been made.

Consideration should be taken to note that the duration of the projects and team participation in Whakakotahi is relatively short. It is known that the time it takes to accurately capture improvements in health outcomes can sometimes be significant. It is not necessarily feasible to expect significant changes within the timeframe for these projects. Some of the earlier projects have identified positive changes, although these have to be balanced by a lack of being able to sustainably lock in those project gains.

"We were noticing some great outcomes and some patients had reduced their HbA1c by more than 30, 40%. But then things fizzled out for a period after Whakakotahi and I would say that some of those figures actually reverted. Which is not great, but it's what happened."

Project team member

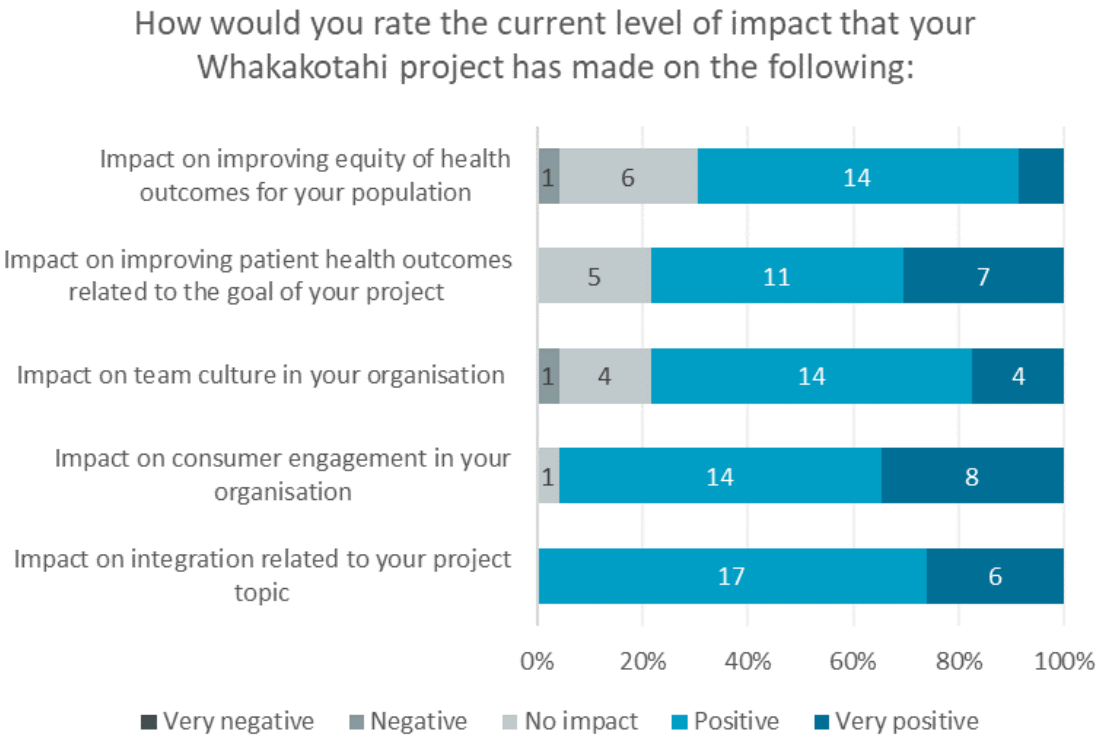
6.2.1 Consumer feedback indicates positive outcomes

There has been some investigation into seeking feedback from patient participants in Whakakotahi projects. Consumers largely indicate positive outcomes from engaging in Whakakotahi projects, and this has resulted often in greater trust, comfort and willingness to engage with the health professionals involved.

Figure 10: Team-collected consumer feedback

Another source of data to understand the impact on health outcomes from Whakakotahi projects comes from the project team survey carried out with all three tranches. In the survey, team members were asked about the impact of their Whakakotahi project across a number of factors. One of these is patient health outcomes related to the goal of their project. Figure displays the survey results from all tranches combined. Eighteen out of 23 respondents identified that they would consider their project to be having a positive or very positive impact on patient outcomes related to their project. This survey was taken towards the end of each tranche of Whakakotahi and so gives a good indication of the perceived impact on health outcomes.

Figure 11: Project team survey results from all tranches on their perceived impact of the project



In order to establish the true impact on patient health outcomes, more sustained follow up with project teams would be needed to explore the data trends over time.

6.3 Whakakotahi and consumer engagement

One of the core underlying principles for Whakakotahi was supporting consumer engagement in primary care. Primary care is not a sector that has traditionally had a large degree of consumer engagement; secondary care generally has a more mature level of awareness and engagement, with wide consumer representation on DHBs and at the governance level of organisations delivering secondary care.

