Knowing when we get there:

An investigation into measuring success in new health service interventions for older people in Te Whatu Ora – Waikato region

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Abstract

Background: Health services are dynamic and undergo significant and ongoing changes. The delivery of services to older people are no different and in many ways the changes are more dramatic as a consequence of the ageing population. Monitoring whether health services meet the needs of the individuals that they serve is important as without such knowledge, it is not possible to determine the success of the interventions. This research explores what does success look like from an older person's perspective, the health professionals delivering that care, through to operational and executive managers.

Objective: To explore the concept of success within health services for older people at Te Whatu Ora – Waikato.

Participants: One-to-one interviews were held with stakeholders, from executive and operational management and operational health professionals (n=7); focus groups with needs assessor service coordinators (n=10) and home care support services (n=6); and patient surveys with older participants (n=67).

Methods: Mixed methods research involving interviews and focus groups with stakeholders and surveys with older people receiving services. Interviews and focus groups were transcribed verbatim and later analysed using a general inductive method of enquiry to generate key themes. Surveys were analysed with descriptive statistics.

Results: The strategic direction of the health services and anticipated outcomes were well communicated and widely consulted and consequently there appeared to be alignment of views from those health professionals involved. All believed that they were making a difference and felt personally rewarded by the role that they do and the contributions they make to the community, population in their care and individual patients. Measures of success focussed on the assessment of quality of life and wellbeing for the older person. This contrasted with the consumer perspective, who generally reported dissatisfaction with the services they received and on the whole their current quality of life.

Conclusions: The research showed that health services tended to focus on an acute response and hospital services dominated conversations. There was little awareness of the need to assess the broader aspects of service delivery.

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Finally, I would like to acknowledge the time given by the participants who agreed to be involved. Consumers and their stories painted a very vivid picture of the life they currently lead and the challenges they experience. The health professionals involved were open and honest about their perceptions of their roles and shared personal stories of whānau experience that were revealing.

Contribution

I, the researcher undertook all aspects of this study under the direct guidance of my supervisors. This entailed selecting the appropriate research design, the data collection and analysis, and the publishing of the findings in this thesis.

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Chapter I: Introduction

> *"I can't give you a sure-fire formula for success, but I can give you a formula for failure: try to please everybody all the time"*
>
> **Herbert Bayward Swope**

Aotearoa – New Zealand (Aotearoa-NZ), like the rest of the world is ageing. Demographic growth for Aotearoa-NZ is projected to be 4.6 percent over the next five years; however, the greatest growth will occur in those aged over 65. In five years, we can expect a more than 20 percent increase in the number of Aotearoa-NZ residents aged 65 and over (Stats NZ, 2022). Since 2006, the Waikato region population has exceeded national growth (Stats NZ, 2018). Not only is our population living longer and as a result increasing the number of older people in our population, the proportion of older people that make up the total is about to grow exponentially over the next 25 years. Resulting in a relatively smaller amount of working population supporting an ever-growing older population. Such demographic shifts require a significant re-think in the way healthcare is delivered.

There is growing pressure on healthcare systems to change the way in which services are delivered. The growing prevalence of long-term conditions, population ageing and the resultant increase in frailty place a heavy burden on health systems. In addition to increasing prevalence of long-term physical health conditions, there is a growing worldwide prevalence of mental illness. Historical service delivery models are financially unsustainable and at distinct risk of no longer being capable of meeting demand, so alternatives are recommended which refocus attention on integration of physical and mental health services for older people across the continuum of care (Ministry of Health, 2004a). This will require a fundamental transformation of how services are provided.

This research will consider how the views of older people and those providing the support and care be captured and how the concept of success can be measured. More considers the following questions:

1. What are the views of health professionals involved in the delivery of care and support to older people in relation to measuring success?
2. What are the views of older people who are currently, or have received health and disability support services in relation to measuring the quality of those services?
3. How do community providers measure success in the services that they provide?

Chapter II: Literature review

"Ageing is just another word for living"

Cindy Joseph

2.1 Introduction to the literature review

Changes in the way in which healthcare is delivered is an ongoing process and inevitable. To ensure that changes deliver genuine benefits and proactively support the target audience and is not simply reactive to demand is a clinical and research imperative. Weaving a path through the literature is important as there is as much evidence highlighting success as there is failure, but with as much to learn from both. A well planned and executed literature review identifies, reviews and critically evaluates the current body of knowledge, theories and data relevant to the area of study in a clear and balanced manner (Green & Thorogood, 2004; Hansen, 2006) and is therefore a critically important step in any research project.

This chapter establishes the contextual construct for the research and is developed through two parts. Part 1 examines population ageing internationally, nationally and locally within the Waikato region; it explores the implications for health and the management of long-term conditions as they relate to physical health and mental health. This is followed by an examination of service delivery options for older people with physical health and mental health needs. Part 2 introduces the topic of success and provides context to the Te Whatu Ora – Waikato (TWO-Waikato) model of care for older people and its approach to long term community supports for the older person. It summarises what has been traditionally a reactive approach that 'does for' the individual and signals a change to a more proactive restorative approach that acts as more of an enabler to support older people to live a more independent life of their choice. It explores the rationale for delivering a continuum of care for older people through examination of the literature on inpatient services, intermediate care alternatives as well as community- based services for older people. The concepts of a restorative approach to long term care, the concepts of choice in health and its implications, the value of a programme / project approach to support service

improvement and finally realisation of benefits and the perceptions of success from a consumer, service delivery, funder, and executive management perspective will be examined. It also considers the concepts of success and how do we know whether services are working well. How do we determine success from the perspectives of the consumer, support team and service provider, management, funder and senior executive level?

2.1.1 Literature search

Articles reviewed were accumulated through computer searches of medical, nursing, psychology and management databases. The database search was performed by the researcher using keywords including 'aged', 'older people', home-based care', 'long term care', 'community', 'patient choice', 'restorative approach', 'programme', 'project', 'success', 'benefits' and 'service improvement'. Most literature identified was from MEDLINE, CINAHL, and the Cochrane Library databases. The Universities of Waikato and TWO – Waikato libraries were utilised for manual searches. Online searches were undertaken using search engines Google (http://www.google.co.nz) and Google Scholar (http://scholar.google.co.nz).

2.1.2 Definitions of terms

There are multiple issues in defining 'old age' and in discussing the specific attributes of older people. In her seminal work, Askham (1988) highlighted that a large number of the problems and difficulties encountered by older people are broadly similar to those experienced by other groups and are not specific to older people. This is reflected by the growing number of 'younger' people presenting with a range of long-term health conditions. Many 50-year-olds with multiple complex health conditions have more traumatic health journeys than relatively healthy 75-year-olds. The World Health Organization (1997) emphasises the particular difficulty in specifying an age that marks the beginning of old age, stressing that there is little doubt that physically active lifestyles benefit individuals throughout the life span and thereby in many respects delay the onset of 'ageing'. In spite of these difficulties, this review will focus on health and social care services specifically for older people and will adopt the upper

retirement age of 65 years as defining older people because of the social and economic perceptions of when old age commences (Tinker, 2002).

The World Health Organization (WHO) identifies that "the purpose of health services is to promote health; to prevent, diagnose and treat diseases - whether acute or chronic, whether physical or mental in origin; and to rehabilitate people incapacitated by disease or injury" (Abel-Smith, 1963, p. 24). Similarly, the Organisation for Economic Co-Operation and Development (OECD, 2006), describes the concept of health care as "the sum of activities performed either by institutions or individuals pursuing, through the application of medical, paramedical and nursing knowledge and technology." Of particular relevance to older people are community-based services that either support or provide direct care to individuals that will enable them to maintain their independence and highest quality of life" (OECD, 2006,). Community based services are viewed as having one of three key objectives: (i) To substitute for acute care hospitalisation; (ii) To prevent the need for institutionalisation; and (iii) Maintain individuals in their own home and community (Fleming & Taylor, 2007).

Internationally, the concept of 'ageing in place' has been gaining relevance for many years. In 1994, the OECD health and social policy ministers stated that "older people, including those in need of care and support should, wherever possible, be enabled to continue living in their own homes, and where this is not possible, they should be enabled to live in a sheltered and supported environment which is as close to their community as possible, in both the social and geographical sense" (OECD, 1994, p. 10). Building on this, within Aotearoa-NZ, ageing in place has been defined as "the ability to make choices in later life about where to live, and receive the support to do so" (Dalziel, 2001; Dyson, 2002). Or more crudely translated, the definition can refer to an older person's ability to remain in a community dwelling, including within retirement villages, with residential care specifically excluded.

Part 1 An ageing world

Demographics relates to statistical data pertaining to the population and particular groups within it. Exploring and understanding demographics, particularly how ageing is impacting on society is important and contextualises this current study. The first section of this literature review examines the global and Aotearoa-NZ population growth, focusing on an ageing of the population. Understanding the reasons for an ageing population are determined. It explores how we try to meet the needs of that older population, its greater numbers, and the resultant effect it has on health care expenditure and demand. It considers both a national and local response to meeting that need.

2.2 The world-wide population

Population ageing is a worldwide phenomenon, particularly in the developed world where populations tend to have low rates of births and deaths that result in older age structures and slow or no growth (Grundy, 2002). Aotearoa-NZ fits into this developed world category, in which "the most pressing public health problem concerns is the growing proportion of old – particularly very old – people, and the possible implications of recent changes in family systems" (Grundy, 2002, p. 809). The older population can be broadly categorised into three stages, that of 'young-old' (65 to 74), 'old-old' (75 to 84) and very old-old (85 plus). With mortality rates declining in most developed and developing countries, the fastest growing age-group of the population are those over 65 years (Anderson et al., 2000); thought in the main to be a consequence of people generally living more healthily alongside improvements in healthcare and factors enabling people to be kept alive longer (United Nations, 2007).

Within Aotearoa-NZ, increases across the 65+ population appear to be accelerating, with this growth expected to continue with a sharp increase in the years 2025 to 2050 when the 'baby boomers' reach ages over 75 years. In 2005, the world population was 6.5 billion. During 1995 to 2000 the population size increased by an average of 78 million annually. Future predictions envisage the annual number and growth rate to decline, though the rate of such change is unclear. By 2050 the world population is expected to be still increasing by 34 million a year and is predicted to reach 9.1 billion

(United Nations, 2006). The world population is ageing, with an increasing proportion of inhabitants who are 60 years and older, correlating to a decline in the proportion of those under 15 years (K. G. Kinsella & V. A. Velkoff, 2001); United Nations, 2002, 2007). It is foreseen that by the year 2050, for the first time in history the global population of older people (65+ years) will surpass the number of younger people (less than 15 years) and it is unlikely this trend will reverse (United Nations, 2002, 2007). The number of people 60 years or over is expected to continue rising and almost triple from 2005 to 2050, with an increase from 672 million to two billion (United Nations, 2002, 2007). The older population is increasing by 2.6 percent annually, significantly faster than the population as a whole (increasing by 1.1 percent annually), and this trend is anticipated to continue for at least the next 25 years (United Nations, 2002, 2007). The 'baby boom generation' refers to those born during a period of high fertility post World War II (1946 to 1960). Subsequently, after 2010 a considerable rise in the proportion of older people is predicted as this cohort begins to reach 65 years. This increase will be most significant by the year 2030 (K. G. Kinsella & V. A. Velkoff, 2001). In developed countries in 2005, 20 percent of the population was 60 years or over. This figure is predicted to increase to 32 percent by 2050 (United Nations, 2006). In comparison, population ageing is occurring at a faster rate in developing countries. Currently, older people account for eight percent of the population in developing countries; by 2050 this is expected to rise to 20 percent (United Nations, 2007). Female life expectancy is higher than males, therefore, the majority of older people are women (United Nations, 2002). In addition to an ageing population, the older population group itself is ageing, with those 80 years or older (labelled the oldest old) increasing by the greatest rate of 3.9 percent annually (United Nations, 2007). By the year 2050, it is forecast the oldest old group will comprise one fifth of the global older population (United Nations, 2002).

Grundy et al. (2006) emphasises this sub-group of the oldest old is particularly vulnerable, and without adequate support, their quality of life may be seriously compromised. Policy initiatives to reduce vulnerability need to focus on ensuring individuals reach the oldest old age group with reserves, a reduction in challenges commonly faced in later life, and provision of adequate supports. In addition, recognition of the heterogeneity of the older population is imperative; this implies

varying approaches will be required to meet the needs of subgroups such as the oldest old. How are we to meet this challenge with a world-wide ageing population that is growing and making up a proportionately greater percentage in the total population?

2.3 Aotearoa-NZ is getting older

Aotearoa-NZ, like the rest of the world is ageing. Demographic growth for Aotearoa-NZ is projected to be 4.6 percent over the next five years, however the greatest growth will occur in those aged over 65. In 5 years, we can expect a more than 20percent increase in the number of NZ (Aotearoa-NZ) residents aged 65 and over (Stats NZ, 2022) (Fig 1). Since 2006, Waikato population growth has exceeded national growth (Stats NZ, 2018) and therefore, we should plan for our proportion of older, chronically unwell patients to surpass national trends. This regional shift was confirmed between 2013 and 2018, when the over 65 population increased by 22 percent. Furthermore, between 2013 and 2018, there was an increase in the proportion of Māori and Pacific peoples in the region (Stats NZ, 2018).

"As elsewhere, Aotearoa-NZ's population is ageing" (Jackson, 2011, p. 2) and the age structure of the population will continue to undergo gradual change. Changes have already occurred in Aotearoa-NZ; there has been a shift from a youthful 'triangular' population structure where the median age was 27, to a more mature 'hourglass' structure where the median age has risen to 37 and as previously mentioned this is largely due to declining fertility and death rates. Aotearoa-NZ is currently a relatively young country, with only one in nine people aged 65 years and over. The total population is projected to grow from 4.472 million in 2013 to over six million in 2050 (K. Kinsella & V. Velkoff, 2001; Statistics New Zealand, 2013), with the rate of growth expected to slow by 2061 (G. Bascand, 2007). Whilst from 2007 to 2061 birth rates are expected to gradually decrease, longevity will continue to increase so the age structure of the population will continue to undergo gradual but significant change. The increase in older people will result in a mortality rate that is predicted to double, narrowing the gap between birth and death rates (G. Bascand, 2007).

An ageing population has a multi-factorial impact across society. On the one hand, the potential for unpaid contribution to local communities' increases, whilst on the

other, the dependency ratio (i.e., the number of dependent people per working person) increases, meaning less tax and less available workers. In Aotearoa-NZ, the older age dependency ratio was 18 per 100 in 2004; it is expected to be 32 per 100 in 2026 and 45 per 100 people in 2051 (Statistics New Zealand, 2007). Under all projected scenarios, the number of New Zealanders aged 65 years and over is projected to exceed one million by the late 2020s, compared with half a million in 2005 (Ministry of Health, 2002a). Over the same period, people over the age of 65 are projected to outnumber those aged less than 15 years. It is also forecast that by the year 2051, people over the age of 65 years will constitute 26 percent of the total population of Aotearoa-NZ, an increase of 165 percent from 1999 (Statistics New Zealand, 2004). By 2061, 1.44 million people will be aged 65 years, and over which is 2.6 times the number in 2009. Within Aotearoa-NZ the older population is itself ageing. The 'old' (those over 75 years) are expected to increase six-fold by 2051 (Cornwall & Davey, 2004; Dunstan & Thomson, 2006), when they will make up 22 percent of the population of people 65 years and over in Aotearoa-NZ. In the same way that international data suggests women will live longer than men, the increase of women aged 85 years and older in Aotearoa-NZ will be particularly high.

In 2020, life expectancy for Aotearoa-NZ was 82.43 years. In 1971 life expectancy was just 71.57 years. Currently Aotearoa-NZ ranks 13th out of the 34 OECD countries in terms of life expectancy rates. However, people living in high socio-economic deprivation and in the bottom decile of income live six to seven years less. Māori have on average; life expectancies of eight to nine years less than non-Māori and these differences are magnified amongst men - life expectancy at birth for Māori males was 73.4 years in 2017-19 and 77.1 years for Māori females. The Māori male life expectancy is approximately one year above the global life expectancy of 72.81. Pacific peoples, are characterised by a high birth rate and high death rate, though have on average a longer life expectancy than Māori. Life expectancy at birth for Pacific males is 75.4 years in 2017-19 and 79.0 years for Pacific Females. Despite these differences, Māori and Pacific peoples are also ageing and population increases for older Māori, Pacific and Asian people are forecast (Cornwall & Davey, 2004). While historically Māori and Pacific peoples have been poorly represented in morbidity and mortality statistics nationally, the demography for these ethnic groups mirror that of national and

international statistics. Even though the age structure for both Māori and Pacific peoples remains much lower than for the rest of New Zealanders, it is estimated that by 2051, Māori will make up ten percent of all older people, with the largest proportion in the 65-to-74-year age group. Pacific peoples will represent 4.4 percent of the older population. Population data regarding the growth in the Asian community is currently less clear as immigration policies impacting this group are subject to potential political changes in the future. However, predictions suggest this group will be heavily represented in the 'old' age group within a decade (Ministry of Health, 2002b).

Whilst all regions in Aotearoa-NZ are experiencing an ageing population, future fertility levels and migration patterns mean there will be on-going regional variations in population structure, both in age and ethnicity (Dunstan & Thomson, 2006). Some regions within Aotearoa-NZ have relatively low populations overall but a high proportion of older people per total population. The North Island of Aotearoa-NZ is currently more ethnically diverse than the South Island with higher proportions of Māori, Pacific and Asian populations and this is anticipated to continue (Tukuitonga, 2011).

2.3.1 Waikato population changes

The proportion of the Te Whatu Ora - Waikato (TWO - Waikato) population aged 65 years and older currently accounts for approximately 13 percent of the total TWO - Waikato population (almost 50,000 people 65 years and over of a total 371,540 people), with six percent male and seven percent female within the total population. More than half of those 65 and over are aged between 65 and 74 years. Tables 1 to 5 present demographic data around older people and Kaumātua in the TWO - Waikato region. Although access to Health of Older Person (HOP) services is routinely limited to those of 65+ years (and for those people between 50 and 64 years, with age related needs), the age for older Māori to qualify for certain Te Whatu services has been lowered to 55 years of age, as testament to the fact that Māori experience age related illnesses at an earlier age as a result of health and socio-economic factors.

Table 1: Count by Māori (55+) and non-Māori (65+), by gender, Te Whatu Ora, Waikato, five-year bands

	2020	2025	2030
Māori			
Total population	**98,383**	**107,808**	**117,275**
55-59	**14,458**	**17,271**	**19,975**
Female	7,922	9,522	11,059
Male	6,536	7,749	8,916
Non-Māori			
Total population	**327,453**	**338,720**	**346,565**
65+	**64,085**	**74,985**	**85,863**
Female	33,852	39,501	45,218
Male	30,233	35,484	40,645

Table 1 highlights the significant increase in the population of older people in the TWO - Waikato region over the next ten years. Tables 2 and 3 illustrate the shift as a percentage of the specific Māori and non-Māori population. In 2030, almost one in six Māori will be over 55 years and one in four non-Māori, over 65 years (Table 3).

Table 2: Percentage as a proportion of population for Māori and non-Māori, by gender, TWO - Waikato, five-year bands

	2020	2025	2030
Māori	**100**	**100**	**100**
55-59	**15**	**16**	**17**
Female	8	8	9
Male	7	8	8
non-Māori	**100**	**100**	**100**
65+	**20**	**22**	**25**
Female	10	12	13
Male	9	10	12

Table 3: Percentage as a proportion of population (Māori, non-Māori) TWO - Waikato, five-year bands

	2020	2025	2030
Māori (55+)	14.7	16.0	17.0
Non-Māori (65+)	19.6	22.1	24.8

Table 4 illustrates the proportion of older Māori and non-Māori in the total population and collectively shifting from 18.4 percent in 2020 to 22.8 percent in 2030.

Table 4: Percentage as a proportion of TOTAL population (Māori, 55+ AND non-Māori, 65+), TWO - Waikato, five-year bands

	2020	2025	2030
Māori (55+)	3.4	3.9	4.3
Non-Māori (65+)	15.0	16.8	18.5
Māori and non-Māori	18.4	20.7	22.8

Table 5 highlights the percentage shift for older Māori (55+) and non-Māori (65+) over a ten-year period in the TWO - Waikato region, a 34 percent increase, with the increase being higher amongst Māori than non-Māori.

Table 5: Change in population as a percentage (Māori, 55+ AND non-Māori, 65+), TWO - Waikato, five-year bands

	2020	2025	2030
Māori (55+)	100	119	138
Non-Māori (65+)	100	117	134

2.4 Kaumātua in the Waikato region

Māori are living longer today than ever before and the increasing Kaumātua population is a cause for celebration. However, socio-economic data show that Kaumātua are less financially stable than non-Māori with fewer owning a mortgage free home or having

access to savings. More Kaumātua will also be associated with increases in age-related illnesses amongst Māori meaning demands on health and disability services will accordingly rise. With this in mind, the TWO - Waikato Model of Care for older people must be cognisant of the specific social and cultural needs of Kaumātua.

2.5 Understanding ageing

2.5.1 Life expectancy

Life expectancy is used as an indicator reflecting population health and is defined as the total number of years that a baby born today can expect to live, assuming current mortality rates continue for the rest of the individual's lifetime (Ministry of Health, 2006b). In line with previous discussions, a review of international data revealed life expectancy rates have been increasing and this trend is expected to continue (Cornwall & Davey, 2003). It is believed, in developed countries, successful advances in medical technology and health interventions have greatly contributed to improved life expectancy (Bunker, 2001; K. Kinsella & V. A. Velkoff, 2001).

Over the past 50 years, similar to global trends, Aotearoa-NZ has also demonstrated improvements in life expectancy (Ministry of Health, 2004c). Recent gains in life expectancy at birth have largely been attributed to a reduction in death rates among late working and retirement age groups (60 to 84 years). As life expectancy advances and the population ages, the proportion of older people rises, resulting in an increase in the prevalence of chronic conditions and disability (Bunker, 2001; Goulding & Rogers, 2003; Jacobzone, 2000). Chronic illnesses largely affects older people, with the likelihood of two or more conditions increasing with age that in turn contribute to disability, reduced quality of life and increased demand and cost for health care (Goulding & Rogers, 2003; Institute of Medicine, 2001). Wiener and Tilly (2002) stated the ageing population would necessitate a shift of focus from acute illnesses to chronic diseases, and provision of ongoing management will be required as disability often accompanies chronic illness. This is now reflected in hospital admissions, with older people making up a greater proportion of admitted patients, with age related complaints and presenting with high patient clinical complexity levels.

2.5.2 Proximity to death and Compression of Morbidity

Moise and Jacobzone (2003) proposed that proximity to death, rather than age itself, is the reason for the positive correlation between health care expenditure and age. They stated health care is more expensive in the last year of life and there are a higher proportion of people aged 65 and over closer to death than younger age groups (Moise & Jacobzone, 2003). Other literature corroborates this argument, believing health care cost and utilisation is strongly associated with proximity to death (McGrail et al., 2000; Miller, 2001). A large study of Medicare beneficiaries in the US revealed health care expenditure increased significantly with age, as a result of mortality rates increasing with age and health care expenditure increasing with closeness to death (Yang, Norton, & Stearns, 2003).

Yang et al. (2003) stipulated older people on average, demonstrate higher health expenditure because their morbidity and mortality rates are higher than younger age groups (Yang, Norton, & Stearns, 2003). Furthermore, a review of health services in the UK revealed that, regardless of age at death, over a quarter of acute health care costs occur within the last 12 months of life (Wanless, 2002). Alternatively, Miller (2001) argued that increases in longevity may lead to postponement of rising health care costs at the end of life, as the proportion of high-cost users would be reduced. In other words, declining mortality would reduce health expenditure by decreasing the proportion of people dying each year (Ministry of Health, 2004c).

Improved longevity raises the issue of whether these projected extra years will be lived in good health. Ideally, increased life expectancy would be accompanied by decreased disability, allowing older people improved quality of life and reducing demand for health care (Jacobzone, 2000). Three alternative health status scenarios are considered in the literature: Firstly, the 'expansion of morbidity' theory proposed the amount of life spent in poor health would rise as life expectancy increased Gruenberg, 1977). Conversely, the 'compression of morbidity' hypothesis postulated the opposite and was introduced in 1980 (Fries, 1980). Fries proposed the age of onset of disability could be increased by postponing chronic illness, disability or other morbidity, and if this postponement were larger than rises in life expectancy, morbidity would be compressed between later onset and time of death (Fries, 1980; 2003). This paradigm

focused on quality of life rather than quantity, where illness in old age will be experienced for a short time, as opposed to living with chronic illnesses and disability for many years (Fries, 2003; Moise & Jacobzone, 2003). In addition, the compression of morbidity paradigm supports the argument that closeness to death strongly correlates to health spending. Compression of morbidity occurs at the end of life when the highest demand for health care exists, and consequently the greatest amount of health care expenditure occurs closer to death (Moise & Jacobzone, 2003). The third scenario, a compromise between the expansion and compression hypotheses, is termed the 'dynamic equilibrium' theory and translated longevity gains into years of good health (Manton, 1982). This theory is commonly referred to as 'healthy ageing' (Organisation for Economic Co-operation and Development, 2006).

A paper exploring public health and long-term care spending for all OECD countries and based on the 'healthy ageing' hypothesis concluded that the average cost per person in the 65+ age group should decrease over time (Organisation for Economic Cooperation and Development, 2006). Robine and Michel (2004) declared individual countries could shift between the three scenarios over time. Their model demonstrated cyclical movement governed by the following factors:

- Longevity gains for more unwell individuals, causing disability rates to increase (i.e., expansion of morbidity);
- The progression of chronic diseases is controlled, creating a small equilibrium as mortality declines and disability increases (i.e., dynamic equilibrium);
- Health status improves and the number of years lived with a disability reduces as new cohorts of healthy people enter the older age group (i.e., compression of morbidity); or
- Average age of death, rises and the number of years lived with disability increases, causing frail very old populations with multiple chronic illnesses (i.e., new expansion of morbidity).

According to this model, healthy ageing, or even the ideal compression of morbidity scenario, is achievable, but may not be guaranteed or permanent (Dormont, Martins,

Pelgrin, & Suhrcke, 2007). Kalache et al. (2002) reported that developed countries have been demonstrating the compression of morbidity scenario for some time. The rising success in managing chronic illnesses has reduced the impact on wellbeing and functional capacity. Consequently, postponement or prevention of the onset of chronic illness is reflected by declining disability trends.

Fries (2003) corroborates this and states that through an examination of United States morbidity and mortality data, it appears that in recent years, disability rates have been declining which exceed increases in life expectancy, demonstrating the compression of morbidity scenario is occurring in this population. In addition, a systematic review in the US examined disability trends in the 1990s and found the prevalence of disability declined significantly for older people. However, the results primarily related to decreasing rates of limitation in instrumental activities of daily living (IADL), whereas reduction of limitations in activities of daily living (ADL) was less clear (Freedman, Martin, & Schoeni, 2002).

A review of international literature on disability trends in older people revealed several developed countries illustrated moderate reduction in chronic disability. A decline in Australia was not found (Waidmann & Manton, 2000). Other research exploring developed nations stated the US, Europe and Japan are in the 'healthy ageing' scenario (Dormont, Martins, Pelgrin, & Suhrcke, 2007). In developing nations, compression of morbidity attributes, such as declining disability, are not apparent and this is unlikely to change due to many countries failing to provide adequate health and education, the spread of infectious diseases, and deteriorating economic circumstances (Kalache, Aboderin, & Hoskins, 2002). Jacobzone (2000) reported that despite optimistic results of declining disability trends, it is likely there will be increases in cost for health care services. Although there will be reduced demand for long-term residential care, it is probable there will be increased costs associated with the additional need for social support and home care services. Jacobzone argues there is a need for more international research focused on exploring such trends and reducing the prevalence of disability.

A review of international literature on disability trends for older people (Cornwall & Davey, 2004) concluded that generally evidence suggests lower rates of severe disability in the future, indicating movement towards the 'compression of morbidity' theory. However, based on current disability data, Aotearoa-NZ does not appear to demonstrate the attributes common to the compression of morbidity scenario.

Specifically, statistics from 2001 reveal the probability of having a disability raises with age, and trends over time indicate disability levels are not decreasing. This reflects the significant increases expected in the demand for disability support services as the population ages (Cornwall & Davey, 2004). However, a trend towards a compression of morbidity or healthy ageing scenario may be masked by disparities between ethnic groups in Aotearoa-NZ. For example, in Aotearoa-NZ stroke is the most significant cause of adult disability and the third leading cause of death (Fink, 2006). A large study in Auckland, Aotearoa-NZ (Carter et al., 2006) investigated trends in stroke incidence across ethnic groups over a 20 year period. Comparing 1981 to 1982 and 2002 to 2003 data, stroke attack and incidence rates significantly declined for Aotearoa-NZ Europeans; attack rates remained static for Māori and increased by 66 percent for Pacific peoples. In addition, the study revealed from 2002 to 2003 data the average age of stroke for Aotearoa-NZ European patients was 76.6 years compared with 60.7 and 64.5 years for Māori and Pacific peoples, respectively. Feigin et al. (2006) explored these data in more detail and concluded that Māori / Pacific and Asian / other people compared with Aotearoa-NZ Europeans, were at greater risk of ischaemic stroke and primary intra-cerebral haemorrhage, while rates of subarachnoid haemorrhage were similar across the ethnic groups. These findings may suggest a trend towards the healthy ageing or compression of morbidity scenarios in the Aotearoa-NZ European ethnic group, but not for ethnic minorities in Aotearoa-NZ.

A large longitudinal study in the US directly tested the compression of morbidity theory by examining lifestyle habits and physical disability prior to death (Hubert, Bloch, Oehlert, & Fries, 2002). Results found those with fewer lifestyle-related health status risk factors experienced reduced overall disability and delayed acceleration in functional decline prior to death. Furthermore, individuals with two or more risk factors reached a higher level of disability earlier in life and earlier acceleration of

functional decline before death. The authors claimed support for the compression of morbidity hypothesis, where healthier lifestyles result in reduction or postponement of disability (Hubert, Bloch, Oehlert, & Fries, 2002). This suggests that healthy ageing, or movement towards the compression of morbidity scenario, may be threatened by other lifestyle choices affecting health status. Hubert et al. (2002) demonstrated in his research the disability burden can be significantly reduced by positive health status. The US demonstrates recent increasing trends in lifestyle illnesses, such as obesity, which result in functional decline, particularly later in life. Consequently, unless dramatic movements towards low-risk health habits are undertaken, movement towards a healthy ageing paradigm may be threatened (Dormont, Martins, Pelgrin, & Suhrcke, 2007).

Aotearoa-NZ statistics reveal adult obesity levels have increased by 50 percent from 1977 to 2003 and Aotearoa-NZ is now one of ten OECD countries where over fifty percent of adults are overweight (Ministry of Health, 2007a). It is forecast that adult obesity will increase from 17 percent in 1996 to 29 percent by 2011 (Ministry of Health, 2002b). Furthermore, despite consumption declines since 2002 (except 2005 which demonstrated a five percent increase), cigarette smoking rates are still high; approximately 27 percent of the adult population (15 years and over) smoked in 2006 (Ministry of Health, 2007a). As these people reach old age, it is probable such smoking rates will negatively affect their health status (Cornwall & Davey, 2004). Combined with population ageing, high rates of obesity, physical inactivity and smoking may increase future disability rates and demand for disability support services (Cornwall & Davey, 2004). If Aotearoa-NZ wants to move in the direction of 'healthy ageing' or 'compression of morbidity' scenarios, it is likely promotion of healthy lifestyle choices to improve health status will be required. Regardless of the reason for increasing health expenditure or whether a compression of morbidity scenario occurs, the future proportion of older people will increase. Therefore, it is inevitable the demand and cost for health and disability services will significantly rise (Cox, Hope, & Davies, 2004; Ministry of Health, 2004c).

As the world population continues to age, it is essential we understand older people's needs and requirements, and that suitable adjustments are made in response to the

changing age structures (Kinsella & Velkoff, 2001). Decisions in relation to providing older people with choices and timely access to high-quality health care services are imperative for future ageing populations (Jacobzone, 2000). How do we meet those needs, providing older people with choices, in a financially challenging environment?

2.6 Meeting the health needs of an ageing population

In general there is a pattern of increasing health care expenditure with age. Therefore, the envisaged Aotearoa-NZ population structure changes will place further pressure on health care demand and cost (Organisation for Economic Co-operation and Development, 2006; Vos, Goss, Begg, & Mann, 2007). A comparison of OECD nations examined age profiles of health expenditure and found, on average, per capita health expenditure for the older age group (65+ years) was three to five times that for the 15 to 64 age group (Moise & Jacobzone, 2003). Aotearoa-NZ statistics reveal similar results; data from 2001-02 showed a strong exponential relationship between per capita health expenditure and age. For the 65 to 69 age group, spending was almost double the all-age average, and for the 85+ age group nearly eight times the all-age average (Ministry of Health, 2004c).

An ageing population affects health care expenditure and Gross Domestic Product (GDP). This occurs due to the declining proportion of those at 'working age', creating downward pressure on economic output (Ministry of Health, 2004c). In 2001, approximately nine percent of GDP was for overall health care expenditure in OECD countries; of this 40 to 50 percent was for the 65+ age group (Oxley & Jacobzone, 2001). Between 2005 and 2050, OECD nation's average expenditure on public health and long-term care as a share of GDP may nearly double, rising from six to seven percent to approximately ten percent (Organisation for Economic Co-operation and Development, 2006). OECD 2003 statistics reveal a positive relationship between GDP and health expenditure; the larger a nation's GDP per capita, the higher its health care expenditure. Comparably, Aotearoa-NZ demonstrates unsurprising health care expenditure based on its level of GDP. It is predicted, as Aotearoa-NZ's economy continues to develop, health care spending per capita will expand in proportion (Ministry of Health, 2007b).

In 2004, Aotearoa-NZ spent 8.5 percent of total GDP on health, slightly lower than the OECD weighted average of 8.7 percent (Ministry of Health, 2007b). Despite the positive correlation between rising age and health spending, some international literature suggests age itself may not be the main determinant of increasing demand for health care and health expenditure (Bryant, Sonerson, Tobias, Cheung, & McHugh, 2005). It has been proposed that prevalence of chronic illness, proximity to death (Ministry of Health, 2004c), health status and 'non-demographic' factors, such as technological advances, are significant drivers of health care demand and expenditure (Bryant, Sonerson, Tobias, Cheung, & McHugh, 2005; Vos, Goss, Begg, & Mann, 2007). The consequence of all of this is now impacting on Aotearoa-NZ hospital and community services significantly. Emergency Departments are in crisis overload, medical wards have high and complex case loads of older people, and the same acute demand is impacting on primary care and community services.

2.7 The Waikato response to ageing

In Aotearoa-NZ, health and disability support services comprise four key sections: public health services and programmes; mental health services; personal health services; and disability support services. Older people are high users of disability support services and personal health services. To access Aotearoa-NZ disability support services; a person with a disability must meet the MoH definition of disability; "a person who has a physical, intellectual, sensory, psychiatric or age-related disability, or a combination of these" (Ministry of Health 2003a, p. 45). In addition, the disability must be likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required (Ministry of Health, 2003a). Assessment is undertaken by a Needs Assessment Service Coordinator (NASC), who determines access to disability support services, identifying and prioritising all aspects of a person's care.

Disability support services are predominantly community based and delivered by private or not-for-profit providers (Ministry of Health, 2002a). In general, disability support services for older people can be categorised into five main service areas:

- Residential care - For older people and individuals with intellectual, physical or sensory disabilities. This includes rest home, continuing care hospitals, secure

facilities for people with dementia, and psychogeriatric care;

- AT&R Outreach service, usually hospital based. Involves assessment of potential for improving both physical and mental functional ability;
- Carer support - unpaid informal carers, for example, respite care;
- Environmental support equipment, home and vehicle modifications; and
- Home care services Provides personal care and household management - Commonly known as home-based support services in Aotearoa-NZ.

In 2003, funding of disability support services for older people was separated from disability support services for people with long-term disabilities (mostly under 65 years) and transferred to regional district health boards in Aotearoa-NZ. The purpose of this devolution was to strengthen the district health boards' ability to implement the Health of Older People strategy and develop a continuum of care, while promoting enhanced coordination and flexibility of services (Ministry of Health, 2004b). In 2001 to 2002, the key components of health expenditure for the older age group were disability support services and personal health services relating to the management of chronic diseases (Ministry of Health, 2004c). Furthermore, the prevalence of chronic disease and disability increased exponentially with age (Ministry of Health, 2004c). Statistics for 2002 and 03 revealed the 65+ age group were considerably more likely to have four or more chronic diseases than younger age groups (Ministry of Health, 2006b).

In 2001, over half (54%) of older people had a disability, compared with 25 percent of 45 to 64 year-olds and 12 percent of 15 to 44 year-olds (Statistics New Zealand, 2004). In 2023 1 in 4 New Zealanders have a have a physical, sensory, learning, mental health or other disability. Of this one in four 4, 35 percent are over 65 years old, this equates to 370,000 people (Office for Disability Issues, 2023). The prevalence of chronic illness and increased disability in older people can also be reflected by health care utilisation statistics (Cox, Hope, & Davies, 2004). Compared to younger age groups, in the last 12 months older people were significantly more likely to have seen a general practitioner (GP), received a higher number of prescriptions and been admitted to a public hospital, based on 2002-03 data (Ministry of Health, 2006b).

A number of older people require increased health and disability support, often during the last few years of their lives, due to chronic illness or disability. Consequently, with

rising age the costs of health services increase considerably (Ministry of Health, 2004c). Cornwall and Davey (2004) undertook an exploration into the impact of Aotearoa-NZ**'s** ageing population on demand for health services. They concluded, due to foreseen rising incidences of chronic illnesses, increased health care demand and expenditure can be expected in the future.

In 2019, TWO – Waikato developed following consultation "He Korowai Oranga o Ngā Kaumātua (A Cloak of Well-being for our Older People)" The model of care was straightforward and concerned the delivery of high quality, targeted anticipatory care with responsive urgent care delivered in the community, resulting in improved outcomes, reduced utilisation of resource constrained specialist services including acute inpatient beds and reduced rate of institutionalisation in Aged Residential Care facilities (ARC). The Model of Care proposed that as a consequence of the shift, older people and their families / whānau will be happier and population groups with complex needs will be better served. Further, the associated increase in productivity will increase job satisfaction of workers across health, social and disability services, increasing staff retention and capability. This integrated model of care was not a new concept and is well articulated across multiple government policy documents (Ryall, 2007). However, progress in achieving the desired changes has been frustratingly slow with progress hampered by other government legislated changes such as pay equity legislation. Achieved correctly this will bring demonstrable results over the next three years and beyond. Measurable changes for clients can be achieved starting in 2020, building through 2025 and with substantial effect from 2022 onward. The focus of He Korowai Oranga o Ngā Kaumātua was on completing the implementation of high quality, flexible community rehabilitation and support services that will fully realise the value equation that can be driven from further development of community-based services, but it is acknowledged that this cannot be fully achieved without the other development outlined.

2.7.1 Inpatient services

Internationally, there is evidence to support the use of specialised inpatient units for older people. One randomised control trial comprised 1,388 hospitalised older people who received care from either an inpatient geriatric unit (intervention) or usual

inpatient care (control) (Cohen et al., 2002). Results showed no difference in mortality, but significantly improved physical function, bodily pain, energy, general health and ADL scores were found within the intervention group compared to the control group. Positive results were found in another randomised controlled trial of 545 older people admitted to a geriatric hospital (Nikolaus et al., 2003). Patients who received a comprehensive geriatric assessment (CGA) coupled with post discharge home intervention demonstrated improved functional capabilities, a significant reduction in length of hospital stay, nursing home placement and hospital readmissions, and direct costs were lower. Similarly, a focused literature review concluded for inpatient geriatric assessment units there was no evidence of lower mortality compared to usual care (Parker et al., 2000). Significant improvement in destination at discharge was noted and inpatient readmission rates may also be reduced. Other trials have investigated health outcomes for older orthopaedic patients receiving specialised inpatient care. A Cochrane review of nine randomised or quasi-randomised trials involving 1,887 patients explored coordinated multi-disciplinary inpatient rehabilitation compared with usual (orthopaedic) care for older people post hip fracture (Cameron, Handoll, Finnegan, Madhok, & Langhorne, 2003). Results were not statistically significant, although the reviewers found combined outcome measures (death, institutional care and functional decline) revealed a trend for improvement with the inpatient rehabilitation group. The reviewers warned results should be interpreted with caution due to heterogeneity.

However, a randomised controlled trial of 279 hip fracture older people (70+ years) compared post-operative interdisciplinary care or usual inpatient care, concluding no significant difference in patient outcomes (Naglie et al., 2002). This finding indicated interdisciplinary post-operative care did not result in significantly improved outcomes for older people with a hip fracture, but the strength of this study was lower than others due to a smaller sample size. A recent small observational cohort study (n=108) evaluated the use of multi-disciplinary pre-operative CGA and post-operative follow-up intervention with elective orthopaedic older patients (Harari et al., 2007). Comparison of two cohorts (intervention versus usual care) revealed the intervention group had fewer post-operative medical complications and significant improvements in pressure sores, pain control, delayed mobilisation and inappropriate catheter use. In

addition, the intervention group had reduced length of stay, fewer delayed discharges related to medical complications, and shorter waiting time for occupational therapy assessment or equipment.

In Aotearoa-NZ, Assessment Treatment & Rehabilitation (AT&R) services are coordinated multi-disciplinary services tailored to meet the complex needs of older people or individuals with disabilities. The aim of these services is to restore functional ability and maximise independent living potential. The services are predominantly provided at specialised inpatient hospital units, but can also be day hospital, outpatient or community based (Ministry of Health, 2003ab). A prospective Aotearoa-NZ study explored older people (60 to 98 years) admitted to an AT&R ward for rehabilitation (n=200) (Wilkinson, Buhrkuhl, & Sainsbury, 1997). The authors found rehabilitation of older people is unpredictable and diverse, with 86 percent experiencing active medical conditions during their rehabilitation. This confirmed the importance of geriatric medical input during inpatient rehabilitation, particularly as older people are more likely to develop a complication when already unwell.