The Commission, through its Partners in Care team, presented on consumer engagement and co-design to Whakakotahi participants at various learning sessions. This was a large focus at the start of each tranche, encouraging teams to partner with their consumers and work together to create better outcomes.

Whakakotahi set out to encourage consumer engagement within the projects that each team carried out, through the experienced based co-design methodology. While there were some great successes and relationships built between consumers and providers, this has not been systematically achieved throughout Whakakotahi. The concept of consumer engagement may not have been well understood by the project teams and was often interpreted as patient-centred care. The intended goal of Whakakotahi was to encourage experience-based co-design, a concept which is taught as part of the formal training supported by the Commission through the Ko Awatea QIF course, and then further supported and strengthened at the first Whakakotahi learning session for each tranche.

> *"There are some really strong examples of consumer engagement across the Whakakotahi teams, there's been great work done…but this has potentially not been as ingrained or successful as we would have hoped."*
>
> Commission stakeholder

There were some concerns raised by teams throughout the duration of Whakakotahi regarding funding for consumers, which resulted in the Commission funding a consumer as a fourth attendee at learning sessions. Despite this, a total of two consumers attended, suggesting there are additional challenges to engaging consumers through this mechanism, in quality improvement projects.

6.3.1 Project team survey indicates positive impact on consumer engagement

Team members across all tranches were asked in the project team surveys to rate the impact of their project on consumer engagement within their organisations. The responses across all tranches were positive, with 22 out of 23 respondents identifying a positive or very positive impact on consumer engagement in their organisation. This data is presented in Figure on the previous page.

6.3.2 Key consumer engagement learnings through Whakakotahi

Despite the range of successes in this aspect of Whakakotahi, the programme and its experience have resulted in some valuable learnings for the Commission. The Commission is now aware that, generally, primary care does not have a strong understanding of experience-based co-design.

Co-design and consumer engagement in the way that Whakakotahi intended may be perceived by project teams as difficult to implement and that may be due to mixed understanding about the concepts themselves. Despite this, there were displays of excellence from several project teams and for those that did not achieve true co-design and consumer engagement, there are several learnings for the Commission.

Key successes include the following:

- **Increased partnerships within their communities.** Past teams spoke of their increased partnerships within their communities. Through actively recruiting for their projects, they engaged with patients or consumers in a way that was different to business as usual. This has supported the development of relationships and partnerships with patients.

  "I think partnerships with the community have been a huge gain for us. Prior to our project we did engage with patients, but not as systematically as we did for Whakakotahi, and that has been one of the things that stuck with us."

  Project team member

- **Consumer engagement going beyond Whakakotahi.** Teams that successfully partnered and engaged with patients through Whakakotahi have also credited this process to a strengthened engagement approach with consumers beyond their participation in Whakakotahi. One team identified that a consumer brought into their project enjoyed being a part of it and made such a valuable contribution that they now sit as a consumer representative at the local DHB.

- **Increased clarity for the Commission for where to next.** Through Whakakotahi, it has been clear that future efforts from the Commission could be aimed at supporting knowledge and capability building directly related to co-design and consumer engagement. Whakakotahi was always partly an exploratory programme for the Commission and it has identified co-design as an area that the primary care sector may need further support.

- **Whakakotahi team has won an award for consumer engagement.** Victory Square pharmacy was a participant in Tranche 3 of Whakakotahi and aimed to improve the physical health of people on opioid substitution therapy. This team was highly engaged with a consumer representative and embraced her as an integral part of the project team. This team recently won the He Tangata/The People – team working with consumer engagement – award at the 2020 Nelson Marlborough District Health Board Health Innovation Awards.

6.4 Integration within Whakakotahi

Integration was intended to be focused on the consumer pathway. There was scope for integration to be hierarchical between primary and secondary care, as well as across the primary care sector, for example between pharmacy and general practice.

It is acknowledged that well-integrated projects are those that have joint leadership and ownership from the start of the project. The Whakakotahi programme supports building capability in integration through the second learning session to encourage teams to seek partners in their community for their improvement work.

There have been some notable successes in integrated projects throughout the duration of Whakakotahi, with some primary care organisations creating relationships with co-located pharmacies or general practices for the first time beyond business as usual engagement. Other teams have created robust relationships with PHOs and DHBs, though this was less common. It is again a concept that has been well achieved in pockets of the programme but is not consistent or systematically successful across all teams participating.

While the project team surveys identified that all teams felt that their project had made a positive impact of some degree on integration related to their project topic,[2] some case examples demonstrated this far more explicitly than others. Figure identifies that, across all tranches, all respondents considered their project to have a positive or very positive impact on integration.

This was highlighted with the focus on medicine access equity added in the third tranche, which resulted in pharmacy and general practice integrating and forming relationships to a greater degree. This is supported by a general sector shift towards more multi-disciplinary teams.

> *"We discussed integration and it's barriers and how to make things easier moving forward. We focussed on targeting the medical centre next door as a PDSA cycle to engage with more participants. They [the medical centre] were receptive to working with us, despite not previously working together and I can see a good relationship developing that could help improve integration for our population going forward."*
>
> Project team member

While integration can sometimes be challenging, many teams who did struggle to engage with other organisations to collaborate on their project began to recognise the importance of integration through this process.

> *"We did go over and work a bit with the pharmacy [co-located], and we've never really engaged with them in this way before… we're all trying to achieve the same thing [supporting patients], so yes we will try to do more with them in the future."*
>
> Project team member

[2] Whakakotahi preliminary findings report, October 2018.

> *"We operate in an increasingly complex system and we're probably not the best at recognising that. Many doctors don't have strong relationships with their pharmacies beyond the minimum and that can't be supporting a coordinated system for our patients and whānau.*
>
> Project team member

This in itself may be a positive outcome, as that recognition may lead to greater future attempts at collaboration and integration.

7. CONTRIBUTION OF WHAKAKOTAHI TO EQUITY

'Improving health equity' is one of the Commission's four strategic priorities. The Commission defines health equity as 'avoidable and unfair differences in health outcomes. Health equity means people receive the care they require – as distinct from health equality (where everyone receives the same)'.[3]

The Commission's focus on health equity led them to explore whether existing quality improvement methodologies enable a focus on equity. The feedback that they gained from key stakeholders suggests that this is possible, but an element of adaptability is important; treating everybody the same will not improve health equity. Differing the service relative to need results in unequal delivery, and this is required to achieve equity.

When reflecting on the contribution of Whakakotahi to equity, it is important to remember that no one programme or initiative can achieve health equity on its own. It can, however, contribute to system change by ensuring that a focus on equity is embedded as a core component of all its work. This section uses the insights from people who have taken part in Whakakotahi, people who have supported its implementation, and stakeholders with strategic oversight of the programme to reflect on the programme's contribution to equity.

7.1 Whakakotahi increased its focus on health equity

Since its initial implementation in 2016, Whakakotahi has increased its emphasis on equity. During the first tranche of implementation, feedback on the quality improvement approach and support from the Commission highlighted the need for greater flexibility. The quality improvement process was critiqued by Māori providers for its focus on Western science, and the wraparound support and processes of engagement from the Commission were critiqued for their inflexibility.

Feedback on tranche 1 highlighted the need to understand context when working across the primary care sector, and the importance of being open to two-way learning. For example, early in the programme, a tranche 1 project team reflected on their expertise on equity and felt that this was not recognised by the Commission.

The Commission responded to this feedback and, in tranche 2 invested more time in developing relationships and establishing mutual understanding and trust. Greater flexibility in reporting was also adopted, and tools to capture the project progress and reporting (through Life QI) enabled a greater role in facilitating engagement between the Commission and project teams rather than continuing with the burden of formal monthly reporting. The Commission sponsors one Life QI licence for each team, which they retain indefinitely. This provision of support was valued by the project teams, including Māori providers. This means of engagement was noted for its role in supporting partnership, and recognising project team's local contexts and needs:

[3] Health Equity. https://www.hqsc.govt.nz/our-programmes/other-topics/new-projects/health-equity/

"Fabulous team support and understanding of situational complexity."

Project team survey response

"Extremely grateful for the support provided and the level of engagement. These have been key to provide [Māori health organisation] the space to participate in."

Project team survey response

The increased focus on health equity also enabled the Commission to be more targeted in its engagement with Māori providers. This was important for ensuring that Māori providers were leading solutions and ideas for Māori patients in their care. A more flexible approach to engagement from the Commission, and the quality improvement process also better enabled Māori providers to participate.

7.1.1 The importance of cultural advice and leadership

After tranche 2, the Commission engaged Te Tihi to provide cultural advice and support for the team. This helped to build the cultural capacity of Whakakotahi, accelerate the focus on equity, and ultimately improve health equity for Māori. The partnership with Te Tihi was also noted for its importance in supporting Māori providers. The cultural advice and expertise at a leadership level within the programme was also important. This ensured that equity was considered when developing and discussing ideas, enabling the Commission to consider how best it identified and provided opportunities to support equity in primary care.

This leadership was reflected in the EOIs for tranche 3 having a stronger focus on equity, and more specifically improving health outcomes for Māori. This tranche also included a focus on equitable access to medicines through the collaboration with PHARMAC.