Hospital-based AT&R services are almost solely utilised by people aged 65 and over; 89 percent of the total AT&R discharges in 2002-03 were for older people. AT&R activity on per capita expenditure, and discharge rates both increase markedly with age. In 2000-01, AT&R hospitalisation rates for people 85+ years was over double the rate for 75- to 84-year-olds, and almost seven times the rate of those aged 65 to 74 years. Based on current per capita discharge rates, combined with an ageing population, the number of AT&R admissions for older people is predicted to rise significantly, from 17,954 discharges in 2002-03 to 30,033 discharges in 2020-21. In particular, the 85+ age group is forecast to increase considerably over this period to 37 percent of total AT&R discharges by 2020-21 (Ministry of Health, 2002c, 2004a).

Older people are also high users of inpatient medical and surgical services, with comparable current patterns of utilisation and substantial increases projected. Hospitalisation rates increase with age and are much higher compared to younger age groups. From age 50, per capita expenditure for hospital admissions increases linearly with age. This is partially due to increased admissions correlating with rising age,

combined with more complex conditions causing lengthened stay in hospital, higher treatment costs and increased complex surgical treatments. In 2000-01, older people accounted for 32 percent of medical and surgical admissions (excluding outpatient and maternity services). In addition, 40 percent of the total medical / surgical expenditure was for older people.

A study analysing Aotearoa-NZ hospital trends from 1989 to 2006 revealed total discharge rates have been constantly increasing (Malcolm, 2007). More specifically, the number of hospital discharges has been increasing significantly for older people (Ministry of Health, 2004a). Data on the number of discharges between 1996-97 and 2000-01 reveals the average rate of growth was 4.3 percent per annum for older people, compared with 3.2 percent for those less than 65 years. As with AT&R discharges, the highest rate of growth is for the 85+ age group. If current medical / surgical discharge rates continue, it is predicted by 2020-2021, nearly 50 percent of total inpatient discharges will be for older people and almost ten percent for the 85+ age group (Ministry of Health, 2002c, 2004a).

Although evidence demonstrates the benefits of specialised inpatient units for older people, future projections of AT&R and hospital discharge rates indicate sustainability may be an issue. As issues of sustainability and rising hospital expenditure surface, alternatives to acute inpatient care are increasingly being investigated (Wainwright, 2003). A number of intermediate care schemes, many utilising home-based services, operate as an interface between hospital and community services. Moving away from traditional inpatient care is not only necessary due to financial constraints, but may even be more beneficial for our older population,

2.7.2 Intermediate care

In the UK, the National Service Framework for Older People (Department of Health, 2001) proposed development of intermediate care beds in the hope of reducing older people 'blocking' acute hospital beds. Intermediate care is an emerging concept with varying definitions (Melis, Olde Rikkert, Parker, & van Eijken, 2004). The British Geriatrics Society (2008, p. 1) supports the Department of Health definition, which states intermediate care are: "(i) Services targeted at people who would otherwise face

unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care, or continuing NHS inpatient care; (ii) Services provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment and opportunity for recovery; (iii) Services which have a planned outcome of maximising independence and typically enabling patients / users to resume living at home; (iv) Services which are time-limited, normally no longer than six weeks, and frequently as little as one to two weeks or less; and (v) Services which involve cross-professional working, with a single assessment framework, single professional records and shared protocols". The two key aims of intermediate care are to provide an alternative to hospital admission and to offer early supported discharges for selected patients. For all health care systems, hospital bed utilisation is a costly resource. In order to reduce bed days and contain health expenditure, it appears a key focus is on reducing hospital admissions (Malcolm, 2007).

Prevention of frail older people being discharged from acute inpatient services directly to long-term care is expected with improved availability and accessibility of intermediate care. Examples of intermediate care schemes include rapid response teams, rehabilitation, hospital at home and early supported discharge (British Geriatrics Society, 2008). Hospital admission can lead to extended stays due to complications, disrupt community support arrangements making discharge home difficult, and may be an immediate precursor to death. Whilst acknowledging this, Grimley and Tallis (2001) argued avoiding hospital admissions may result in a number of older people missing out on the full range of necessary inpatient treatment which could improve clinical outcomes (Grimley & Tallis, 2001; Parker et al., 2000). Grimley and Tallis (2001) raised concerns older people may be sent directly to intermediate care, evading essential skilled diagnostic evaluation, which is pertinent due to the complexities of old age. In addition, intermediate care was criticised for not working in the past, and the requirement for valuable resources to be allocated to specialist inpatient geriatric rehabilitative units was emphasised. Similarly, others state alternatives to hospital care could be positive, although drawbacks include older people being deprived of the full variety of investigations and professional opinions with potential for missed diagnosis

and substandard care. Despite potential cost benefits, it is essential provision of care at home is not of lesser quality (Corrado, 2001; Mulley, 2001).

Nevertheless, due to the combined effects of an ageing population, rising health care demand and expenditure, and a shift from acute illness to management of chronic conditions, alternatives to inpatient care are essential. Sainsbury and Wilkinson (2002) emphasise, particularly in Aotearoa-NZ, that rigorous evaluation of alternative programmes for older people is urgent, where 'before and after' research is inadequate and randomised control trials are required. Furthermore, they state it is irresponsible and unethical to implement new schemes based on assumptions of improvement or the belief it may be a cheaper option. Whilst transitional care options reduce the "hospitalisation" of an older person, are there options delivering care at home that would add more value?

2.7.3 Rapid response teams

Rapid response teams aim to prevent avoidable acute hospital admission through provision of rapid assessment for individuals and necessary organisation of community based services. These schemes are relatively new and primarily based in emergency departments or primary health care (Ministry of Health, 2004a). Aminzadeh and Dalziel (2002) undertook a review of older people's use of emergency departments, and found five studies which involved comprehensive geriatric screening of older emergency patients. Findings from these studies revealed increased detection of geriatric syndromes and other missed diagnoses, increased community referrals and avoidance of hospital admission. Although only one of these studies was a RCT. Similarly, a Canadian study examined a quick response service based in three acute care hospital emergency departments which aimed to facilitate rapid access to intensive home-based services and prevent inpatient admission for older people (n=96) (Brazil, Bolton, Ulrichsen, & Knott, 1998). Results revealed that 66 percent of those admitted to the programme were 'averted hospital admissions'. Patients and informal carers found the service beneficial, but no cost savings were determined. An evaluation of the cost-effectiveness of home care included a sub-study of a quick response programme (Hollander & Chappell, 2002). The quick response programme assessed

older people in the emergency department and arranged appropriate community services to avoid hospital admission. Results showed in the quick response programme the average cost of providing community care for patients was less than the cost of being admitted to hospital. The authors commented unless the hospital beds were closed, which would be unusual, then a quick response programme would be an additional cost, thus highlighting the focus was on addressing capacity issues rather than reducing bed numbers.

2.7.4 Rehabilitation at home

Rehabilitation at home aims to provide a home-based alternative to inpatient hospital rehabilitation. Studies largely report on services for a specific patient diagnosis, principally stroke, fractured neck of femur, or pulmonary disease. Rehabilitation at home may be combined with early supported discharge programmes to reduce the length of hospital stay and prevent readmission (Wainwright, 2003).

A Cochrane systematic review of 11 RCT investigated early supported discharge schemes, which incorporated rehabilitation care at home compared with conventional inpatient rehabilitation services for acute stroke patients (Early Supported Discharge Trialists, 2005). The review revealed length of hospital stay was significantly reduced for the early supported discharge rehabilitation group. Patients receiving the intervention were more likely to be living at home independently six months post-stroke, score higher on extended ADL (EADL) scores, and report satisfaction when compared with conventional services. The reviewers concluded results were based on a small number of trials and the cost benefit was uncertain. A similar review identified 14 RCTs involving rehabilitation at home for stroke patients compared with conventional or no care (Outpatient Service Trialists, 2005). Findings revealed home-based rehabilitation reduced the odds of death or deterioration in ability to perform ADL and patients' personal ADL and EADL performance increased.

An earlier review by Britton and Andersson (2000) identified seven controlled studies of home-based rehabilitation for stroke patients compared to conventional inpatient, outpatient or day care. Results differed from above as no significant differences in patient outcomes were found and home rehabilitation was less expensive than regular

day care, but more costly than inpatient treatment. Only four trials assessed cost. In contrast, a systematic review of evaluative studies for older people reported home-based rehabilitation was more costly than outpatient rehabilitation, but less expensive than inpatient or day hospital rehabilitation (Parker et al., 2000). Similar to the review by Britton and Andersson, conclusions regarding cost were tentative due to limited evidence.

A systematic review and meta-analysis of 15 rehabilitation programmes for home-based older people revealed significant reduction in mortality and admission to institutional care (Elkan et al., 2001). No significant effect on hospital admissions, health status or ADL was found. Of note, this study included only a small number of trials in the analysis. Contrasting evidence was found in a RCT of 188 physically frail home-based older people (75+ years) comparing an at home rehabilitation programme (intervention) with an educational programme (control) (Gill et al., 2002). Results showed moderately frail participants in the intervention group had reduced functional decline over time compared to the control group. No significant difference between groups was found regarding admissions to institutional care.

A recent trial evaluated a targeted early rehabilitation at home scheme for patients recovering from a total hip replacement (THR n=220) or total knee replacement (TKR, n=174) (Iyengar, Nadkarni, Ivanovic, & Mahale, 2007). The rehabilitation scheme resulted in shortened length of hospital stay without increased complications. Despite patients recovering from a TKR requiring a considerably higher number of visits by the rehabilitation team, the overall costs were significantly reduced without an increase in hospital readmission rates.

There are now several successful rehabilitation at home models in New Zealand. Most notably Te Whatu Ora Waikato's START service – Supported Transfer and Accelerated Rehabilitation Team. These services deliver care on the patient's terms, in an environment that makes sense to them – their own home, and realise goals that are practical. It is a shift though for the health professionals involved in delivering the care, so in the context of this study, how do we ensure that the health professionals involved in the service delivery identify this model as successful?

2.7.5 Hospital at home

Hospital at home services provide treatment by health professionals in a patient's home for a limited time when hospital inpatient care would otherwise be necessary. These services are usually provided as hospital diversion, which involves reducing or preventing inpatient admission, or as an early supported discharge service to reduce the length of inpatient hospital stay (Shepperd & Iliffe, 2008). Hospital diversion can also be coupled with rapid response teams based in emergency departments or primary health care (Ministry of Health, 2004a).

Corrado (2001) undertook a review of available literature which revealed a number of descriptive observational studies, but few randomised controlled trials, comparing inpatient hospital care with hospital at home schemes. There was mounting evidence to support hospital at home programmes as an effective alternative to standard hospital care, with acceptable patient outcomes or no differences between treatment and control groups, but cost-effectiveness results were conflicting. A more recent review of randomised trials comparing hospital at home care with acute hospital inpatient care for adults (18 years and over) identified 22 studies (Shepperd & Iliffe, 2008). Overall, the authors concluded for hospital at home patients, when compared with inpatient hospital care there was no significant difference in health outcomes; there was some evidence of improved patient satisfaction; length of hospital stay and readmission rates may be reduced. Additionally, findings revealed overall length of care can increase and caregiver burden may be raised. In corroboration with Corrado, cost-effectiveness was unclear. Of note, the low number of patients admitted to hospital at home schemes meant these trials were small; hence meta-analysis did not detect a difference in health outcomes or hospital readmission. Although this could indicate there simply was no difference, suggesting hospital at home is a viable and safe alternative for older people.

A recent prospective randomised controlled trial examined hospital at home care versus inpatient care for older people with acute COPD (Aimonino et al., 2008). Hospital at home care demonstrated significant reduction in the risk of inpatient readmission at six months, improved quality of life and reduced health care costs. Leff et al. (2005) found similar results; compared to inpatient hospital care, the average cost

was lower for hospital at home care. In addition, hospital at home treatment resulted in a shorter length of stay, but there was limited evidence for reduced complications. In Aotearoa-NZ, a randomised trial of 285 older people comparing a hospital at home programme to inpatient hospital care found as with many other studies, there were no significant differences in health outcomes and the hospital at home group reported higher satisfaction (Harris, Ashton, Broad, Connolly, & Richmond, 2005).

However, in contrast to Aimonio et al. (2008) and Leff et al. (2005), cost was significantly greater when compared to usual hospital care. The authors stated the hospital at home programme was not operating at full capacity, which would explain why the cost was greater. Interestingly if the programme was operating at full capacity, there may have been potential for reduced patient satisfaction.

Other studies have explored the impact hospital at home schemes have on informal carers. A moderately sized prospective non-randomised clinical trial compared hospital at home as an alternative to inpatient care for home-based older people requiring treatment for pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease (COPD) or cellulitis. Results showed hospital at home programmes resulted in reduced stress for family members, and the burden of care did not appear to shift from hospital staff to family members (Leff et al., 2008).

In agreement, a randomised control trial compared hospital at home patients with hospital care, and investigated carer satisfaction. Results showed carers in the hospital at home group did not report greater burden (Wilson, Wynn, & Parker, 2002). Both Leff et al. and Wilson et al. also found patients and family members reported greater satisfaction for hospital at home care when compared with traditional hospital care.

The use of technology can further support these approaches. Currently there are a number of trials in New Zealand that look at remote monitoring devices. These cover conditions such as Cardiology, Renal patients and COPD. Nearly all of the cohorts involved are elderly. How will technology support programmes like this moving forward? It will be important that the technology is easy for the consumer to use, and it adds value to the programme by supporting care.

2.7.6 Early supported discharge

Early supported discharge schemes provide community based services for people leaving hospital who require care which would otherwise prolong their length of stay. In general, the services are short-term, require less specialist input than hospital at home schemes, but are more intensive than usual home care. Interventions are often both hospital and home-based (Ministry of Health, 2004a; Wainwright, 2003). A number of previous studies have incorporated early supported discharge schemes; this section will present more specific trials of early supported discharge and supported discharge programmes. A systematic review assessed supported discharge post-hospitalisation for older people compared with usual support, identifying nine randomised or quasi-RCT studies published up to the end of 1997 (Hyde, Robert, & Sinclair, 2000). The authors stated these studies were not bias free and results should be interpreted with caution. The review deduced with 'relative certainty' that supported discharge increased the proportion of people at home, may result in reduced admissions to institutional care, and did not affect mortality six to 12 months post-admission. However, the overall effectiveness of supported discharge was uncertain due to inconclusive evidence regarding hospital admissions, function status, patient and carer satisfaction.

An earlier systematic review from 1981 to 1994 of people with chronic conditions and frail older people identified 17 controlled trials (Bours, Ketelaars, Frederiks, Abu-Saad, & Wouters, 1998). Similarly, the majority of these studies were of poor methodological design and results did not demonstrate any clear benefits in favour of supported discharge post-hospitalisation. There was limited evidence supporting cost benefit and improved quality of care. In contrast, a systematic review of evaluative research reported early supported discharge schemes do not disadvantage older people in relation to mortality or hospital readmission, while costs do not appear to increase and may be reduced (Parker et al., 2000). Furthermore, benefit may exist with the number of older people returning home and remaining there.

Other trials have reported more conclusive evidence, particularly regarding the cost of supported discharge schemes. Lim, Lambert, and Gray (2003) undertook a prospective

multi-centre RCT evaluating a supported discharge scheme involving coordinated community services through a Post-Acute Care (PAC) programme for older people discharged from hospital (intervention) compared with usual discharge planning (control).

Between the PAC and control groups no difference in mortality or unplanned readmissions was found. At one month follow-up, patients in the PAC group demonstrated significantly higher quality of life scores and utilised significantly less hospital bed days over the six months post-discharge. Furthermore, total costs, including hospital care, community services and the PAC programme, were lower in the PAC than the control group. A recent study examined early supported discharge by reviewing hospital admissions due to exacerbations of COPD over a one year period (Ringbaek, Nielsen, Admasu, & Lange, 2008). The authors were unable to determine whether this scheme reduced the length of time in hospital, although income and costs related to early supported discharge appeared to balance.

As referenced earlier, Te Whatu Ora Waikato's START model is seen as an exemplar. The service halves readmission rates at 90 days and reduces the length of time an older person spends in hospital by 40 percent over the course of a year. The Ministry of Health in New Zealand have challenged other regions to deliver similar supported discharge models.

2.7.7 Aged residential care

Internationally, there are various terms for residential care. In the UK, NZ 'rest home' level care is not provided in an institutional setting. Residential care is often referred to as 'care homes', 'residential care homes' or 'nursing homes'. These establishments provide support for people with very high needs. The Care Standards Act (United Kingdom Parliament, 2000, p. 2) defines a care home as *"an establishment providing accommodation, together with nursing or personal care, for persons who are or have been ill, dependent on alcohol or drugs, have or have had a mental disorder, or are disabled"*. In addition, an establishment is not deemed a care home if it is a hospital, independent clinic or children's home.

In the US, a residential care facility is commonly termed a 'nursing home'. The US National Institute on Aging describes a nursing home as a place providing 24-hour care for people who can't manage at home, but do not require inpatient hospital care. Delivery of care in nursing homes varies. A number are similar to hospitals and provide medical care, physical, speech and occupational therapy; others aim to be more 'like home' with no fixed daily schedule. Some nursing homes have special care units for people with dementia (US National Library of Medicine & National Institutes of Health, 2008c). The US also has assisted living facilities for older people with low to moderate needs. The Assisted Living Federation of America defines assisted living as: "a special combination of housing, personalised supportive services, and health care designed to respond to the individual needs of those who require help with activities of daily living. Assisted living care promotes maximum independence and dignity while encouraging the involvement of a resident's family, neighbours, and friends" (Gorshe, 2000, p. 20).

Inhabitants usually have their own units or apartment, but more services are offered than in a retirement facility (Gorshe, 2000). These facilities provide support for people who do not require the intensive nursing home level of care, but need assistance with activities such as dressing, personal cares, toileting or eating (US National Library of Medicine & National Institutes of Health, 2008a).

A number of studies have reported negative outcomes associated with residential care. One study of residents in a nursing home (n=158) found over 30 percent reported a decline in physical activity since admission (Ruuskanen & Parkatti, 1994). This was especially pertinent for elderly women, as physical activity in older women was associated with higher contentment and fewer depressive symptoms, indicating the importance of physical activity to mental wellbeing. A longitudinal study of older people admitted to nursing homes found the probability of dying was 2.74 times greater compared to those who remained in the community (Wolinsky, Callahan, Fitzgerald, & Johnson, 1992). Aotearoa-NZ statistics from 1999-2000 revealed 20 percent of people admitted to residential care survived less than three months, and 40 percent survived less than 12 months (Ministry of Health, 2002c).

Residential care has also appears to increase the risk of falls compared with community dwelling older people. Falls cause substantial morbidity, immobility and mortality, particularly for older people living in nursing homes. Consequently, due to the high incidence of recurrent falls in residential care, there is greater probability of a resulting injury (Rubenstein, Josephson, & Robbins, 1994). An Aotearoa-NZ study found older people living in residential care were almost four times more likely to sustain a hip fracture compared to home-based older people (Norton et al., 1999). A prospective study over six years identified key determinants for older people entering residential care (Branch & Jette, 1982). Five variables were significantly related to institutionalisation, including advancing age, use of ambulatory aids, living alone, mental disorientation, and assistance to perform IADL. In recent years, both the US and UK have shown residential care occupancy rates for older people have been falling (Department of Health, 2002; Lakdawalla et al., 2003). However, it is forecast by 2020 there will be an increase in the prevalence of older people in nursing homes due to the rising prevalence of disability as younger cohorts reaching 65+ years (Bhattacharya et al., 2004; Lakdawalla et al., 2003). Stone (2000) concurs; due to the ageing population there will be a shift from acute hospital care, resulting in an increase in long-term residential care of older people. The United Nations also envisage an increased demand for long-term care as the proportion of older people rises and their health deteriorates with age (United Nations, 2007). Correspondingly, a recent study from the US discovered despite decreased demand, over the past 30 years residential care prices have increased at a higher rate than inflation (Stewart, Grabowski, & Lakdawalla, 2009). Moreover, growth in prices was expected to continue as the demand for residential care increases due to the baby boom cohort ageing.

Based on the ageing population and increased numbers of dependent older people (60+ years), an Australian study predicted an overall shortage of residential care from the year 2000. In particular, a shortfall of nursing home beds was probable for highly dependent older people, particularly between 2006 and 2016 (Gibson & Liu, 1996). Of note, predictions were based on current utilisation trends and the assumption that age and sex-specific levels of severe disability would not change significantly up to 2021. Similarly, in the UK, one study predicted the number of older people receiving long-term residential care would increase by approximately 65 percent between 1996

and 2031 (Wittenberg & Pickard, 2001). Forecasts assumed unchanged trends of care, stable relationship between utilisation of informal care, age, dependency levels and household composition. In addition, projections were very sensitive to assumed future dependency rates for older people. In contrast, Manton (2003) believes nursing home utilisation will continue to decline, largely due to a reduction in the prevalence of severe cognitive impairment, which is a main driver of residential care.

Manton highlights studies which illustrate the rate of decline in severe cognitive impairment and suggests this will continue as a result of education, enhanced knowledge and improved interventions. Based on the ageing population, a UK study projected the number of older people in residential care homes or nursing homes would increase by approximately 23 percent between 2000 and 2020, with potential for demand to be greater than supply (Department of Health, 2002). These forecasts were extremely sensitive to the interaction between home care services and residential care. Further analysis revealed if care shifted to greater home care utilisation, the projected demand for residential beds would approximately halve. This observation is particularly pertinent to the present study which is seeking to evaluate the impact of a new home care service.