7.2 Collaboration with PHARMAC placed emphasis on medicines access equity

PHARMAC has set a bold goal to eliminate inequities in access to medicines by 2025.[4] This goal recognises that everyone should have a fair opportunity to access funded medicine to attain their full health potential, and that no one should be disadvantaged from reaching their potential. Currently, not all New Zealanders are achieving 'best health outcomes' from medicines that we fund. In this context, unequal inputs are required to attain a fair opportunity to access funded medicines.

PHARMAC has made *equitable use and access to medicines and medical devices* a strategic priority in its next four-year plan 2020-2024 which encompasses the intent of the bold goal to eliminate inequities in access to medicine by 2025. PHARMAC is initially focusing its efforts in primary care and welcomed the opportunity to collaborate with the

[4] Achieving medicine access equity in Aotearoa New Zealand towards a theory of change https://www.pharmac.govt.nz/assets/achieving-medicine-access-equity-in-aotearoa-new-zealand-towards-a-theory-of-change.pdf

Commission to enable primary care to work towards medicines access equity through a number of Whakakotahi projects.

PHARMAC recognises that the causes of health inequities are complex, and solutions do not lie solely with the funding of medicines, or within the health system. Barriers to health equity relate to access barriers, such as costs and transport, structural barriers, such as how health care is organised, and the ability of providers to address a person's needs. In recognition of these drivers, PHARMAC has developed a theory of change to achieve equitable access to medicines. It identifies five primary drivers that facilitate medicines access:

- Medicine availability
- Medicine accessibility
- Medicine affordability
- Medicine acceptability
- Medicine appropriateness.

The driver diagram underpinning PHARMAC's medicine access equity work is attached as an appendix to this report.

PHARMAC's collaboration was designed to support projects focused on medicines access equity. These projects could address specific drivers of inequities, and choose to focus on a specific medicine, group of medicines, or a disease or condition where equitable access is a concern. Priority populations for the project were Māori, Pacific, socioeconomic deprivation, refugee backgrounds, and geographical areas where residents face greater inequities than other locations. The three projects focusing on medicines access equity were:

1. Westbury Pharmacy and Hora Te Pai, who implemented the new BPAC guidelines for gout within Hora Te Pai health services.
2. The Tongan Health Society focused on developing a Pacific innovative service to support Pacific patients who are beginning or intensifying their insulin usage to manage diabetes.
3. Te Whānau ā Apanui Community Health Centre implemented a project to improve timely access to medicines in a rural context.

Further information on these projects and their influence on medicines access equity is explored below.

7.3 Stakeholder's perspectives on the contribution to equity

The quality improvement data provides a useful insight into the influence of Whakakotahi on health outcomes. With this level of data, however, it is harder to determine the influence on health equity. Even with sufficient data, attributing the impact of a specific programme on health equity can be difficult:

> *"On a system level [impact on equity] is very hard to determine this, it is incremental and [you] hope that philosophically if you can get models embedded like this, there would be… better outcomes for people."*
>
> Commission stakeholder

Understanding improvements in health equity is a long-term journey that is best achieved through a systems approach, and subsequently understood through a systems-based approach to measurement. While this was beyond the scope of this evaluation, the project teams were asked to reflect on their contribution to health equity particularly in Tranche 3, where equity measurement advice was sought from a number of experts in this field.

Most of the project teams felt that they had positively contributed to health equity outcomes through their work. One team in Tranche 1, however, highlighted the challenges of impacting on health equity for patient populations. The project team felt that they had made no impact on patient health equity, as they had struggled to engage a Māori partner. While this was associated with the limited capacity of that organisation, the project leader felt that cultural advice on where and how to approach local partners for cultural expertise would have been beneficial.

The increased emphasis on equity in Tranche 3 enabled the Commission to support projects that had a strong equity focus. During this time, the Commission also engaged Te Tihi, enabling cultural expertise to inform decisions being made by the Commission through the selection process. The collaboration with PHARMAC also gave a specific focus to equity, and more specifically medicines access equity. An overview of these projects, and their perceived contribution to health outcomes and equity are summarised here.

7.3.1 Westbury Pharmacy and Hora Te Pai

Westbury Pharmacy and Hora Te Pai together have been implementing the new bpac^{nz} guidelines for gout within Hora Te Pai health services. The approach uses a multi-disciplinary approach with a GP, nurse and community pharmacist working together to support patients.

The project has removed access barriers for patients needing gout medication, with free scripts and home deliveries as part of the package. Hora Te Pai operates as a Health Care Home, which supports continuous quality improvement processes. The project team felt that Whakakotahi enabled them to put a clear structure around their activities and define them in a way that might not otherwise have happened.

The team reported some great outcomes and believe their project is recognising and responding to unmet need in the community, through capturing people who normally would never have walked through the door. Key successes include bringing whānau together and supporting education and realisation about the realities of living with gout and how to manage it, as well as successfully lowering serum urate levels for some patients below 0.36mmol/L.

7.3.2 Turanga Health

Turanga Health is an iwi health provider in Gisborne; they participated in Tranche 2 of Whakakotahi in 2018. The Turanga project involved the development of the Tu Mahi programme, which is a work wellness programme, which has expanded to follow up home visits to ensure at risk clients have access to wraparound services.

Their project offers on the job health checks, flu vaccinations, smoking cessation services, among others, to the area's primary industry workers. The groups it works with include a largely Māori workforce, who are often disconnected from the health system. The project then identifies at-risk individuals to be followed up with a home visit, connecting them with primary care. The team has reported some great outcomes from their project and going into whānau homes has allowed them to introduce other initiatives, like lifestyle programmes, long-term conditions programmes and the Healthy Homes initiatives. There are significant equity gains being made here, as more comprehensive services are available to those who require them. The project team reflect that the knowledge and methods learnt through Whakakotahi have been critical to support the expansion and continued success of the project.

Following the Whakakotahi experience, the project expanded to include home visits, as well as now being engaged with 17 workplaces. The team has credited Whakakotahi with supporting the project to get off the ground using robust, sustainable approaches to unlocking the whānau voice.

7.3.3 Tongan Health Society

The Tongan Health Society focused on developing a Pacific innovative service to support Pacific patients who are beginning or intensifying their insulin usage to manage diabetes. The team identified social factors were influencing adherence and uptake of appropriate medication and engaged patients in the project through self-management education sessions, group sessions and patient champions to share their experiences.

This team felt that the support they received through Whakakotahi, including the QIF course added a lot of value to the work they were undertaking. The additional support from PHARMAC was valued, and the team enjoyed the relationship building that came from these connections.

For this project, the acceptability of medicines was challenged, as the cultural beliefs about health care and medicine in this population contrasts with the Western model our health system was built on. As a result, education and support from health navigators in the on-site pharmacy proved to be a significant support. Despite this, cost was still identified as the most significant barrier to accessing medicines.

7.3.4 The Fono

The Fono's project Happy Skin focused on addressing skin infections in their enrolled population, with a particular focus on the Tuvaluan community. The clinic worked extensively with the West Auckland Tuvaluan community to understand their specific needs and what would help them to be well and stay well. Skin infections had been on the rise for this community, despite the overall down-trend in Pacific communities.

They worked to test a series of changes to support the prevention, early identification and treatment of skin infections in the Tuvaluan community. This community has high rates of skin infections, poverty and overcrowding, and The Fono identified the need to do things differently to support this group.

Through their existing relationships, The Fono engaged in health promotion activities with the Tuvaluan community, including attending Sunday church services to hand out soap and other collateral to raise awareness about skin infections. The project team recognised that an equitable approach to supporting this community would involve adapting their current methods of support.

The Happy Skin project aimed to reduce the rate of skin infections among under-25-year-olds in West Auckland's Tuvaluan community by 25 percent, but actually achieved a more than 40 percent reduction. The equity gap also decreased between the Tuvaluan population and other Pacific groups from 9 per 1,000 patients to 5 per 1,000, and from 16 per 1,000 to 9 per 1,000 for non-Pacific groups.[5]

The project has gone on to win the Ministry of Health's Equity award at the 2020 New Zealand Primary Healthcare Awards.

7.3.5 Te Whānau ā Apanui/Te Kaha

Te Whānau ā Apanui Community Health Centre is a 'special area doctor' that operates without a PHO in a rural setting and covers a wide geographic area from Hawai to Potaka. They are interested in learning how quality improvement practices can be conducted in low-resourced settings. This is specific to highly rural contexts with limited access to health care and medicine.

Te Whānau ā Apanui Community Health Centre implemented a project to increase access to timely and accurate medicines. This was in response to having a number of

[5] https://www.hqsc.govt.nz/our-programmes/primary-care/news-and-events/news/3955

patients who would call the medical centre complaining that they had not received their medications within an appropriate timeframe. Transport barriers to accessing medicines and the closest pharmacy being nearly an hour away mean that a number of medicines are couriered by the pharmacy, which the Health Centre has a partnership.

One of the challenges for their team was the uniqueness of the medicine access equity topic. This made defining the topic and findings measures they could collect evidence on difficult for the team. The low level of technological infrastructure in their remote and low resource setting further complicated the process.

They have tested a change in the practice process for scripts to reduce errors which has been successful. Visiting locums have also noticed this process improvement and it has resulted in improved access and accuracy of medicines for patients – no patients have called to complain about missing or incorrect medicines since the change was implemented.