In Aotearoa-NZ, approximately six percent of older people move into residential care and the probability increases with age. In 2001, 1.8 percent aged 65 to 74 lived in residential care, compared with 5.9 percent for the 75 to 84 age group and 27 percent of the 85+ age group. Despite the small percentage of older people in residential care, in 2002-03 more than 50 percent of disability support service expenditure went to this area. In line with other developed countries, Aotearoa-NZ's ageing population is increasing the demand for residential care and there are concerns demand will outgrow supply. Bed day utilisation for residential care from 1996-97 and 2003-04 revealed rest home care remained relatively constant, while secure dementia facility and especially continuing-care hospital bed days increased at a steady rate.

Residential care expenditure shows a similar pattern; continuing-care hospital expenditure demonstrated the greatest growth of 25 percent between 1996-97 and 2002-03, while rest home expenditure remained relatively constant over this period

and secure dementia facility expenditure increased 11 percent from 2001-02 to 2002-03. These trends of utilisation may reflect postponed entry to residential care and consequent increased levels of disability or frailty (Ministry of Health, 2003a, 2004b). Due to the negative outcomes associated with residential care, the ageing population and increasing numbers of older people, viable alternatives are essential (Hockenstad, 2005). Consequently, home care services are increasingly being examined to support the long-term care needs of older people. Aged residential care serves a purpose, despite the negative outcomes we see in some studies, the question has to be how can we incorporate the purposeful use of aged residential care to successfully support short and long term outcomes for our older population, as part of a suite of options that make sure that consumers access the right care at the right time and in the right place?

2.7.8 Home and community care services

A systematic review, identifying 26 studies, examined the definition of home care (Thome, Dykes, & Hallberg, 2003). The reviewers found home care aims to improve quality of life, increase functional ability and/or maintain independence, allowing the person to remain at home. Through assessment, support is determined by the patient's needs, and hospital care is minimised by assisting the individual at their home. Globally, home care services are commonly termed 'home care'. A report prepared for the WHO defined home care as: "the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximal level of comfort, function and health including care toward a dignified death. Home care services can be classified into preventive / promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories" (Havens, 1999b, p. ix). In the UK, home care services are often referred to as home care or domiciliary care agencies defined by the UK Care Standards (United Kingdom Parliament, 2000, p. 2) as: "an undertaking which consists of or includes arranging the provision of personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance".

In the US, home care services are often referred to as home care or personal assistance services (Kaye, Chapman, Newcomer, & Harrington, 2006). In Aotearoa-NZ, home care services provide personal care and household management to promote and

maintain the independence of older people living at home (Ministry of Health, 2003a). A number of the intermediate care studies described in this section have incorporated home care services. There is limited evidence of home care without specific mention of programmes such as rapid response teams, rehabilitation, hospital at home, or supported discharge. A few more general trials of home care are explored here.

Some studies have revealed home care services demonstrate no health outcome benefits or may result in negative effects. A review of acute home care for adult patients with hip fracture, hip replacement, chronic obstructive respiratory disease (CORD), hysterectomy or knee replacement identified four studies which met their inclusion criteria (Soderstrom, Tousignant, & Kaufman, 1999). No differences were found for patient or caregiver health outcomes when comparing home care with hospital care. Home care revealed overall cost savings for hip fracture patients, but was more expensive for hip and knee replacements.

A synthesis of long-term care studies for older people showed 17 of 32 (53 percent) studies reported that paid help increased the likelihood of entering residential care (Miller & Weissert, 2000). In addition, ten of 15 (67 %) studies indicated that paid help may increase the risk of mortality. However, this study was critiqued as many of the reviewed trials were limited in study design, sample size and length of follow-up (Albert, Simone, Brassard, Stern, & Mayeux, 2005).

Despite results of these two studies, a number of trials have found positive outcomes associated with home care services. A meta-analysis of 20 home care trials, including skilled home care models, home health aide programmes and hospice programmes, found a significant reduction in hospital days due to home care (Hughes et al., 1997). However, effect sizes were small to moderate and results were based on few trials. A more recent prospective study investigated adequate home care and hospital readmission of older people with congestive heart failure (n=253) (Proctor, Morrow-Howell, Li, & Dore, 2000). Adequate home care was determined by patient-perceived adequacy of formal and informal assistance. Findings revealed older people with adequate home care experienced significantly reduced rates of hospital readmission.

Given the findings were based on patient-perceived responses results from this trial may have been strongly related to self-efficacy.

A US study (n=288) explored a home care program providing personal care and housekeeping assistance, as well as regular nursing assessments for older people (Albert, Simone, Brassard, Stern, & Mayeux, 2005). For older people with ADL disability, use of the home care program was associated with a significantly reduced risk of death. This indicated a supportive home care service for vulnerable older people can reduce mortality risk. The authors proposed these findings may be due to older people who receive home care undertaking greater utilisation of medical services and specific features of home care which may reduce the likelihood of health problems. In addition, survival benefit appeared to be linked with program participation rather than additional hours, suggesting the attributees within the program rather than delivery of additional formal hours are beneficial.

A study in Italy (n=252) investigated a home health care programme offering integrated, flexible and client-centred services for frail older people (Di Gioacchino et al., 2004). Assessments were undertaken at baseline and at one year. Findings revealed the home care programme prevented deterioration of cognitive performance and functional ADL and EADL performance. Substantial improvements in mood disorders were also found.

So, given the challenges of an ageing population and finite resources, how can it be determined that the services being delivered are of a high quality and deliver a good return on the investment?

Part 2 How do we know we're doing a good job?

2.8 Introduction

Whilst health care needs to meet the needs of its population, service delivery is often driven by the skillset and the desire of the clinicians and individuals within a service. Traditional services are often developed to meet the needs of the health professional, an environment that they are comfortable with, reasonable working hours and services delivered in a prescriptive manner. Given the focus on meeting the needs of the provider, how can the needs of the consumer be met?

2.9 The challenge of meeting demand whilst delivering a quality service

Improving the ability of health and welfare systems to respond to the needs of older people is among the greatest challenges of our time. In 2019, it is estimated that there are over 0.6 million people over the age of 65 in Aotearoa-NZ, which will increase to 1.4 million by 2050. Of more significance however, is the almost fourfold increase in those people over 75 years over the same period. Advancing age is associated with decline in physiological reserve and physical functioning and a higher risk of disability and dependency. Consequently, 75+ year olds utilise three times the health care resources of other age groups and the impact of this increasing age group is anticipated to have a considerable impact on health and disability resources. Old age is associated with an increase in long-term conditions with over two thirds of people over 75 years reporting three or more long-term conditions. The confluence of an ageing society and associated increase in non-communicative diseases is, and, will continue to place pressure on primary, secondary and tertiary health services.

Te Whatu Ora Waikato, like all services and providers is faced with this challenge of meeting the need of a growing older population, making up a greater proportion of our population. With this comes greater numbers and greater complexity. This means service have to prioritise interventions. In order to meet this demand, complexity has to be targeted. Traditionally NASC activity was prescriptive all patients treated the same way. Of the more than 9,000 patients in the Waikato, all were assessed at on admission, reviewed annually with a reassessment at 3-years. The greater complexity

numbers means that a 'case-mix' methodology is now being applied to categorise patients. This results in patients identified as more complex are seen more frequently and older patients who are cognitively well and less complex seen less frequently but encouraged to contact services if they are experiencing difficulties. This approach could be seen as make the best use of the resource available to us. It could of course be viewed as reducing some service and support to the less complex in our population and as a result compromising care. How we manage expectations is the challenge here, how does a service manage the expectations of an older population who may have some supports reduced, who at the same time see others having their services increased? How does a service ensure and monitor those with service reduction and how do we ensure they continue to have good quality outcomes?

2.10 The challenge of developing a high performing quality restorative service

As discussed, developing services must contend with meeting an increasing demand, with ever strained resources as well as meeting the needs of the individual. Compounding this challenge is the fact that it has been shown is that older people want a sense of control (Netten, Ryan et al. 2002), so a restorative model such as Te Whatu Ora Waikato's shift from a dependency model and aims to put older people in control of their own plan of care, increases that challenge, however if done well it is identified that restorative home care is associated with an increased likelihood of staying at home, improved self-care, reduced likelihood of visiting emergency care, improved mobility, and better coordination of care (Parsons, Anderson et al. 2005; Resnick, Simpson et al. 2006).

2.11 Approaches to evaluating health services

Choosing a method to evaluate the effectiveness of a health programme must be directed by the perspective(s) guiding the evaluation (Aday, Begley et al. 1998). Choosing criteria for assessing the effectiveness of a health programme requires a value judgement about whether a population or a clinical perspective is guiding the evaluation. The population perspective considers the role of physical, social, and economic environments on the health of a population. The clinical perspective focuses

on the interactions of clients and health practitioners in the health care system and the resulting clinical improvements or health benefits achieved by the clients.

Any redesign of services must result in better outcomes that are measured in balanced ways and provide better value and enhanced involvement for the workforce. Service improvement must also acknowledge that increasingly paid caregivers are involved in complex interactions with each other, the client, and the client's family, and that there is a need for better processes and systems of care to link them (Parsons, Dixon et al. 2004). Caregiving processes are under great tension; they were originally designed for a different set of interactions and results, so that clients now often experience services that are neither respectful nor personal, and of a lower standard than is expected from other interactions in life where service is offered and received. The caregivers both paid and unpaid, and the client, all bring their own knowledge and values to the health or care problem. There has to be appreciation of the complex, living systems of interaction that effectively shape, constrain, and enable the daily life and work of clients, their families, and the health care providers. Otherwise, health professionals may see the system as something they need to beat or protect their client from rather than try to understand, redesign, change, and improve it (Batalden and Splaine 2002).

2.12 The triple and quadruple aim in health

Successful health care organisations improve the health of their population whilst simultaneously delivering high quality care, at optimised costs. A commonly used approach in health service development is the "triple aim" which considers the following three dimensions:

- Improving the patient experience (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Theoretically, this ensures we are meeting the needs of the individual in our care, meeting the needs of the community in an equitable way, and also delivering a return on the investment. When the Triple Aim Initiative was launched in 2007 by the Institute for Healthcare Improvement (IHI), it was viewed as a ground-breaking, patient-centric solution to improve the U.S. healthcare system by simultaneously

aspiring to three "aims": improving patient experience of care, improving population health and reducing the per capita costs of care. The following example of the triple aim includes reference to Te Whatu Ora Waikato's model of care which is relevant to this study.

Figure 1: The triple aim

2.12.1 Enhanced patient experience

The first part of the Triple Aim framework focuses primarily on enhancing the patient experience within the healthcare system. There are many significant parts to improving patient experience, including:

- Ensuring patients are knowledgeable about their diagnosis and fully understand their condition. When clinicians and service providers take the time to talk to the patient, look them in the eye, speak to them in plain language, and show compassion, it improves patient satisfaction and therefore improves the overall patient experience. Improving health literacy in patients is also an important aspect in actively engaging a patient in their care plan, and improving patient outcomes, which in turn improves patient experience and satisfaction.
- Improving access to care in rural areas. When patients have ease of access to quality healthcare, especially telehealth solutions like hospital-in-home, and remote monitoring devices, it helps improve their patient experience. Improved access to care truly supports the Triple Aim as a whole, as it ultimately improves population outcomes and reduces per capita costs.
- Using team-based care to improve the patient experience. To further the

transition to value-based care models in the healthcare industry, team-based care focuses on engaging all members of a patient's healthcare team to work together, and to the extent of their education, certification, and specialties. This not only facilitates a deepened relationship between healthcare professionals but simultaneously improves patient satisfaction by promoting teamwork amongst providers.

2.12.2 Improved population health and patient outcomes

Improving population health is the second facet of the Triple Aim. By taking a population health approach, healthcare providers and organizations can improve patient outcomes for specific populations sharing the same or similar conditions, like diabetes, COPD, or CHF. There are several strategies for improving population health:

- Identifying risk factors. Certain modifiable risk factors are leading to many chronic diseases that span across all populations, including poor diet, tobacco use, alcohol use, and physical activity. Each of these risk factors contributes to specific health conditions, including obesity, liver disease, hyperglycemia, high triglyceride levels, and hypertension. Screening for and educating patients about these risk factors leads to improved population health by reducing said risk factors leading to chronic diseases.
- Transitioning from volume-based care to value-based care. The United States health system has traditionally been focused on volume over value. Providers have not been incentivized to consider how the astronomical cost of healthcare negatively impacts population health by limiting access to those with limited means or without access to affordable health insurance.
  Although the shift to value-based care has begun, the process is slow and quality, affordable healthcare is still not accessible to all patient populations. Telehealth and remote monitoring can be cost-effective ways to bridge the financial gap and provide value-based care to patient populations that previously lacked access.
- Focusing resources to promote overall health. It is common knowledge that people living in poverty or who are disadvantaged in some way have less access to healthcare, leading to poorer health than those with financial means and advantages. Focusing on these populations is crucial to improving overall population health, as that is where the need is greatest. By spending more resources on disease prevention and health promotion, patient outcomes can be drastically improved through the development of healthier communities.
- Segmenting patient populations. Populations can be naturally grouped by modifiable and non-modifiable risk factors like age, disease, condition, and lifestyle habits, as well as similarities like gender, demographics, behaviours, and social factors. By segmenting populations using risk stratification, providers can identify the precise services and care for each population segment.

2.12.3 Lower costs

This facet of the Triple Aim seeks to provide improved patient experience and outcomes while reducing the per capita cost of healthcare. The aim is to enhance the health of people so that they don't require visiting service providers more often. The Triple Aim attempts to reduce waste in healthcare while simultaneously increasing the value of care provided. To improve clinical care within the Triple Aim, healthcare professionals are required to work across patient populations and disciplines.

Specific care and payment models to help achieve the Triple Aim while reducing costs include:

- Building care coordination and management systems.
- Designing a care delivery model that is patient-centric.
- Incorporating social health determinants and behavioural health with physical health to deliver a complete model of care.
- Engaging both patients and the healthcare system with the necessary technology and information.

2.12.4 Quadruple aim

However, it is apparent to healthcare professionals that the Triple Aim had a very significant shortcoming – it didn't take them into account. Clinicians and service providers can experience burnout, which can then lead to the opposite effect of the original intention of the Triple Aim. With this current piece of work we are extending our view to a quadruple aim.

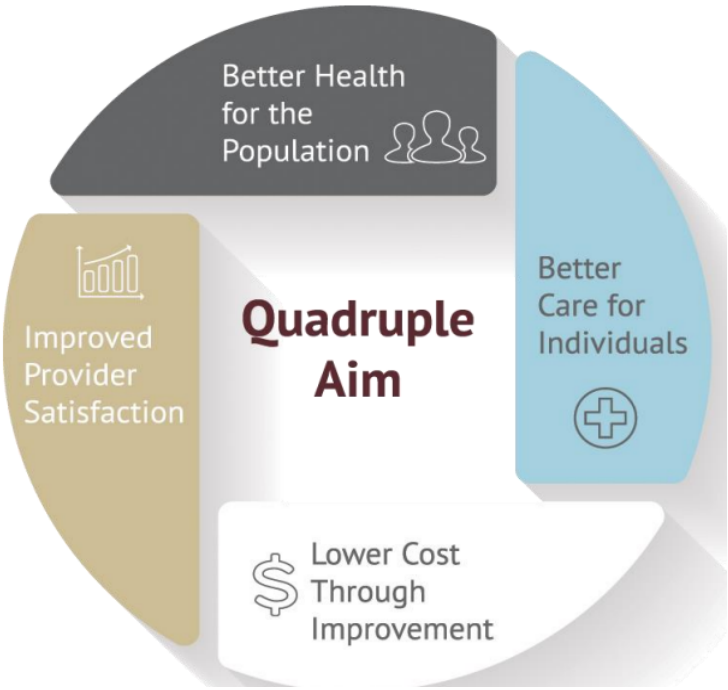

Figure 2: Quadruple aim – inclusive of provider satisfaction

In this example, the views of the provider, managers and executive leadership are also considered.

2.13 The balanced scorecard health – measuring performance

A more objective performance measure adopted by healthcare is that of a balanced scorecard. The balanced scorecard in health care simplifies performance management by identifying key indicators that are most important to each are of the business and focusing on areas in which data will have the greatest impact. A review of the use of the balanced scorecard approach within health (Zelman, Pink et al. 2003) found that it had been implemented in a number of types of health care organisations; for example, hospitals, hospital systems, University departments, long-term care services, national health care organisations, and the US Federal Government. Commonly, the data is assembled internally using a reporting framework and methods determined by the organisation. For the health care sector, comparability across organisations is important, with the relevant performance comparison being health care sector benchmarks. Therefore, the indicators have to be relevant to a large number of providers and thus tend to be more general, reflecting common services and

programmes. The data is assembled by a third-party using data from organisations that may or may not report data in the same manner, or use the same methods (Zelman, Pink et al. 2003).

It is a customer-based planning and process improvement system aimed at focusing and driving change by translating strategy into an integrated set of financial and non-financial measures that translate the strategy of the organisation to employees and provides those employees with actionable feedback on the attainment of objectives (Pineno 2002). The benefits from the use of balanced scorecards across a range of businesses have been summarised as promoting the active formulation and implementation of organisational strategies, thus making organisational strategies current and visible, improving communication within organisations, improving alignment among individual or divisional goals and the organisation's goals and strategies, aligning annual or short-term operating goals with long-term strategies, and aligning performance evaluation measures and strategies (Bailey, Chow et al. 1999). A strategy is a set of relationships that present hypotheses about cause and effect (Kaplan and Norton 2001).

2.14 Benchmarking

Benchmarking has been defined as: Evaluating and improving an organisation, its units or a network's performance, technology, process, competence, and/or strategy with a chosen geographical scope by learning from and/or with its own units, other organisations, or a network that is identified as having best practices in its respective field as a competitor, as operating in the same industry, cluster or sector or in the larger area within its geographical scope (Kyro 2003). Benchmarking, therefore, is a process to assist learning by identifying what works well and why. It is, in other words, part of a continuous quality improvement programme or performance management process (Kyro 2003).

Benchmarking is common practice across health regions in Aotearoa-NZ. Both formally though the Ministry of Health and informally between providers who are keen to gauge their performance with peers. Much of this benchmarking focusses on performance. For example, timeframes to contact a patient and whānau, timeframe to

carry out an assessment, timeframe to coordinate services and have services delivered to the client. Performance can be measured against some outcomes such as reducing emergency department presentations, but in the case of older people requiring support in the community the factors that influence outcomes are multiple. Stakeholders across Aotearoa-NZ are searching for an efficient and effective way to deliver restorative services.

2.15 Policy and contracting

All of this then informs how we contract and fund services. The quality of public services delivered by contractors depends largely on the quality of contract management provided by public managers (Van Slyke 2005). However, contract management for health service provision is difficult. Funders like a contract where a set number of interventions result in an expected outcome. When working with a population whose age range maybe 40+ years, with very varied issues and complexities, then identifying success and a return on an investment is hard to define.

2.16 Change management informing service development

The extent to which health services need to change to meet growing demand should not be underestimated (Institute of Medicine, 2001). Managing successful change has been poorly researched in the health sector, so attention must turn to literature arising from commercial environments. The statistics paint a bleak picture; high failure rates of 70-80 percent have been reported, despite a plethora of change management models and frameworks. The importance of the people side of change and the emotions that undoubtedly accompany this has been widely discussed, as have the criticality of early staff engagement, clear and consistent communication and strong, empathetic leadership. Nevertheless, failure rates remain high, and despite the interaction between personal life and work life being acknowledged, managers and leaders are still often poorly equipped to support staff through the turbulence associated with change. While the ingredients for successful change are well understood, applying these effectively in the health sector can be challenging.

Considered an expert in the field of organisational change, By (2005) argues that successful change management is crucial to any organisation in order to survive and

succeed in the competitive and ever evolving business environment and healthcare organisations are not immune to this. Despite this, it can be daunting, confusing and challenging for healthcare organisations to change the way they deliver services. In the case of this study, whilst change may be identified as necessary, this can be uncomfortable at all level; receivers of services, support workers, managers and executive leadership. Evidence arising from literature can be used as leverage in the area of health care integration, to reassure the parties involved, providing recent examples of change management successes and lessons learned.

While failure is common, Allen and Stevens (2007) suggest it is not inevitable. They present a case study in change management and while the health service integration was viewed positively, the change management process was not. Participants commented on the lack of vision, inconsistency of resource allocation and leadership styles which were too autocratic to achieve the desired integration, thereby suggesting a need for greater planning and transparency. Allen and Stevens (2007) describe a single interpretative case study involving the integration of acute and community health services in one medium sized urban Australian health service. Structured interviews and focus groups were used to explore the success of process used to integrate the health services. They report a range of difficulties experienced which resulted in negative consequences. These were categorized broadly as issues related to vision, leadership and structure, resources and culture.

Leutz (1999) made an important point regarding the importance of involving clients, employees and other stakeholders at all stages of the development, the aim of which was to ensure engagement. If this does not occur, there is a risk that those who wield the most power in the organisation will shape the end-state integrated service. Critical evaluation of integration initiatives is needed to understand the barriers and enablers to the integration process. The change process must involve the views of all involved.