7.3.6 Systemic causes of health inequity remain a challenge but present an opportunity to inform system change

When reflecting on the contribution to equity, key stakeholders noted the systemic causes of health inequity. While the projects had reduced some of the barriers to medicines access equity, system level barriers such as costs, and how medicines are funded remained a challenge. The types of medicines and devices that are funded, and who can access subsidies contribute to barriers in achieving equity. An example of this was shared from the Tongan Health Society project team, who spoke about the availability of funded diabetes meters for patients living with diabetes. These devices are only funded for patients who meet certain criteria, however, if all patients were able to test their levels it may support them to self-manage more effectively.

> *"If all my patients had a meter, they would be able to look themselves and see… how they are doing. It is a beneficial thing for all diabetes patients to be able to measure and monitor in this way… but it is only available for patients who meet the criteria."*
>
> Project team member

Cost-related barriers remain the most significant inhibitor of accessing medicines. Cost barriers are both direct and indirect, and often simply paying for a primary care consultation prevents access to medicines and primary care. Some projects had

decided to make the cost of prescriptions free, and this was highlighted as a key driver for supporting patient engagement in the project.

> *"Making it free – free medication, free scripts – has meant that people have been picking up their medicine… They're [patients] really keen, they're ringing up two weeks before saying 'oh my insulin is nearly finished can I have a script'."*
>
> Project team member

Stakeholders from the Commission and PHARMAC suggested that these challenges provided important insights to inform system level change. The opportunity to learn from the sector was also highlighted as one of the key drivers for PHARMAC's engagement in Whakakotahi.

> *"PHARMAC wanted the benefit of insights from grassroot levels, what is going to make a difference for medicine access equity. They know that by gaining understanding at the grassroots, they can influence system level changes. So they were quite keen to kind of say, see what the projects were coming up with. And if there were any leavers that PHARMAC could actually influence or change around improving medicine access equity."*
>
> PHARMAC stakeholder

Stakeholders from the Commission also saw this as an opportunity to learn from the primary care sector. Whakakotahi presented an opportunity to establish collaborative relationships with primary care with a view to promoting health equity, and quality improvement practice.

In terms of changes in the primary care system, the projects also identified some important facilitators of success. When improving medicines access, for example, the projects highlighted the value of supporting connections between pharmacy and primary care. In particular, the value of supporting pharmacists and enabling them to support patients as navigators and clinical advocators was recognised. For example, the projects highlighted the value of pharmacists helping patients to understand and translate clinical conversations around medicine. The formative evaluation phases also highlighted the value of incorporating quality improvement methods into pharmacy sector organisations.

7.3.7 Changing systems and process for engagement

When reflecting on the contribution to equity, some of the project teams felt that the systems and processes for engagement made it harder, for those with higher needs, to take part.

One project team highlighted that providers and organisations working in the areas with the greatest need for quality improvement may struggle with capacity to engage with the Commission and participate in Whakakotahi. Barriers to engagement were noted in the EOI writing process, which requires different skills and considerable time to formulate and develop projects according to the criteria of the application. They perceived that structural and policy change was required to support improved capacity and resource for those with higher needs to be able to engage with programmes such as Whakakotahi.

This feedback highlights the value of working differently with the primary care sector to facilitate change in those areas of greatest need. This type of feedback is not unique to Whakakotahi, and reflects ideas relating to system change or transformation, in terms of how services are procured, projects implemented and the ways in which government agencies work with primary care and community providers.

7.4 Contributing to equity through quality improvement

The Western science lens of quality improvement and its associated processes did not always flex and adapt to reflect a Māori worldview, or the different contexts and needs of the Whakakotahi projects. While this posed challenges during Tranche 1, the feedback from the project teams also presented an opportunity to bring together te ao Māori with quality improvement approaches. This work was noted as one of the successes of Whakakotahi, and was supported by the project teams, the Commission, Te Tihi and PHARMAC. The results of this work were noted as something that could be used to inform quality improvement in New Zealand by stakeholders:

> *"It revealed an opportunity to be thinking about kaupapa Māori tools and quality improvement. What does that mean? what does that look like, so challenge some of that thinking. And I think that's hugely valuable, and I think whatever happens with Whakakotahi, I think there's legs for that regardless. Yeah, how do you do quality improvement with a kaupapa Māori approach?"*
>
> PHARMAC stakeholder

The results of this work warrant further development and exploration with other Māori providers. This could be supported through other work programmes with the Commission and/or PHARMAC.