Bamford and Daniel (2005) reflect on the lessons learned in the health-related case study they present in their paper. There are three key messages, firstly, the reasons and vision for change needs to be clearly, effectively and consistently communicated, secondly, effective and positive leadership is fundamental to gaining commitment for

change and developing a culture which is supportive of change and thirdly, the change process needs to be managed in a way which is sensitive to the impact the change has on the organisation and the individuals within it.

Commonalities for successful change management include the need for early and continued staff engagement and communication, a clearly articulated and compelling vision, strong, yet sensitive leadership, careful and detailed planning and appropriate resourcing during the change process. The uncertain and rapidly changing environment in which health operates adds significant complexity, which is reflected in many of the change processes. This research focuses on facilitating change through a consultative process, engaging the views of service recipients as well as those delivering service and leading change. Delivering a restorative model of care that will work to meet the needs of the ageing Waikato population.

2.17 Research underpinning the study

Many authors have argued that in light of the high failure rate of change programmes and the lack of a valid framework for organisational change management, research efforts should be targeted towards identifying critical success factors for the management of change and developing a suitable and pragmatic framework (By, 2005; Clack, 1995). This thesis seeks to understand critical success factors at all levels of influence when delivering healthcare service to our older population. Clack (2005) commented that change is a process, not an event, and as such there are a wide variety of emergent and planned approaches. Dawson (1996), advises that change does not happen quickly, therefore studying change 'as it happens' is far more insightful as the processes associated with change will "reveal themselves over time and in context" (Dawson, 1996). Dibella (2007), suggests that studying how perceptions alter over the course of a change project helps researchers understand how and under what conditions perceptions change, and if in fact there are certain managerial behaviours and change management practices that positively and negatively influence perceptions. This thesis explores these important aspects of success through identifying the impact behaviours and success perceptions at all levels.

Much has been written about the individuals involved in change, however change is rarely driven by human concerns, more often by organisational interests (Griffith, 2001). While the importance of understanding reasons for change, early engagement and support of the workforce in the development and implementation of change, role-modelling positive leadership behaviours and consistent communication are frequently referred to in literature, these key steps are often ignored. Change leaders are well aware of the importance of these elements, but often they are completed poorly or not at all. There has been significant dialogue regarding change resistance and the emotional response and behaviours that follow when change is poorly communicated, introduced, led and received (Chapman, 2004), so this thesis will pay particular attention to understanding how managers can be supported to assess change readiness in staff and mitigate potential problems, as well as the steps that can be taken to ensure leaders, managers and clinicians lead change to positively impact final outcomes.

2.18 The question in this study

From the research we can see there are some well-defined models that can identify and evaluate success. However, when applying these to the variables of individuals and their very specific needs, then identifying success and failure is problematic. Which brings us back to the purpose of this study. This study seeks to identify the success factors as a result of service and system re-design. The intent is to understand what is considered success at all levels, encompassing the expectations of: Executive Leadership; Service Managers; Service Providers; Staff; Consumers and Whānau; and Communities.

This study seeks to explore the concept of success within health services for older people at Te Whatu Ora – Waikato. More specifically, it seeks to address the following questions:

1. What are the views of health professionals involved in the delivery of care and support to older people in relation to measuring success?
2. What are the views of older people who are currently, or have received health and disability support services in relation to measuring the quality of those services?
3. How do community providers measure success in the services that they provide?

Chapter III: Methodology

Research is formalised curiosity. It is poking and prying with a purpose."

Zora Neale Hurston, 1903 - 1996

3.1 Introduction to the methodology

Methodology has been described as a fundamental approach to research that connects research methods and techniques to particular philosophical frameworks (Cresswell & Piano Clark, 2007; Tashakkori & Teddlie, 2003). This chapter will identify and investigate the theoretical models and principles that were considered to address the questions raised by this research. As with many research projects, a variety of methods have been used to gather information. Whilst this project focusses on the well-being of older people, it canvases the opinions of a wide range of clients, providers and stakeholders.

Often, those consumers engaged in research are those that are highly skilled at voicing their opinions. Conversely, those who are more reluctant to do this are less as they fear it might affect the service they receive. To ensure that all voices are heard it requires a variety of forums and formats. This ensure that quieter voices are heard as well as the more dominant voices of management and senior executives. The research aims to draw out the value of a new model of care for older people, the value of a change process and the benefits realised for all involved at every level. From service users to service providers, needs assessors, service managers, funding managers and senior executives. The outcomes will inform future funding and service delivery of older person's services throughout Te Whatu Ora - Waikato (TWO - Waikato).

3.2 Research paradigm

A paradigm is a way of understanding the reality of the world and studying it. This involves using multiple approaches to understand and evaluate that reality. Whilst the model of care this research evaluates is a health service, the outcomes and benefits realised are far ranging and have as many social outcomes as they do health outcomes. Health regions as well as health providers often focus on the health intervention and

outcomes in isolation, without considering how the wider social aspects a person's life directly influences their well-being and impacts on their health. This is apparent in older person's services were complex health needs can be compounded by other factors such as poor housing, social isolation and low mood, which can be strong indicators of increased emergent care visits.

3.3 Qualitative research

Qualitative research seeks to understand the specific behaviours and reactions, along with subtle variations that naturally occur in response to an intervention. The same intervention across a population can be perceived and interpreted differently with a wide range of responses. In the case of this research, the event is the understanding and knowledge of the implementation of the new model of care at various levels of accountability and responsibility. Qualitative descriptive designs typically are an eclectic but reasonable combination of sampling and data collection combined with analysis and representation techniques. In this example statements have been collected from all of the participants and thematic analysis undertaken.

3.3.1 Data collection and analysis, interviews and focus groups

Often the preferred method of collecting information is through personal interviews such as those carried out in this thesis research process. This method is seen to encourage cooperation, which results in higher response rates and a better quality of data. Individuals and focus groups will be accessed to determine their views and comments regarding a pre-developed set of questions relating to the Health of the Older People model of care. Interviews and focus groups will be audio recorded, transcribed verbatim and later analysed using a general inductive method of enquiry to develop codes, categories and themes. Surveys will be analysed statistically using appropriate statistical tests, such as Chi Squared and regression.

3.3.2 Researching older people through focus group contributions

As a component of this study, the researcher will seek views and comments from consumers. Specifically, this relates to older people who are, or will be, affected by the services delivered by the model of care. Surveys and telephone interviews will capture

strong themes from the cohort involved. The downside is that quieter voices can be missed and as a result all consumers will be given alternative ways of communicating with the researcher to ensure all views are captured.

3.4 Quantitative research

Quantitative research involves deductive testing and verification of theories and hypotheses (Punch, 2005; Tashakkori & Teddlie, 2003). Typically, this type of data are measured and described as categorical or numerical data. Data can be collected from scores of instruments, checklists or other accessible documents (Creswell & Clark, 2007; Tashakkori & Teddlie, 2003). Statistical procedures are used for analysis, which involves comparison of frequencies or measurements across participants or categories (Creswell & Clark, 2007; Tashakkori & Teddlie, 2003). Through analysis, differences between groups or correlations between variables are identified (Tashakkori & Teddlie, 2003). The main intention of quantitative research is to accept or reject the hypothesis to establish the theory (Creswell & Clark, 2007).

3.5 Mixed methods

Mixed methods is adopted where a researcher combines quantitative and qualitative research techniques, multiple methods and approaches within a single study. Mixed methods research involves collection and analysis of both quantitative and qualitative data (Creswell & Plano Clark, 2007). This design involves a mixture of data being collected in order to answer the research questions (Tashakkori & Teddlie, 2003). Mixed methods research has been defined as *"… collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies"* (Creswell & Plano Clark, 2007, p. 5). Use of a mixed methods approach to strengthen study design has widespread support for numerous reasons. Over-reliance on a single research method is undesirable as each approach demonstrates its own strengths and weaknesses. A mixed methods design allows for compensation of the weaknesses while capitalising on the strengths of each method (Punch, 2005). Stronger inferences can be made, as mixed methods produce different types of data allowing for cross-data validity checks (Patton, 2002; Tashakkori & Teddlie, 2003). When compared to a single method, a mixed method design provides greater diversity and comprehensive evidence,

enhancing understanding of the research problems (Creswell & Plano Clark, 2007; Tashakkori & Teddlie, 2003).

3.5.1 Triangulation

Triangulation is a common approach to mixed methods research and is based on the principle a single method is unable to sufficiently answer research question(s) (Patton, 2002). Triangulation uses different, but complementary, data to explore the same phenomenon, allowing for greater understanding of the research problem (Creswell & Plano Clark, 2007; Tashakkori & Teddlie, 2003). The aim is to reduce bias by converging both qualitative and quantitative methods (Creswell & Plano Clark, 2007; Patton, 2002). Denzin determined four basic types of triangulation (Patton, 2002; Tashakkori & Teddlie, 2003): data triangulation uses a variety of data sources in a study; investigator triangulation uses several different researchers; theory triangulation uses multiple perspectives to interpret the results of a study; and methodological triangulation uses multiple methods to study a research problem. To further understand the advantages of a mixed methods design, it is necessary to distinguish the differences between quantitative and qualitative research.

3.6 Credibility and trustworthiness

Procedures for assessing trustworthiness of the data analysis include consistency checks. This involves having another coder take the category descriptions and find the text that belongs to those categories. A further procedure is that of stakeholder checks. This involves those individuals involved in the study as participants of either focus groups or one-to-one interviews commenting on the categories and/or interpretations made (Erlandson et al., 1993). Polit and Hungler (1995) suggest that as the researcher is the data collector and interpreter of the data, along with the creator of the analytical process, the background details of the researcher should be made known within the report.

3.7 Researcher background

The researcher is a United Kingdom and New Zealand registered physiotherapist with 19 years' experience in various roles within the primary care and District Health Board

environment in Aotearoa-NZ. The researcher is currently the Operations Director for Acute Medicine, Older Persons and Rehabilitation for TWO - Waikato. Qualifications held include a Post Graduate Diploma in Health Science Rehabilitation, and the researcher is currently engaged in the completion of a Master's thesis.

3.8 Methodology summary

The purpose of this study is to explore the concept of success, how that is perceived at different levels, and how that translates into maximising the health of the older person in Aotearoa-NZ and how this is developed and implemented. More specifically, it aims to elicit the vision for maximising the health and welfare of older people and determine how this vision is implemented across healthcare at Te Whatu Ora - Waikato. The study has employed a mixed method research design using focus groups, one to one interviews and patient surveys to gather information from consumers and their perceptions and experiences relative to the model of care, the needs assessment process and the delivery of long-term home supports.

Chapter IV: Methods

"No research without action, no action without research"

Kurt Lewin (1890-1947)

4.1 Introduction to the methods

Changes in the way in which healthcare is delivered is an ongoing process and inevitable. To ensure that changes deliver genuine benefits and proactively support the target audience and is not simply reactive to demand is a clinical and research imperative. Te Whatu Ora - Waikato (TWO - Waikato) is undertaking an extensive redesign of its community services in order to support older people to continue living in their residence of choice. The new approach has been developed in response to the growing older population; that is living longer, in greater numbers and also wishing to have more choices in how they can continue to lead an independent life of their choice. Rehabilitation and Support as a service within Older Person Rehabilitation at Te Whatu Ora - Waikato has positioned itself to deliver this change and re-design with a locality based approach.

This research will also examine how change management and programme methodology can be instrumental in enabling the voice of the consumer, their whānau, their community and the staff working alongside them are duly considered and enabled to influence change. Further, to invest in change without evaluating its level of success is problematic as without such, it is impossible to determine the impact of the changes.

4.2 Purpose

Te Whatu Ora - Waikato is implementing a new model of care that aims to address the Ministry of Health aim of supporting "older people to live well, age well and have a respectful end of life in age-friendly communities." The model of care incorporates multiple interventions, which collectively aim to support older people to achieve this goal. Success factors are useful in providing a lead into how services should be configured and orientated. However, the needs of community dwelling older people are often complex and consequently, success factors have not been developed and

therefore such guidance is missing and further, it is difficult to determine the relative success of interventions. The development of success factors must incorporate the views of care of care and support, from the client, their family/whānau to health professionals.

This mixed methods research will have two key phases. The first will involve interviews, focus groups and surveys with older people, their families / whānau, health professionals and operational and executive health managers to develop key success indicators in relation to the delivery of community based services for older people. Key success indicators will be developed and tested through a series of focus groups and a survey with older people. The second phase will involve using the success factors to determine the progress of the model of care. This second phase will involve the use of routinely collected health information. The research will be significant in that it will provide clear indicators which will guide the delivery of care and support for older people in the Waikato region and further it will be of significant value in assessing health service implementation.

4.3 Population

In Aotearoa-NZ, services are delivered by a complex network of organisations, and this is equally apparent in Waikato, the location of the current study. Te Whatu Ora - Waikato (TWO - Waikato) has a population of 371,540 people of which over half reside outside Hamilton and of these almost three quarters are located within rural or minor urban settlements. Statistics New Zealand (G. Bascand, 2007; Dunstan & Thomson, 2006; Statistics New Zealand, 2004, 2005) have identified that Aotearoa-NZ's older population is concentrated across certain geographical locations with over half of the country's population, aged 65 and over in 2001 in three regions: Auckland, Christchurch and Wellington. Four other regions were also found to exceed the national growth rate in the 65 and over age group, of which Waikato was one. There is an inherent belief that every individual has a role in working with others across the system to achieve better health for New Zealanders and it was important to garner these potentially unique perspectives. The study focussed on the views and perceptions of success' roles in healthcare and therefore draws on the views of

executive management, operational management, service providers as well as patients and whanau themselves.

Health professionals and health managers (Group 1) will be invited through email to participate in the research by the Disability Support Link administrator, who will attach the information sheet. If the participant is willing to proceed, their name and email address is passed to the researcher who contacts the participant by email and arranges a mutually convenient time to meet for consent and interview. Participants of focus groups will be invited in the same manner. Group 1 includes executive management such as; Chief Executive Officer, Chief Operations Officer, Executive Director Strategy and Funding, Service Managers, Needs Assessor Service Coordinators and Service Providers. Capturing all aspects of service delivery. Group 2 involves older people and their family/whānau who are clients of TWO - Waikato community services. Their names and addresses are kept in a patient information management system by local Te Whatu Ora region. As part of their care, they receive an annual review and the date is known. The first 50 clients to be reviewed following the research commencing will be sent a copy of the self-completed survey with a stamped addressed envelope by the Disability Support Link Coordinator. This will ensure that the sample is representative of the population. Older people included in the research will represent the users of health of older people services in the Waikato region, including Māori, Pacific, NZ – European and other ethnicities.

4.3.1 Local executive leadership

Te Whatu Ora is responsible for providing and/or funding the provision of health services in their district. Executive leadership is represented in this study by the Chief Executive Officer, the Chief Operation Officer and the Executive Director for Strategy and Funding. Operational management and service delivery at a health region level is managed by both its funding and provider arms.

4.3.2 Operational management

One-to-one interviews were undertaken with the Operations Manager for Rehabilitation and Support at Te Whatu Ora - Waikato. This role oversees the regions

Needs Assessment Service Coordination Agency, Disability Support Link. The acting Charge Nurse Manager for Disability Support Link was also engaged.

4.3.3 Providers of services

Non-Government Organisations (NGO) receive funding from both the Ministry of Health and Te Whatu Ora. Many are not for profit and along with providing services to consumers; they are a valuable contact at the community level. NGOs have a long, well-established record of contribution to Aotearoa-NZ's health and disability service delivery. Health and disability NGOs include a wide range of organisations that provide flexible, responsive and innovative frontline service delivery. Senior management representation from NGO Home Based Providers was also included in the one-to-one interviews.

4.3.4 Service delivery - Focus Groups

Two focus group meetings took place. The first one involved staff representing the home-based providers. This involved staff who work in older people's homes providing support services. The second group involved the Needs Assessor Service coordinators from the Disability Support Link team. This team carry out the Needs Assessment with older patients and their whanau, determining an appropriate package of care. Whilst staff members and contractors may be asked to talk about processes that may not work for them, a co-design approach to service delivery has been adopted over many years and this has shaped older persons service and model of care. This is a familiar and safe process for them where feedback on all aspects of service delivery is welcomed.

4.3.5 Consumers of services

Consumers are a critical measurement of service delivery in terms of their expectations and views of service delivery at the sharp end. The determinants of health at older ages are complex and the ageing population is likely to put increasing pressure on the healthcare system and on health funding. Key issues for the TWO - Waikato in relation to the older population include increasing prevalence of dementia, exponential increase in expenditure on long-term disability supports (such as home care and aged residential

care), and an increase in depression and suicide. Patient surveys were sent out and telephone questionnaires were undertaken to capture these views. The service users being interviewed will be older people with an age-related disability need. However, the interviews and surveys will involve cognitively well service users who would not be affected by taking part. No service users with cognitive impairment will be interviewed or involved in the focus groups.

4.4 Data collection

There are three forms of data collection: One-to-one interviews; Focus groups; and Surveys.

4.4.1 One-to-one interviews

Qualitative interviews will occur with specific individuals within this research. Interviews are one of the main data collection tools in quantitative research and provides a useful context to assess individuals meanings and perceptions (Punch, 2005). Polit (1996) notes the need for a structured approach which operates within a formal, written instrument or interview schedule. The structured instrument consists of a set of questions or items whereby subjects are asked to respond to the same questions, in the same order, and they have the same set of options for their responses. The interviewer will guide the respondent through a set of questions pre-determined and relative to the research. Specifically, this methodology has been chosen to complement focus group information and in recognition that it may be possible for readers to identify participants.

4.4.2 Focus groups

Knodel (1995) assessed focus groups as an effective method for stimulating dialogue about a phenomenon of interest among diverse older adults. A number of informative projects and studies using focus groups, including a growing body of research with older people demonstrate the utility of focus group methodology to collect data in both an efficient and effective manner. A focus group is a data collection procedure in the form of a carefully planned group discussion, in order to obtain diverse ideas and perceptions on a topic of interest in a relaxed and permissive environment that

fosters the expressions of different points of view, with no pressure for consensus (Barbour, 2005). Building rapport by establishing a connection with participants that facilitates comfortable and open communication will be imperative. Rapport is important to the facilitation process because it can dramatically influence the willingness of participants to answer questions, and how openly and honestly they answer the questions they are asked. The purpose of focus groups is to gain information about the topic(s) of interest from the perspective of participants. Individuals were invited to participate in the focus groups because they were viewed as possessing important knowledge about their particular experiences, needs, or perspectives that the researcher hopes to learn more about. The researcher informed the participants that the purpose of the session was to learn from them. It was anticipated that expressing this to participants would contribute to establishing a respectful appreciation for valuable contributions that they make to the session.

Focus groups are useful as group dialogue tends to generate rich information, as participant's insights often trigger the sharing of other personal experiences and perspectives in a manner that can more easily tease out the nuances and tensions of complex topics and subjects – a dynamic not present during formal interviews. Focus groups also enable the provision of information directly from individuals who are invested in the issue or who hold expert opinions on a topic. This in return, can provide insights into actual conditions and situations, diverse opinions and ideas and is a relatively low cost and efficient way to generate a large amount of information. Within this research, three focus groups were held with 12 individuals. The focus group membership and make-up was selected as representative of the various operational and direct care providers of publicly funded health service delivery for the health of older people in the Waikato region. All participants fitted the criteria for inclusion and participation, and the diversity of the group members is also representative of the diverse service delivery for older people in Aotearoa-NZ.

4.4.3 Surveys and telephone interviews

To capture the views of patients and whanau, a combination of patient surveys and telephone interviews were undertaken. Surveys were distributed, along with a stamp addressed envelope, to clients and whanau. Clients and whanau would complete and

return these to the Disability Support Link office. To promote further feedback and support clients who were not able to complete the survey form themselves, a series of telephone interviews undertaken to capture the views from patients and their whānau.

4.5 Data analysis

Mixed methodology analysis will be undertaken with both quantitative and qualitative captured and reviewed. Each interviewee and focus group attendee was coded to protect confidentiality. Qualitative data emerging from the semi-structured interviews and focus groups with participants were analysed using a general inductive inquiry whereby interview transcripts were transcribed verbatim and major themes elicited. The method for analysing the data was thematic analysis, which is historically a conventional practice in qualitative research, which involves searching through data to identify any recurrent patterns (Aronson, 1994). A theme is a cluster of linked categories conveying similar meanings. The exploratory power of this popular technique can be enhanced if the analyst lacks previous knowledge of the research topic, meaning they are not guided by any preconceptions. As a result, the analyst does not have to be an expert in the research topic. However, in order to begin analysis a researcher must have, at least, some conceptual understanding to guide the insight processes. Qualitative thematic analysis is analysis based on the identification of themes in qualitative material, often identified by means of a coding scheme. Coding is a widely used approach to qualitative analysis, generally treating accounts as a resource for finding out about the reality or experiences to which they refer. Questionnaires, interview schedules and psychological tests and scales normally depend on the respondents' capacity for self-insight or willingness to share personal information with the researcher. Projective techniques give free play to the subjects' imagination by providing them with a task that permits an almost unlimited number and variety of responses (Hungler & Polit, 1999).

Patient surveys where collated and a combination of quantitative and qualitative analysis undertaken. Population data from the participants was quantified. Participant were also given the ability to "rate" the value of the services they receive. They were also able to add a narrative to explain that rating, qualitative analysis of this was undertaken as has been described in the previous paragraph.