The formative evaluation phases also highlighted the contribution of Whakakotahi to the capability and leadership development for the Māori workforce. The capability building was valued for its potential contribution to developing the Māori workforce, and over time, leadership. For example, a few project teams used the learning and development opportunities through Whakakotahi to intentionally build the capability of the Māori staff in their teams. It was suggested that this way of working has the potential to provide a platform from which these staff can step into leadership positions. This could provide more capacity for decisions to be made by Māori for Māori.

Overall, it is acknowledged that Whakakotahi can only have a limited impact on broader system equity. There are other factors, such as the social determinants of health, that impact on equity beyond the influence and scope of Whakakotahi. It will take change, commitment and collaboration from multiple organisations across the system to support health equity, and equity more broadly.

8. STRATEGIC CONTRIBUTION OF WHAKAKOTAHI

The Commission is also interested in understanding the strategic fit of Whakakotahi. There are several ways in which this programme aligns with the Commission's strategic priorities, but also aligns with the strategic goals of the wider health sector.

Whakakotahi contributes to the Commission's strategic priorities through:

- Creating **collaborative partnerships** between the Commission and primary care, particularly providers serving priority population groups.
- Creating an environment for **interagency collaboration** to occur between national agencies.
- Providing **training and education in quality improvement methods**, through the use of resources and tools.
- Supporting **sector-led quality improvement initiatives** chosen by the project teams.
- Developing a base of **primary care improvement science knowledge** (both across primary care and the Commission).

The strategic contribution of the programme was also enabled through its focus on **equity, integration,** and **consumer engagement (co-design)**. The insights from the evaluation highlight the contribution of Whakakotahi to building leadership, developing the sector's capability for improvement, and contributing to improving equity, and reducing unwarranted variation in care.

8.1 Collaboration and partnerships were key strategic contributions of Whakakotahi

The collaboration and partnerships that Whakakotahi facilitated were the most frequently noted strategic contribution of the programme. Stakeholders noted the value of the connections and collaboration with primary care, and the insight that this gave in terms of how best to support quality improvement capability and implementation. The equity knowledge and expertise of the project teams was also important. Māori providers, and their feedback on the initial implementation of Whakakotahi helped shape and inform its future direction. This was crucial to better enabling Māori providers to engage in the programme, and more importantly for the equity projects to be led by Māori.

The leadership and expertise of Te Tihi was crucial for providing cultural support for the programme and facilitating strategic engagement with Māori providers and advisory groups. This relationship was valued for guiding the work programme and enabling Whakakotahi to place increased emphasis on equity.

8.1.1 Collaboration and partnership with PHARMAC

The collaboration with PHARMAC provides another opportunity to enhance the focus on equity, and medicines access equity more specifically. Stakeholders from both organisations noted the value of the collaboration. For PHARMAC, Whakakotahi provided an opportunity to understand more about the drivers of medicines access equity in primary care, and the role that they could have in enabling change. The fact that Whakakotahi was well-established was also appealing, as this made it easier for PHARMAC to become involved. Quality improvement is also a new area for PHARMAC,

so Whakakotahi was seen as an ideal opportunity to embrace a new way of working for PHARMAC and show the benefits and value of this collaborative approach.

For the Commission, PHARMAC contributed additional expertise in terms of medicines access equity and there was a strong alignment across the strategic priorities of both organisations. The shared commitment to equity was a key enabler for this collaboration. It was anticipated that both organisations would find value in seeking out other ways of working together to support health equity. The interagency collaboration was also important for moving out of silos, and ultimately better understanding and supporting integrated care for consumers. Stakeholders also suggested that the collaboration provided better value for the project teams, and complementary use of resources and shared learning across the two organisations.

When reflecting on the strategic contribution of Whakakotahi, the collaboration and partnerships were most frequently noted. The value of the connections and collaboration with primary care were highly valued by the Commission and contributed to the government's strategic priority of interagency partnerships.

9. OVERVIEW AND KEY CONSIDERATIONS

Overall, the evaluation has highlighted the achievements of Whakakotahi in relation to its intended aims:

- Building collaborative partnerships between the Commission and primary care.
- Supporting sector-led improvement projects to build and spread improvement science expertise and skills in the primary care sector.
- Identifying improvement projects/initiatives that are suitable for implementing at a local level, with potential for regional and national implementation in the future.
- Raising improvement science capability in the primary care setting, although predominantly focussed on the project teams or organisations involved in the programme.
- Improving one or more health outcomes with stakeholders highlighting associated improvements in equity and integration, and consumer co-design for a few projects.

When reflecting on the programme's contribution to health outcomes and equity, it is important to note that this evidence in largely based on quality improvement data and the perceptions of project teams. While the focus on understanding how to measure changes in equity improved over the course of Whakakotahi, attributing changes in health equity to a single project is challenging. The insights from the interviews, however, highlight the value of the work. The success of initiatives such as Whakakotahi would be further enhanced by system changes, such as changes in the cost or structural barriers to accessing medicine and primary care.