4.5.1 Thematic analysis

Using a general inductive approach, the researcher constructed codes and themes from the interview and focus group data (Thomas, 2006). The inductive approach to enquiry builds generalisations out of observations of specific events. It starts with singular or particular statements and ends up with general or universal propositions and presupposes that explanations about the workings of the world should be based on facts gained from pure, dispassionate and neutral observation, rather than on preconceived notions; that nature will reveal itself to a passively receptive mind. The inductive strategy assumes that all science starts with observations, which provides a secure basis from which knowledge can be derived and claims that reality impinges directly on the senses; hence there is correspondence between sensory experiences, albeit extended by instrumentation, and the objects of those experiences. The conclusion of an inductive argument makes claims that exceed what is contained in the premises and so promises to extend knowledge by going beyond actual experience. The more observations that demonstrate a relationship between phenomena, the higher the probability that the general statement is true. Verification of derived generalisations comes through observations about phenomena that appear to support it.

4.5.2 Statistical concerns

Descriptive statistical analysis was undertaken with the Likert scale responses generated from the surveys. This included: Mean, Median and Standard Deviations.

4.6 Ethical concerns

This study will clearly identify what is considered success for older person health and community services in the Waikato in Aotearoa-NZ and identify whether this is consistent at all levels, from executive leadership, through operational management, service delivery and from the perspective of patients and whanau themselves. The findings will directly inform how future services will be delivered in Waikato. From a research perspective informed consent, privacy and confidentiality of participants are of critical importance, as failure to respect these principles can have wide ranging impacts on participants. All participants will be invited to participate and will be

provided with an information sheet and consent form to complete prior to the meeting. Although themes and findings are anonymised, given that a number of the participants have significant and inter-related roles, it may be possible for readers to identify the individuals responsible for specific themes and quotes. This study received clearance from The University of Waikato Human Participants Ethics Committee, providing ethics approval for this study, reference number HREC (Health) 2020#81.

4.7 Summary of the methods

For older person's services, identifying positive outcomes, in a population that is ageing and finding life harder is challenging. Any intervention is countered by the fact that often the person in its care is now likely in its last 1000 days of life and is likely to be requiring more General Practice intervention and more hospital visits. With this in mind, the research undertaken has a strong emphasis on capturing qualitative information and capturing the detail of how a service user and service provider feel a service is performing. These views are supported by the quantitative data captured to get a measurable indicator of how the new model of care is performing, that can then be revisited in the future to identify if things are improving, stayed the same or have even got worse.

Chapter V: Findings

"People work for money but go the extra mile for recognition, praise and rewards"

Dale Carnegie, Leadership Training Guru (2020)

5.1 Introduction

This chapter presents the findings and analysis gathered from the interviews, focus groups and patient surveys described in the previous chapter. The sample population represent multiple tiers of leadership, service delivery, consumers and their whānau. Specifically, the findings are representative of the analysis and themes derived from the key stakeholder's interviews, focus groups, telephone interviews and surveys. To retain anonymity, the representative classifications will be used in all quotes. There is often a philosophical tension between the funders and managers of services and stakeholder freedom of choice when organisations implement services, particularly when those services are publicly funded and there is a managerial imperative to make things happen through performance management (Simons, 1995). Whilst all involved are implementing change with good intent. All will have different motivations and different perceptions of what is successful change.

This results chapter has two sections: the first is qualitative and captures the views of the executive management, operational management and service delivery teams. Quantitative data are captured to analyse the value of the services they are receiving along with qualitative statements that are themed to further inform the data captured.

Part 1: Qualitative findings

5.2 Sample

A total of 23 people were interviewed either as one-to-one interviews or as part of the two focus groups.

5.2.1 Interviews

A total of seven interviews were undertaken with leadership at different levels to understand the different perceptions of success. The interviewees were asked the same set of questions, tailored to reflect their roles. The interviews where of approximately 1.5 hours in duration. Whilst set questions were used, the interviewees were given free rein to expand and draw on personal experience with many citing the experience of family members receiving older person's services, as well as their work experience. The roles of those interviewed are highlighted in Table 6 on the following page.

Table 6: Interview sample

Role	Leadership level	Sample	Description
Chief Executive Officer	Executive	1	Provide regional and local vision and strategy in support of national policy intent, provide leadership, act as stewards of the system, oversight of all Te Whatu Ora activity.
Chief Operating Officer	Executive – Hospital and Community Services	1	
Executive Director – Strategy and Funding	Executive – Funder of Services	1	
Operations Manager, Rehabilitation and Support	Service Manager – Community Services	1	Oversight and management of the day-to-day activities of various health services. This group includes Managers of Needs Assessment and Service Coordination (NASC) Services.
Charge Nurse Manager, Disability Support Link	Manager, Needs Assessment and Service Coordination	1	
Area Manager – Home Based Provider	Manager – Service Delivery	1	Oversight and management of the day-to-day activities of the home-based support provider delivering care in the patients home
Charge Nurse Manager, Older Persons and Rehabilitation	Manager – Hospital Services	1	Oversight and management of the Older Persons and Rehabilitation inpatient service.

5.2.2 Focus groups

Two focus group interviews took place. The focus groups were facilitated by independent facilitators, to ensure that the staff involved were able to respond honestly to the questions. The Disability Support Team are the Needs Assessor Service Coordinators who carry out the needs assessment in a person's home, and then work with the consumer and whanau to determine the appropriate package of care. The Home-Based Providers then deliver that care, on anything from a weekly to a three times per week basis. The same set of questions were used as with the one-to-one interviews, with group discussion encouraged and supported by the independent facilitators.

Table 7: Focus group participants

Group	Number of participants	Role
Disability Support Link Team	10	Needs Assessor Service Coordinators
Home Based Providers	6	Representation from each of the home-based providers in the Waikato

5.3 Thematic analysis

The comments from the interviews where compiled, there were generated from the transcripts arising from one-on-one interviews and focus groups, which were then condensed into 100 codes. Overlapping codes were reduced, as were redundant codes, which resulted in 11 categories. The most significant themes were elicited to represent the findings of the research and these are described in more detail below and are accompanied by quotes from those interviewed. The five key themes resultant from the process included: Why do we do what we do; How do we know we are good; How do we continually improve; How do we know we are delivering what people want; and What is important?

Figure 3 on the following page, summarises the general inductive analysis. Despite the group representing the breadth of healthcare providers from executive leadership to local based providers, and including representatives from strategy to operational activity, the themes described herein clearly indicate a cohesiveness of thoughts.

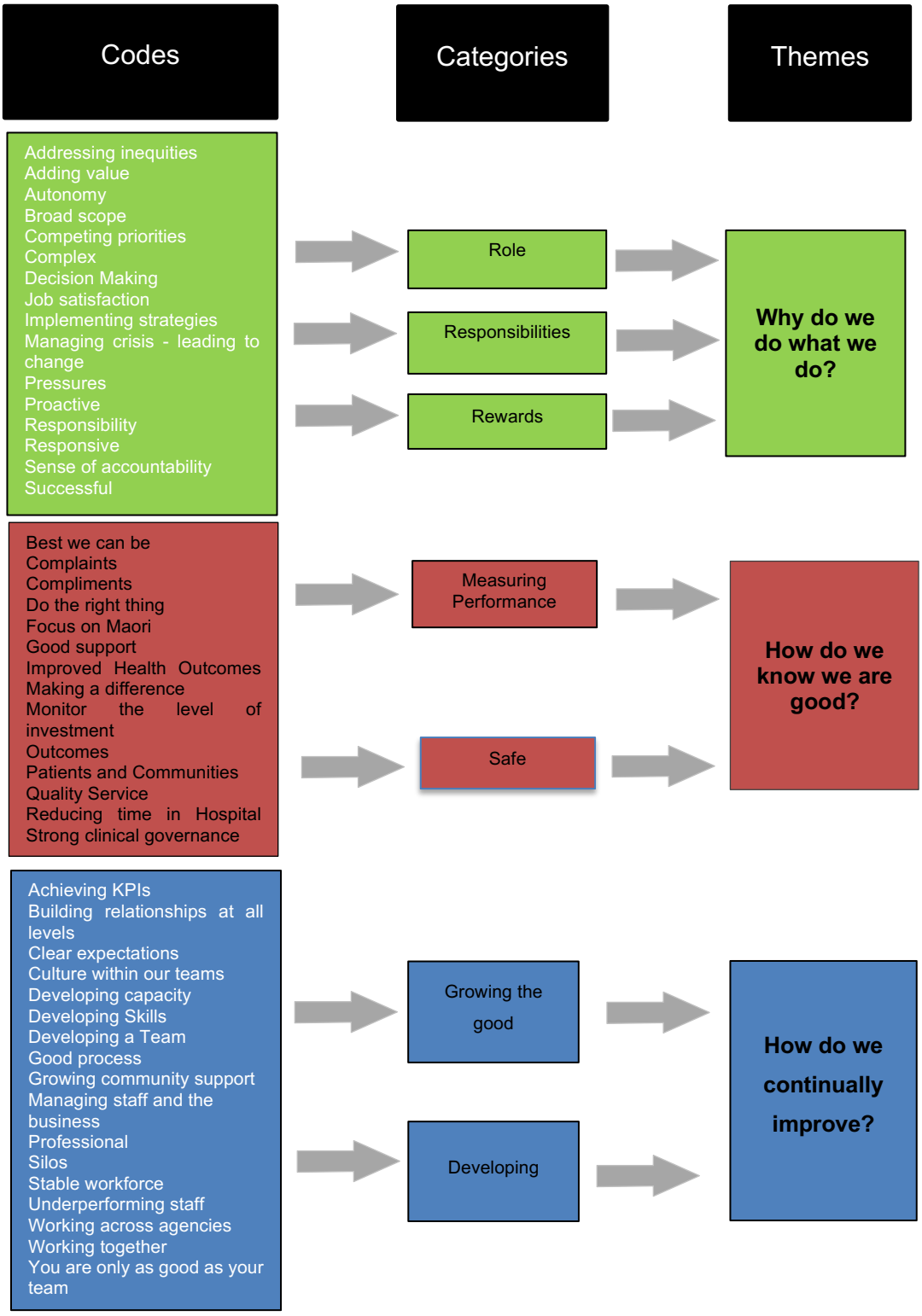

Figure 3: Thematic analysis

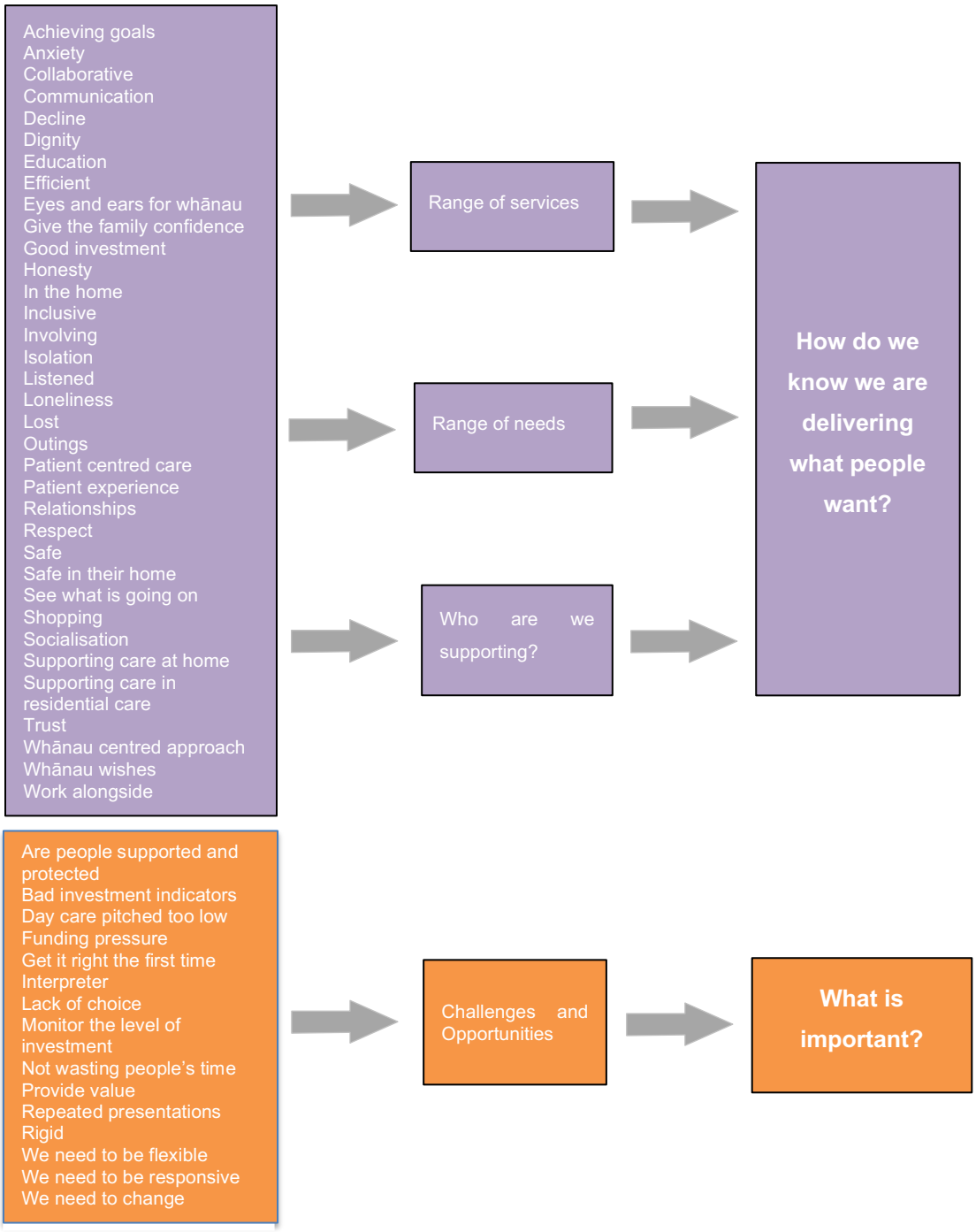

Figure 3: Thematic analysis (continued)

5.3.1 Why do we do what we do.?

The theme emerged from 16 codes that were developed, represented by three categories: perceptions of roles, responsibilities and rewards. Across all the interviews regardless of whether the participant was a senior executive, funder, service manager, needs assessor or support worker, there was a strong sense of doing the right thing and making a difference. It was clear from all the interviews, at every level, staff reported on frustrations and yet continually felt that their work was rewarding.

> *"It's about doing the right thing, being able to make a difference to our communities."*
>
> Executive Leader, TWO-Waikato.

> *"I suppose I made the change from a clinical role to a senior manager because I like to get things done, so you can make changes and see the benefits of those changes appearing."*
>
> Executive Leader, TWO-Waikato.

> *"I suppose it is also making sure that we can recognise the importance of our role as a driver of GDP (Gross Domestic Product) and employment, not simply the services that we can deliver."*
>
> Executive Leader, TWO-Waikato.

For senior executives, this sense of responsibility and the feeling of adding value and making a difference, extended beyond the patients in our care and the services supporting them. There was an acute understanding of how as a major employer in the region, that the success of the service is felt far beyond the patient. The fact the service is supporting people at home, employing staff who are successful in their roles, which helps them to support their families and results in better well-being and health outcomes for their family is significant.

> *I enjoy the decision making. I don't like the pressure. And it's a big team. So it's a lot of responsibility for a big team. But I do enjoy the building knowledge and being able to share that knowledge with the team. That's one thing I do like, I like educating the staff.*
>
> Charge Nurse Manager, TWO-Waikato.

> *"I enjoy the complexity, dealing with the difficult stuff and having the autonomy to make decisions"*
>
> Executive Leader, TWO-Waikato.

> *"It is difficult determining what a client and whānau want and what will make a difference, but that is what makes the work so interesting and rewarding"*
>
> Needs Assessor Service Coordinator, TWO-Waikato.

The complexities of the work, and the patients and whānau, were factors that influenced why staff undertake the work they do. Senior executives and managers enjoy the complexities of leading a service. Needs Assessors, Service Coordinators and Support Workers all relish the fact that the population they support is varied, with complex medical conditions and complicated family and social situations around them, that requires skilled processing and decision making. It reflects that finding solutions at every level is rewarding and why people have adopted the roles they have undertaken.

> *"All of my jobs have been to turn around organisations. So, I like to turn around organisations and I like building teams.*
>
> Executive Leader, TWO-Waikato.

> *"I enjoy service development, I am enjoying operationalising some of the things on the work plan, putting things in place and making things happen:*
>
> Operations Manager, TWO-Waikato.

> *"I think as an assessor coordinator, you have a lot of autonomy, which is great. So, you can you structure your day, you can be in the office and out of the office. It's nice to see clients in their homes, it's a very different scenario and makes a difference."*
>
> Needs Assessor Service Coordinator, TWO-Waikato.

> *"There is a lot more pressure and responsibility for the team to perform often. Pressure from the wards to support discharge. Huge responsibility in the community supporting what can be very challenging clients and families."*
>
> Needs Assessor Service Coordinator, TWO-Waikato.

With that complexity comes the heavy burden of pressure. Whilst staff talk about the complexity and problem solving in a positive way when solutions are identified, it is

also clear from the interviews that pressure, from responding to media enquiries, to meeting targets and budgets, to managing performance in an team, to managing the demands of whanau and the high volume of work can quickly tip things into uncomfortable. The autonomy of the roles, the ability to be proactive and make a difference, ultimately drive those in these positions to keep doing what they do and look to do better.

5.3.2 How do we know we are good?

Senior executives identify that as their roles broaden to cover numerous areas and responsibilities, they become more and more dependent on the knowledge and skills around them. While their advice is often sought re decision making, they are frequently dependent on the knowledge around them to inform that decision making.

> *"When you get to a role like this you are only as good as your team"*
>
> Executive Leader, TWO-Waikato

They are no longer the subject matter expert. To support this, robust reporting frameworks are required to inform decision making, demonstrate performance targets are being met, and importantly that there is a strong quality focus that ensures that patients, whanau and the staff delivering care are safe.

> *"I am 100percent sure that we are helping people, and that can be seen in the compliments we receive."*
>
> Operations Manager – TWO-Waikato.

> *"This can come through different pathways, things like health and disability commission, compliments and complaints, all those sorts of things. But if we are monitoring the right things, and if we've got good, strong clinical governance, we should not get a lot of surprises in that space."*
>
> Executive Leader, TWO-Waikato

Whilst complaints are a strong barometer of how the service is doing and can appear punitive to the service, the involvement of the Health and Disability Commission was viewed positively. Managers surveyed identified that patient expectations and those of

the family can be unrealistic. The 'NASC' team and the service providers may well be meeting timeframes, delivering supports that seem fair and equitable, but this may still not be enough for patients and whanau, who may expect more. The NASC team will often use colleagues and other NASC agencies to peer review and ensure they are being fair. Where resolution cannot be found and complaints progress to the involvement of advocacy services and the health and disability commission, the managers in the service saw this as opportunity for the health and disability commission to be the voice of reason. Naturally, leaders and managers do not want to have excessive amounts of health and disability complaints, but when required the involvement of the commission was seen as fair.

> *"You can manage expectations by being clear about what you can deliver and when"*
>
> Executive Leader – TWO-Waikato.

> *I think the services are a good investment. But we need to be really mindful and keep it and monitor the level of investment.*
>
> Executive Leader – TWO-Waikato.

> *"In my role you can get a good outcome for the patient, and you can get them moving through the service and being at home. I really like the focus of the work, we do with older people, because they are at a stage of their lives, that is really precious, it also more of a family centred approach, and the family becomes really important in aged care."*
>
> Nurse Manager – TWO-Waikato

> *Obviously from a business prospective, were efficient, we've got a workforce, that is stable, and it's not turning over too quickly, both at a work support level, branch level, the staff within those branches, where the training of those staff, their comments, their assessments are up to date etc.*
>
> Regional Manager – Home Based Support Provider.

> *From a service delivery perspective, we are meeting the KPI's and targets within those, and I guess one area of success, that we would measure ourselves, is complaints as well, if we are not hearing any noise, complaints etc. It is not the only success factor, but it gives us that sense we are on track, so its efficiency, we have a number of financial, it's a business that has a tight margin, so you have to manage that business well, manage your workforce well, so you haven't got the wastage, there's a few areas, that you could lose money as well so.*
>
> Regional Manager – Home Based Support Provider.

> *"The nice part about the job is every now and again, you will get letters back from the community, and family members. Maybe it's after you know, Mum and Dad have passed away and what they have said, when we have done well the support workers, have been complimentary about their support, without that, Mum and dad wouldn't have been able to stay at home for as long as they did.*
>
> Regional Manager – Home Based Support Provider.

5.3.3 How do we continually improve?

A strong governance and quality and patient safety framework were seen as keyways to ensure service improvement is continuous. Ongoing monitoring and review of process essential.

> *"I am absolutely passionate about driving a quality improvement patient safety culture."*
>
> Executive Leader, TWO-Waikato

> *I don't know that we completely, been able to implement as we would like, that whole restorative model and really proactively getting people, hitting goals, setting goals, as much as the theory in the philosophy is aiming for, but in general, we are keeping people safe at home,*
>
> Regional Manager, Home Based Provider.

Service reviews and service improvement were seen as essential. No service should stand still, and managers and staff were always questioning why we do the work we do and how we can do things better. The new model and approach were seen as a positive one, but providers and staff questioned whether they were truly delivering on the intent of the model. The implementation of the InterRAI needs assessment tool was seen as a major influencer of service improvement. Needs Assessment and Service Coordination work is a lengthy and expensive process. Historically, regions used a paper-based assessment, with a range of people carrying out the assessment. The assessments were loose, many regions creating their own version, information was captured as narrative and there were numerous options to cut corners. This led to poor outcomes for the patients being assessed and huge variance in what was delivered.

The InterRAI assessment is an internationally recognised, evidence based, electronic assessment tool. It contains over 600 reference data items, 30 triggered client

assessment protocols and a further 10 outcome scores. The ministry of health mandated use of this assessment tool in every region has led to us understanding our older population better and has led to more consistent and informed decision making about their care. We have gone from a conceptual idea of what our older population needs, to strong evidence that informs what they need, the difference interventions make and what services we should be investing in going forward. Hence the conflict we see where patients are demanding of more care such as household management, and funders and managers want to reduce these services as we are seeing they are not a good investment when it comes to reducing outcomes such as reducing emergency department presentations and hospital admissions.

5.3.4 How do we know we are delivering what people want?

Many of the staff interviewed had personal experience of accessing care for their older relatives. There was a consensus in the statements made, where despite their involvement in health and knowledge of some of the services, they found navigating care for their relative difficult. Their statements echoed some of the comments from patients and their whanau. The feelings of 'decisions made about their older relative,' a lack of inclusion, the process being over complicated and the need to "find the right person" to make things happen, all suggest a process that is over complicated and difficult to access the right care. It is almost like the difficulties to access care act like a gate keeper to services

> *"From a population perspective, you would hope to see an older population that is less disabled, you would want to see a change in the usage of secondary services, you would also want to have some consumer measures that evidence people are happy with the supports they receive."*
>
> Executive Leader – TWO- Waikato.

> *"The process, for my Mother and us as a family, was only inclusive when I jumped in and got involved"*
>
> Executive Leader – TWO- Waikato.

> *"Once you get the right person, then it is an easy process"*
>
> Executive Leader – TWO-Waikato.

"I think we can do better, I have just been through "it" and it was not a good process".

Operations Manager – TWO-Waikato.

"Process is complicated, you hear clients say "I just gave up"."

Needs Assessor Service Coordinator, TWO-Waikato.

"I think there's a lot of loneliness in the community, I don't always think that the day programs are structured enough for some of our highly cognitively functioning clients."

Needs Assessor Service Coordinator, TWO-Waikato.

"That isolation and loneliness is a really consistent theme across assessments."

Needs Assessor Service Coordinator, TWO-Waikato.

"We haven't got that flexibility and our system. And I think that's a real problem for a lot of our consumers."

Needs Assessor Service Coordinator, TWO-Waikato.

Front line staff and managers identified the consistent theme of isolation and loneliness. Supports tend to focus on the physical support needs of a person, how we can help them shower, dress and feed themselves. However, there was a definite sense that loneliness is not being addressed. Patients wanted company, and whilst support workers were visiting to help them specifically shower and dress, the visit and the conversation was what was often of most value to clients. How we meet this unmet need is of course challenging. Physical supports have measurable benefits such as a person being safe in their home, reduced falls and reduced hospital use. Addressing loneliness and isolation will look very different across our older population, with patient preference varied. That variance makes things difficult for funders and providers of services.

"I think there are times where families feel a sense of entitlement and the difficulties are the blurring of the lines, as to what is a family's responsibility and what the health system should be paying for."

Regional Manager, Home Based Support Provider.

The sense of entitlement and the request for more is acutely felt by providers and needs assessors. They feel they face the brunt of patient and families' expectations and have to be the people that say no. Whilst investment in services goes up alongside the growth in our ageing population, the complexity within that population with increased chronic health conditions means that the investment will only stretch so far.

5.3.5 What is important?

Easing the burden of patients, their whanau and support network around them are how staff see the importance of their work. Some of these benefits are difficult to measure of course. Seeing patients within a certain timeframe, delivering care on time are all strong measurable. The harder to measure benefits such as reducing the demand on a partner, accessing day care so the daughter does not have to come round every day, support workers going in daily, so the neighbour does not have to call in every day, are all strong benefits we do not capture, but we know make a difference in the community.

> *"It is about making sure we are doing the best we can to do the right thing for our older population, and their families, because it is not only the patient, it is the support network around that patient".*
>
> Executive Leader, TWO-Waikato

> *"We talk about giving people choices, but do we really do that?"*
>
> Needs Assessor Service Coordinator, TWO-Waikato.

The topic of choice is repeatedly raised as a key area of interest, and yet it is mostly in relation to limited choice rather than choice per se. It is also recognised by executive leadership that monitoring that investment is essential. All interviewed identified with aspire to being flexible, provide choice and different options, but all identify we could do better.

5.4 Qualitative findings summary

In conclusion, at every level of responsibility, there was a strong sense of feeling we make a difference and services being of value. Strong governance and key

performance indicators as ways to monitor how we are doing and measure success. However, there was a consistent self-reflection that questioned how we were doing, were we meeting a need, could we be doing more and are we truly offering choice. While a service might meet ministry of health time frames and performance indicators, the subjective nature of our older population and its varied needs seems to leave us questioning whether we are being successful and making a difference.

Part 2: Survey findings

5.5 Survey results

5.5.1 Demographics

A total of 64 consumers participated. Of these, 37 identified as female and 27 as male. The age distribution is presented in Figure 6.

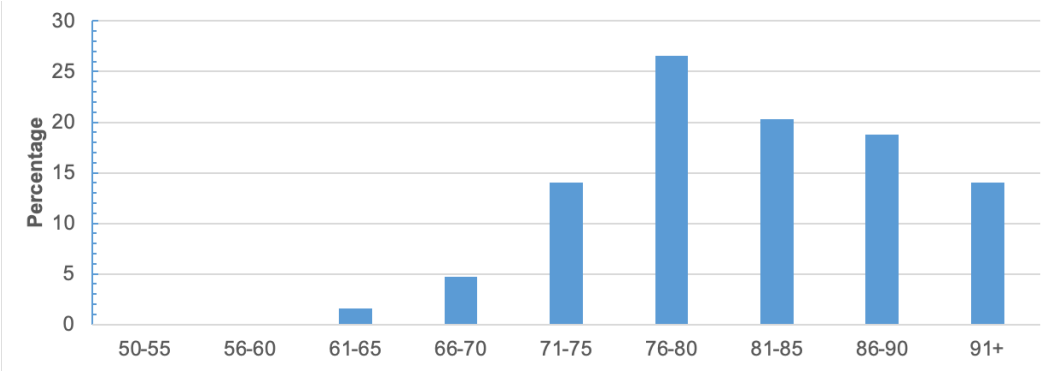

Figure 6: Age distribution of survey sample

A range of services are available to the older population in Waikato, with most respondents reporting that they receive home support.

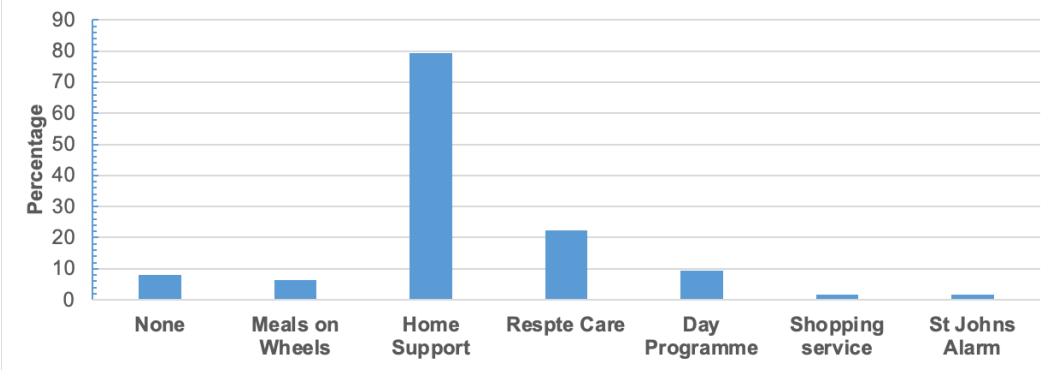

Figure 7: Services provided

Figure 8 reveals that most respondents had someone living with them.

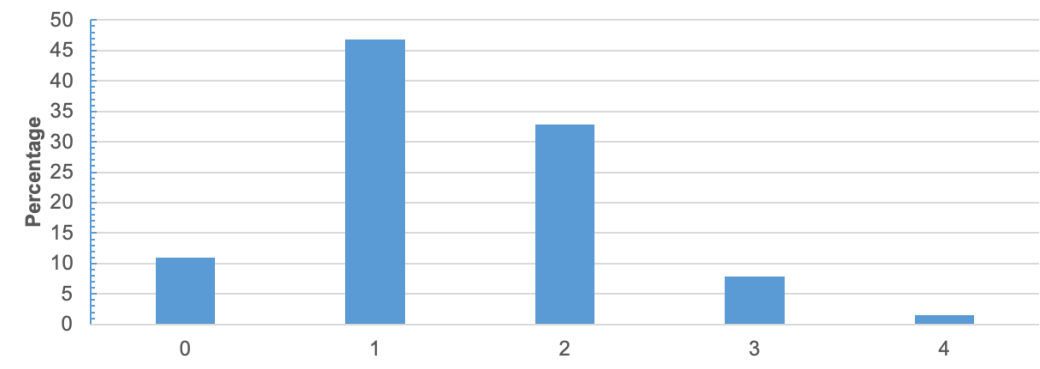

Figure 8: Number of people living in same home as respondent

5.5.2 Survey results, questions

The consumers were then asked a range of questions around the care they receive and the results are shown in Figure 9.

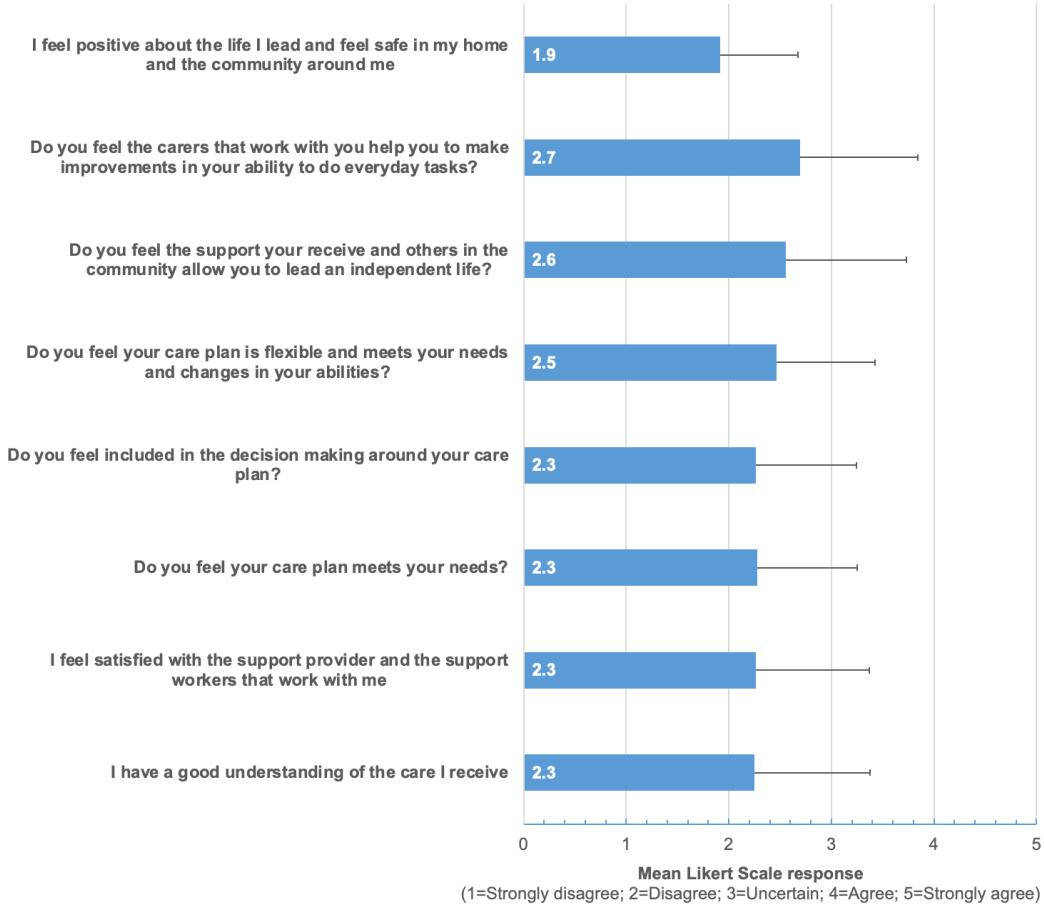

Figure 9: Mean response to survey questions (error bar = 1 SD)

The responses reflected a population that is in general both unhappy with the services they received and with the quality of the care. Consumers surveyed did not feel positive about life or safe in their home and the community around them. They did not feel that the supports they receive help them to make improvements with tasks and they did not promote independence. Participants did not feel included in their care plan. They identified the lack of flexibility and the responses reflect decisions being made about them as opposed to truly consulting and including them.

Patients and whānau were equally unhappy with their support worker and support provider and had a poor understanding of the care plan they receive. As is identified in the qualitative data, the importance of good communication is paramount. Interviews with staff identify its importance, yet the statements made by patients in the survey reflect that is an identified issue.

5.5.3 Survey results, qualitative

The consumers were also given an opportunity to expand on their answers in the survey, providing context to the scored response. A total of 52 codes, translated to 13 categories and five themes: (i) Communication – talk to us, hear us; (ii) Service – we need more; (iii) Quality – what we expect; (iv) Getting it right – getting what we want; and (v) Opportunities – what is important to us!

Figure 10: Thematic analysis, surveys

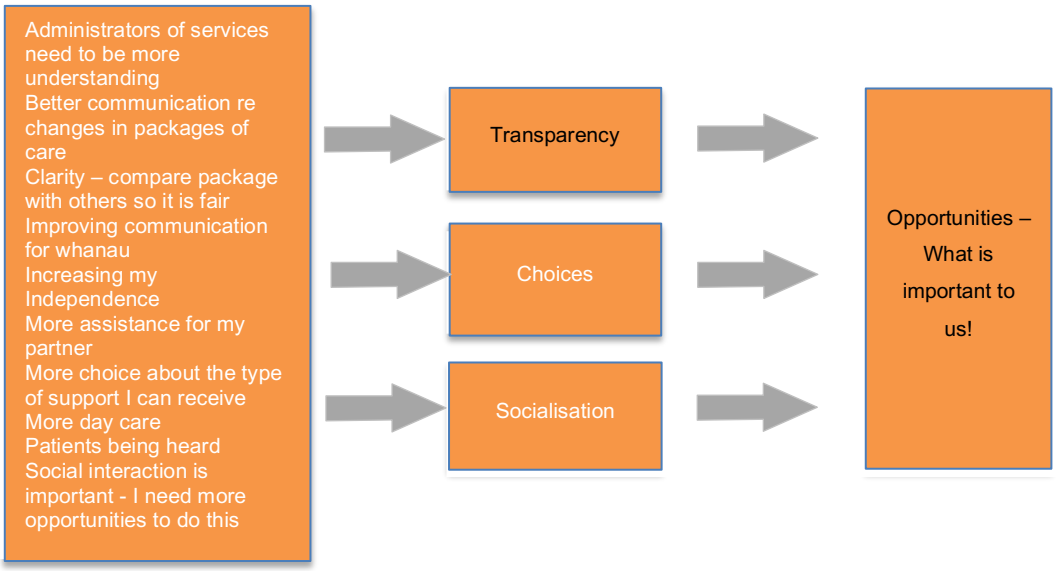

Figure 10: Thematic analysis, surveys (continued)

5.5.4 Communication - talk to us, hear us!

Consistent with the interviews with the staff participants, communication was seen as a key factor in either supporting success or leading to failure. This ranged from decisions being made about consumers without including them, lack of communication around plans changing and lack of engagement.

> *"It looks as though I have been involved in the planning of my future, but that is not the case, only I can do this."*
>
> Service user

> *"One night, prior to discharge, they tried to decide what would be best for me, this would mean going into care, and they were surprised when I refused to even consider it".*
>
> Service user

Communication issues were a reoccurring theme throughout the patient journey. Patients and whānau were unaware of referrals being made. Despite patients having a nominated point of contact, often other whānau became involved which added to the confusion. Consequently, participants were often left feeling powerless, with a process happening "around" them as opposed to involving them.

5.5.5 Service amount – we need more!

Many of the responses focussed on the need for more support. Household management being a good example. Many regions have stopped household management and those that do still offer this service only offer the very minimum amount, just one-hour per week. Funders invariably regard this as a non-essential 'housekeeping' service, opting to invest in a more restorative approach. However, participants viewed this very differently. Many see this as more important than increasing personal care support. Consumers would often prefer to try and do more for themselves in terms of dressing and showering, if the provider was doing more to keep the home clean and tidy.

> *"I could not manage without the support of my family"*
>
> Service user

> *"My whanau have to do too much to help me, it is not fair on them, they have busy lives and children to look after, they cannot keep coming round to help me, get my shopping and take me to appointments."*
>
> Service user

Shopping, transport and attending appointments are all aspects of service delivery that consumers feel there should be more of that is missing from their plan. Increasing the number of visits and services are all aspects of a care package that consumers see will ease the burden of care for the consumer and most notably their whānau who they feel are having to do too much.

5.5.6 Service Quality - what we expect!

Qualitative responses in the surveys reflected a number of frustrations with the service providers and support staff. This involved cancelled appointments, support workers being late, work not being of the standard expected. Consumers stated being frustrated with support workers, not happy with their care and attributing their decline with the level of care. Lack of communication and/or poor communication being key contributing factors.

> *"The service provider is useless".*

Service user

"There have been numerous people supporting me who should not have been working as a care giver"

Service user

"I am happy with the support workers that come out to me, but the organisation they work for is a disorganised mess, nobody seem to know what is happening."

Service user

Day care support was viewed negatively. Several participants stated it was "boring". It was felt that the day care programmes where cognitively pitched too low for the user. Whilst they provided a day out of the home, and the opportunity for partners and whanau to have some much-needed rest, they attendees did not warm to the content of the programme and did not relish going.

5.5.7 Getting it right – getting what we want!

Whilst there is a degree of dissatisfaction about levels of care, relationships with providers and communication issues, by contrast patients and families are grateful and happy with the services they receive. Consumers often build relationships with support workers that go beyond service provision. This helps address key concerns about loneliness of our older isolated population. It is also rewarding for service providers, which is reflected in the statements made at all levels.

"The supports I receive allow me to stay out of care and remain living at home independently"

Service user

"Yes, the support available makes it possible to have a good and enjoyable life".

Service user

Participants commented on the quality of service, with several feeling lucky to have the support they received. Several identified benefits, such as reduced hospital

presentations and improved quality of life. A priority for patients, which is reflected in the themes and responses, is the easing of the burden on their partners. Patients are acutely aware of how life is challenging for their partner, if they are still together, so frequently the comments reflected requests for more help for their partner. Reducing stress and worry for whanau was also important to patients. Whilst the choice of support can be limited, the ability to choose their own support provider and also change if unhappy was commented on. The Māori participants valued being able to access a Kaupapa Māori service provider as well as the ability to access a Māori needs assessor.

5.5.8 Opportunities - what is important to us?

Participants were generally vocal about the care they received and pointed to the prescriptive nature of NASC funded services. It could be argued there is an inevitability in this when it comes to managing the support needs of a population of 9,500 or more. However, there needs to be sufficient options available that there is some ability to meet the varied needs of our older population.

> *"I would like more choice…"*
>
> Service user

> *"I am very happy with my life, health wise it is not too bad, I have great neighbours, my son in England rings me each morning, I am also in touch with family and friends with my iPhone and iPad, two carers and a person delivering meals in wheels allows me to have an enjoyable life"*
>
> Service user

Providing greater choice is challenging and unsettling for executive leaders, funders and service providers, in that inevitably control shifts to the individual client and their whānau. Whilst this might meet the patient's needs, there is less assurance that people would be safely supported at home for longer. By contrast, others do not want that choice, they are happy for the supports they receive and the routine that comes with those regular visits.

> **"***I need more help to get out, this is important to me. I want help to go the shops and help to get to my doctor's appointment. It is not fair to keep asking my daughter to take me, she works and does not have time".*
>
> Service user

Reducing social isolation is an identified key need. Delivering this is challenging for funders and also for safety reasons challenging for providers. As has been touched on elsewhere, whilst day care is helpful, it is often pitched too low for some clients and in many ways the activity is not the activity of choice for patients. There may be benefits for partners who are given one or two days rest per week and the ability to do other tasks, but the format of the programmes is not well received by many patients and is not how they would choose to socialise.

5.6 Findings summary

When the quantitative and qualitative data are considered, there appears to be a general dissatisfaction with how care and support is delivered across the Waikato region. Whilst numerous responses reflect gratitude, a greater number reflect a need for more, for better communication, for the ability to go our more, for their house to be tidier and cleaner. It seems there is a wish to have access to all of the "abilities" they had as a younger person, and the realisation that this cannot be delivered is ultimately dissatisfying.