Whakakotahi also achieved the following positive unintended consequences:

- Collaboration and partnership with Māori providers that shaped subsequent phases of the programme with a view to increasing the emphasis on equity.
- Building the internal knowledge and understanding of the Commission's programme team through their engagement with Māori providers, primary care more broadly, and the cultural expertise and leadership from Te Tihi.
- Collaboration and partnership with PHARMAC, which built off their commitment to improving equity through primary care. The collaboration of the Commission and PHARMAC working together with the sector enabled a focus on medicines access equity, further enhancing the focus on equity through the programme.
- Quality improvement capability spreading beyond the Whakakotahi projects, as some project teams used their new skills and expertise to support other quality improvement projects.

While not an outcome, the evaluation team would like to recognise the Commission's Whakakotahi team and their commitment to continual learning and improvement. The evaluation was embedded from the outset as a key part of the programme implementation, enabling regular feedback. This has enabled the programme to continually learn and adapt with a view to better supporting its intended objectives.

9.1 Key considerations

The reflections from stakeholders and the evaluation have highlighted the following key considerations.

- **Capability development**
  - Primary care needs to be supported with the management of quality improvement data. There are some challenges in the way primary care has been set up that make the management and use of quality data difficult. Existing data systems to support the use of data in this way could be beneficial to employ in primary care.
  - Strategies need to be developed to support the sustainability of the quality improvement capability that project teams develop through Whakakotahi.
  - There was a sense that primary care was getting to grips with the quality improvement approach, and some gave less attention to co-design with patients. If patient co-design is an ongoing goal of Whakakotahi, there needs to be more support and/or emphasis placed on this aspect of the programme. This approach would also align to the programme's focus on equity.

- **Further enhancing the focus on equity**
  - Consider other ways to engage Māori providers in Whakakotahi, as EOIs and Response to Funding Tenders can exclude those with the greatest need from taking part.
  - Continue to integrate te ao Māori and quality improvement approaches to ensure relevance and value for Māori providers. The insights from this aspect of the programme should also be shared with other work programmes at the Commission.
  - Equity would be further enhanced by focusing on a few topic areas that would have a greater impact on health equity. This could include specific health topics, such as diabetes or gout, as well as aspects relating to clinical practice, such as prescriber behaviour.

- **Scale and sustainability**
  - The current model of support needs to be adapted to work at scale. There may be value in collaborating with quality improvement advisors at DHBs and PHOs to extend the reach of Whakakotahi.
  - Focusing Whakakotahi on a few core areas would support the development of implementation ideas that could be shared at regional and national level. For example, a suite of quality improvement ideas relating to gout may identify local and system level changes that are needed to achieve equity. These insights could be used to facilitate change at a system level.

- **Collaboration and partnerships**
  - There is significant value in partnering with other national agencies to collaborate to achieve shared goals. The partnership between the Commission and PHARMAC suggests that these relationships are mutually beneficial and create value for the programme and stakeholders.

    - These relationships have the potential to be truly operational and partnering at that working level supports shared buy-in, positive working environments and a collaborative approach to success.
    - Shared visions, strategies and goals for outcomes are critical to sustain effective partnerships at a national level.
    - Partnerships at the primary care level also bring benefits, such as the partnership with Te Tihi. These relationships could continue to be capitalised on, as they bring immense value for both partners.

- **Building an evidence base**
    - To substantiate stakeholders' views and experiences of Whakakotahi, it would be useful to draw on system level data that is accessible to be used to drive equity informed improvement initiatives. This could include the Commission's Atlas data or data relating to PHARMAC's medicines access equity outcomes framework.
    - Focusing on core topic areas would create opportunities to aggregate outcome data across projects. This would provide a more extensive evidence base to demonstrate improvements in equity and health outcomes.

A number of these considerations highlight the value of focusing on a few core areas, while this makes sense for the reasons outlined above, it is important that these topics are co-defined with the sector to ensure that Whakakotahi remains relevant to local providers and the needs of the populations they serve.

Whakakotahi has evolved since its initial inception and progressed towards a well-defined, robust quality improvement programme for primary care. It is largely achieving its intended outcomes, and there have been some great learnings from this exploratory programme. The Commission should be proud of the work that has gone into developing this programme and be excited for where these learnings could take them.

In the future, a balanced approach should be taken; one that continues to support primary care at the grassroots community level to ensure individual gains in quality improvement capability continue to be made, but also a broader systems approach to support the sustained, scalable outputs of programmes like Whakakotahi.

APPENDIX 1: PHARMAC DRIVER DIAGRAM