Chapter VI: Discussion

> *"Our prime purpose in this life is to help others. And if you can't help them, at least don't hurt them."*
>
> Dalai Lama

6.0 Introduction

This chapter concludes the thesis and interprets the results presented in Chapter V. The aim of this research was to review a new model of care and identify what would be considered a successful implementation, at every level, from executive leadership right through every level of responsibility and onto and including the consumers and their whanau who are recipients of this service. This section is split into two parts. The first section will consider the following three research questions:

1. What are the views of health professionals involved in the delivery of care and support to older people in relation to measuring success?
2. What are the views of older people who are currently, or have received health and disability support services in relation to measuring the quality of those services?
3. How do community providers measure success in the services that they provide?

The second part considers what we have learnt and what this will mean for the model of care and the services involved moving forward. Identifying success with this approach is challenging. The different levels of responsibility for the care of this population, will have very different agendas and motivations for a good outcome from a patient and population perspective. Older people and their whānau will also have very different agendas and motivations around what is an effective care plan.

Part 1: The research questions

6.1 What are the views of health professionals involved in the delivery of care and support to older people in relation to measuring success?

Society views success in many different ways and it is very much dependent on the perception of the individual. However, a simple definition could be as straight forward as a favourable or desired outcome. In the case of Health Services in general, Older Persons Services and Needs Assessment and Service Coordination, we are looking to improve the health of our population, assist that population to have an independent life of their choice and help manage demand for health services. What is evident from the health professionals who were interviewed was that there is a strong common purpose. There is a view at every level that the work they are doing is of value, it is making a difference in the community from a whole of population effect and also making a difference for the individuals in our care. Executive leadership reported that there is a need to invest in services that are of good value and that benefits must be realised. They are identified that a successful service leads to good outcomes for the patients in its care, but also leads to good outcomes for its staff who are happy in their role and see purpose and value in that role, this in turn also has a positive effect on their families, their community and the local economy. Those interviewed from operational management reported the same broad values.

All of the staff interviewed had a vocational approach to the work they were doing. This was work they wanted to add and the value they felt they were adding was a personal reward. With an older working population and an overall population that we have seen is ageing with a greater proportion of older people within that population, the personal experience of those interviews has certainly informed that view. Virtually all of the interviewed health professionals shared an experience of their older family members and their experience of trying to access services. That personal experience reinforced the health professional's view of the value of their work, but also highlighted where things need to improve and how we could do better.

It is clear that accessing the right care at the right time is challenging for patients, especially those in later life, not as cognitively well or as independently mobile as they used to be. The views of the health professionals identified the complexity of what people are eligible for, how it is funded, the process of assessments and funding eligibility are confusing. This was apparent when they were supporting their older relative and they expressed frustrations such as have to "speak to the right person" and "it was only when I got involved that things happened". If our health professionals working in the system identify these challenges and are frustrated by them, then this is even more challenging for patients and whanau who have no knowledge of the health services who could be involved in their care. How the success of these services is measured by the health professionals involved is multi-factorial with different measures valuable at different levels. One consistent theme throughout was complaints and compliments. These come through a variety of ways. Health and Disability supported complaints that come direct to the Chief Executive Office, which filtered through the Chief Operating Office to the Service Manager to respond.

Performance targets are a focus for managers, funders and executive leadership. In isolation, this is quite a blunt tool for managing performance. The patients in the care of the service are complex, with multiple co-morbidities and often challenging issues such as housing and family dynamics. Whilst an assessment and a review may be expected to take a set amount of time, the work around this such as contacting GP's, other health professionals supporting the patient, reviewing notes and history, following up with home-based providers, varies greatly. Too much time could be spent on a relatively straight-forward client with no greater outcome. Equally a brief assessment and brief follow up may appear good performance, but with a complex client this may fall far short of meeting their expectations and providing a good outcome.

The Ministry of Health mandated the use of the internationally recognised interRAI needs assessment tool, this is now used in all Needs Assessment and Service Coordination agencies across Aotearoa-NZ. This electronic evidence based assessment tool theoretically does not allow for corners to be cut. All questions have to be answered for the assessment to be completed. The assessment contains 600

reference data items, 30 triggered Client Assessment Protocols (CAPSs) and 10 different outcome scores. It has led to greater consistency with decision making and has provided us with evidence of what our population needs. However, both nationally and locally in the Waikato, there remain no consistency around how many assessments Needs Assessors should compete. The varied complexity in the population that is demonstrated by case mix methodology further compounds this. This provides some anxiety for staff and managers who struggle to demonstrate efficiencies, alongside delivering a quality service that meet peoples need. This is reflected in the interviews and is a recurrent topic in Service Performance meetings at Te Whatu Ora Waikato and Needs Assessment Service Coordination agency forums at Ministry of Health.

6.2 What are the views of older people who are currently, or have received health and disability support services in relation to measuring the quality of those services?

As with the health professionals interviewed, the measures of success for older people are multi-factorial. What is apparent from the responses is that when a consumer is unhappy about service delivery, they are more vocal than those that are happy with the service. Interviews with clients who were happy with a service were brief, complimentary and straight forward. Unhappy consumers had longer conversations that were detailed and focussed on more than just the service that was being reviewed.

Communication was at the root of the complaints. For our older clients there appeared to be a feeling that services and changes were occurring outside of their control and not including them. If services were cancelled, they were not informed, or if they were difficult to get hold of little effort was made. It should be remembered that the surveys were undertaken during a period that was influenced by COVID, with services impacted by lockdowns and sickness. During this period, Te Whatu Ora Waikato and its five home based providers collaborated to give patients regular welfare check telephone calls. The aim was to keep our older population informed and connected through this unsettling period. Weekly phone calls were made to all clients receiving home-based supports, as well as receiving their normal supports. Despite

these efforts, it is clear from the feedback that communication and the lack of it remains a problem and participants did not see this as successful.

As part of the restorative approach, some traditional supports have been reduced, to allow for further inputs that are considered more essential. Household management is a good example of this. This has caused and continues to cause angst with many clients. Many health districts no longer allocate household management. Te Whatu Ora Waikato continues to allocate 1-hour per week household management alongside other personal care supports. Patients and their whanau see this as inadequate. Their desire is that this support was increased so that their house can be kept in the manner it was when they were much younger and more able. This is not viewed as good use of health dollars; hence the bare minimum being allocated. In the financially constrained environment that health is, with many competing demands for those health dollars, increasing household allocation management would be seen as a luxury and not a necessity. Nevertheless, the lack of it, or even worse withdrawal of it, is seen very negatively and makes for very emotive negative media publicity. As such providers and funders find themselves challenged, trying to meet the needs of its patients, but having to be judicious with what it is spent on. In reality, the choice given older people is the ability to decline some services. Not truly decide what services they want. Participants saw the easing of the burden on their partner and wider family as a marker of success. They reported as being acutely aware of the burden they have now become.

6.3 How do community providers measure success in the services that they provide?

Te Whatu Ora Waikato has five contracted home-based support providers. Three more mainstream larger providers who have a presence in the majority of districts across Aotearoa-NZ. Two Māori home-based providers with a local presence limited to distinct parts of the Waikato. Home based providers use many of the objective measures Te Whatu Ora Waikato uses. Timeframes to see patients, monitoring complaints and compliments, capturing feedback from patients and their whanau. The potential to build on this with a more outcomes-based review of service, in partnership with a Te Whatu Ora Waikato, makes for an exciting and challenging opportunity.

Matching traditional service performance, along with hospital and urgent care presentations, is possible using the data we capture in InterRAI, alongside hospital data and also data the providers collect. The opportunity is there for providers to demonstrate success, equally, it could highlight where they are failing. At this early stage of the new model, there is a willingness on the part of the providers and Te Whatu Ora Waikato to work together on this, but a strong note of caution by all parties as to what this will highlight.

One of the larger national home-based providers has recently undertaken an exercise that reduces its local presence, adopting a more national call centre approach. The interviews with patients, the home-based providers and NASC staff all viewed this negatively. Value was placed on local knowledge and local people on the phone involved in identifying solutions. The diverse nature of the Waikato and its distinct and resilient communities has been seen as a strength when it comes to identifying solutions. With this in mind, Te Whatu Ora Waikato has shifted from a Hamilton based service to a locality-based service. Needs Assessor Service Coordinators are based in local communities across the district, so they know local GPs, know local providers, know community groups, it means that packages of care reflect the community and the resource available to it. As the providers move to a more national call entre approach, there will be inevitable efficiencies that can be seen as a marker of success, but it is at odds with the model of care in the Waikato and at this stage has not been well received.

Part 2: Knowing when we get there

6.4 An integrated approach to communication

At this stage of the evolving model of care there is cohesion between those responsible for leading, managing and delivering care, but a disconnect from the service users and whānau accessing care. This is illustrated in Figure 11.

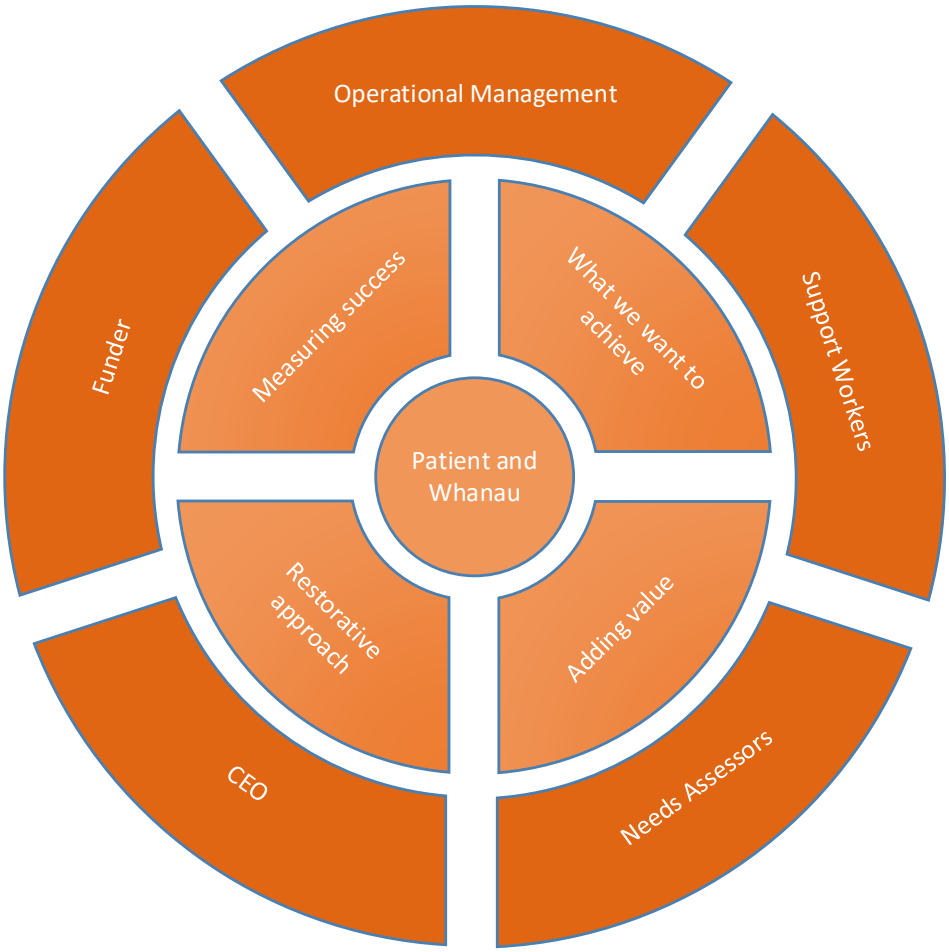

Figure 11: The disconnect between service delivery and service users

In terms of this model of care, and the staff implementing and supporting this, from executive leadership through to service delivery, there is a strong sense of purpose. For the health professionals involved, the identified successes were: The consistent messaging; An evidence-based approach to the development of the model of care; Involving staff at every level with the development of the model of care through

ongoing consultation and clinical governance oversight; and Agreeing key performance indicators and expectations of service delivery with staff at every level of the service.

6.5 Limitations

A limitation of the study is that the interviews with patients and the staff involved have occurred in the early stages of the developing model of care. Nonetheless, the issues that patients primarily were less about the model of care and more about the quality of service and poor communication. The influence of COVID and lockdowns during the implementation should also be considered. Staff sick leave in the home-based providers and at Te Whatu Ora Waikato have been at higher levels than normal. Health providers have also been hit by staff leaving and retiring and no overseas health professionals coming into the country to replace them. This has led to 3 years of quite disjointed services as supports stop and start and recruiting staff remains difficult.

Currently, expectations of service performance across Aotearoa-NZ are vague and vary from district to district. There are no clear identifiable key performance indicators for needs assessors and service coordination teams. Discussions at Ministry of Health forums identifies that variance. Whilst interRAI has standardised some aspects of practice, there is still variance in how often people are assessed, how often they are reviewed and variance in the productivity of individual team members. This makes it difficult for managers and leaders to feel confident that their service is performing well. There are no clear ways to benchmark that performance with peers in other districts.

6.5 Conclusions

In conclusion, He Korowai Oranga o Nga Kaumatua has provided a vision for Older Person's services in Te Whatu Ora Waikato that will inform practice over the next five to ten years. The level of engagement and support for the model by the health professionals involved supports its ongoing development. Staff involved feel they are making a difference and this shared value supports the further development of a successful model of care and successful outcomes for the population it is supporting.

Having said that, we have to consider that the people we are trying to support are not identifying this value. More work needs to happen around communicating the intent of the model, setting expectations that are realistic and major improvements on how we communicate with our older population. We cannot discount their wishes in support of their needs, however, we do have to continue to monitor the cost of those interventions to ensure successful outcomes are achieved with a judiciously managed dollar spend.

6.6 Policy and practice implications

Enabling Good Lives is trial currently favoured by Ministry of Health. This model is being rolled out in Disability Support Service Needs Assessment Service Coordination agencies across Aotearoa-NZ. Disability Support Services fund the long-term support for clients with an intellectual, physical, and/or sensory disability. The aim is to empower young people living with a long-term disability to lead an independent life of their choice. It gives the client more choice around who is their service provider, what type of supports they receive and when. It places the budget for their supports in the hands of the service user, and alongside a navigator allows them to control how they use that support. In general, the choices available to a younger person with a disability tend to be more creative than those clients supported under Health of Older People. Choices in Community Living being another option available to Disability Support Service clients.

There are calls for a similar approach to be implemented for our older population. This is often voiced by some of our clients at forums, especially younger clients with chronic health conditions that due to their now age-related issues find themselves falling under health of older people funding. Whilst every NASC agency aspires to the values behind Enabling Good Lives, the model still has some concerns. It has been driven to some extent by a cognitively well, well informed client with perhaps a physical disability. Concerns for how safe some of our intellectually disabled clients are managed in this model have been raised. Concerns about their vulnerability to providers and whanau even who may contribute to mismanagement of these supports. Needs Assessment Service Coordination Agencies are reluctant to let go of that gate keeper role that ensures supports are fairly provided and judiciously used.

Whilst the views of patients in these thesis would support an approach like Enabling Good Lives; more choice, supports when they need them, the supports that they want for example. This however should be explored with caution. To some extent the supports patients want more of we have concerns will not have the best health outcomes and will potentially lead to increased hospital demand and increased spend on health dollars. Providing our older population with choice and the ability to live an independent life of their choice is behind He Korowai Oranga o Nga Kaumatua, but it is there with caveats. Further research would need to look at that balance of choice that an older person wants for their support and what is actually needed and will make the most difference.

6.7 Future research

Outcomes based data for our older population is something that is poorly identified and researched. The use of the interRAI evidence based electronic assessment tool has started to give us evidence of what our older population needs and where and what we should be investing in. However, identifying the difference we make for that population is problematic. As we have identified, this population is in its last 1000 days of life and every day activities are getting harder. They are getting sicker and requiring more care. We can measure how timely we are, how often we are seeing people and the types of intervention we provide, but how do we know that the investment we have has truly made a difference in a population that we know is deteriorating? An opportunity for further research would be look at where we are under and over investing, trying to determine the right level of investment for the best outcomes. It comes back to an earlier statement in one of the interviews, we know the supports we provide make a difference, but we have to monitor that level of support to make sure we are not over delivering and we are making good use of the health dollars we are investing.

This thesis has been undertaken relatively early on in the current model of care. Home based providers are still learning the restorative approach. This is a shift for them at every level. Support workers are learning a different approach to supporting their clients, for managers of service the long term support of a client may become more

fluid and this will influence how they allocate the resource available to them, it also changes the funding relationship between the provider and Strategy and Funding at Te Whatu Ora Waikato. This will take time to refine. Currently there is a strong working relationship between the funder, provider and the NASC team, this bodes well for further development and future evaluation.

How we capture activity and match that to our hospital and InterRAI is developing as the model of care is evolving. In many ways this thesis has established a baseline measure that should be revisited. Making data "live" instead of retrospective will further inform the programme. Too often we get to the end of month, review service performance and consider could we have done better. The wealth of data InterRAI gives us means we know more about our older population than ever before. Matching this with hospital data and other sources further informs this. Qlik and Power BI data management gives us the ability to make this data "live" and make it talk to us, so it is informing and influencing practice on a daily basis. This means we can respond to demand there and then, identify and address trends in our community there and then, making interventions more timely, leading to better outcomes for our population and better management of their needs as we continue to refine this model.

Appendix 1.

Key Questions

All of the participants were asked essentially the same questions, worded to reflect whether they were a recipient of services, deliverer of services, manager, funder or senior executive. The intent then with each answer is to understand what is important and considered an indicator of success at all those different levels.

Consumers and whānau were asked to rate each question with; Strongly Agree, Agree, Uncertain, Agree, Disagree. They were given scope to add a narrative to each question to further explain the answer. The core set of questions to consumers and whānau are as follows:

In want age band are you in (please circle)?
50-55, 56-60, 61-65, 66-70, 71-75, 76-80, 81-85, 86-90, 91+

Are you (please circle)?
Male Female Non-binary

What services do receive (please circle)?
Meals on wheels Home support Respite care Day programme Other

How many years have you been receiving services?

How many people live in your home with you?

I have a good understanding of the purpose of the care I receive
Strongly Agree Agree Uncertain Disagree Strongly Disagree

I feel satisfied with the support provider and support workers that work with me.
Strongly Agree Agree Uncertain Disagree Strongly Disagree

Do you feel your care plan meets your needs?
Strongly Agree Agree Uncertain Disagree Strongly Disagree

Do you feel included in the decision making around your care plan?
Strongly Agree Agree Uncertain Disagree Strongly Disagree

Do you feel your care plan is flexible and meets your needs and any changes in your abilities?
Strongly Agree Agree Uncertain Disagree Strongly Disagree

Do you feel the support you and others receive in our community allow you to lead an independent life?
Strongly Agree Agree Uncertain Disagree Strongly Disagree

Do you feel the carers that work with you help you to make improvements in your ability to do everyday tasks?
Strongly Agree Agree Uncertain Disagree Strongly Disagree

I feel positive about the life I lead and feel safe in my home and the community around me.
Strongly Agree Agree Uncertain Disagree Strongly Disagree

Thinking about the services you receive, how would we know if we're doing a good job at meeting your needs (for example, keeping you out of hospital, not falling over, staying in contact with friends and family)?

If you were able to improve the support options available to you what developments would you put in place?

Is there anything else that you would like us to know?

Whilst not identical, the questions to the focus groups and one to one interviews with executive and service management reflect the same questions about service and what

might be considered a successful outcome. The questions to the focus groups and one to one interviews are as follows:

Can you tell me about yourself?

Can you tell me about the services you are receiving/delivering/allocating/managing/funding?

How you do know the service you are receiving/delivering/allocating/managing/funding are working well?

How do you feed this back (patient/whānau)?

How do you measure this (provider/funder/manager/executive)?

What do you consider good support from a service?

How do these supports help you/whanau/clients?

How do you know the services you are receiving/delivering/allocating is NOT working well?

How do you feed this back (patient/whānau)?

How is this fed back (provider/funder/manager/executive)?

Are the services responsive to the feedback (patient/whānau)?

How do you respond to feedback (provider/funder/manager/executive)?

Do you think the money spent on these services is of value?

Why do you feel they are a good/bad investment? How do you identify this?

Do you find the Needs Assessment / Service Coordination / Service Delivery / Assessment and Referral process easy?

Are your Population you are supporting / Service Provider / Needs Assessment agency / Team responsive?

Do you feel the Needs Assessment Service Coordination process is inclusive?

Do you feel involved in the decision making around your plan (consumer)?

Do you feel included in the development of the plan? Are you given choices and do these choices meet the needs that you identify (consumer)?

Think about what a good outcome would look like for you (consumer)?

What was life like beforehand and now (consumer)?

Do you feel the patient is involved in the decision making around your plan (provider/assessor)?

Do you involve the client and whānau in the development of the plan? Are they given choices and do these choices meet the needs that you identify (provider/assessor)?

Think about what a good outcome would look like for you (provider/assessor)?

What was life like beforehand and now (provider/assessor)?

How do you know when the community package is working well (All)?

If we could how well a service is going what do you think we should look for (All)?

What would things look like if they weren't going well (All)?

Can you think about the things that are important to you? What are they? Why are they important? (All)

If you were able to improve the support options available what improvements would you put in place? (All).

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