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Implementation as a systematic manageable process rather than a Pandora’s Box of confusion

Reshaping community home care services for older people
Stephen Phillip Jacobs
A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Medicine, The University of Auckland, 2010
Abstract

Background: The population is ageing with a concomitant increase in people living with chronic conditions. This is leading to increased demand for home care services that support people to maintain or increase their independence and level of functioning as long as possible. Finding a methodical approach to develop and implement such services is a vital task for the people responsible for funding them. In New Zealand this is mainly planners and funders in the Government funded district health boards.

Objective: To develop an implementation pathway, incorporating a performance management and measurement system, that is accepted by the sector as a method for developing and implementing restorative home care services for older people.

Participants: Key stakeholders in District Health Boards, including planners and funders, members of the Disability Services Advisory Committees, Needs Assessment and Service Coordination agency staff, and home care provider staff.

Methods: In Phase 1, participatory action research was used with focus groups in three District Health Boards sequentially to design an implementation pathway, plus a management scorecard with critical success factors. The acceptability of the results was then tested with a national focus group of District Health Board planners and funders. In Phase 2, the implementation pathway and performance management and measurement system were tested as part of a benchmarking programme with five District Health Boards.

Conclusion: A standard process for developing, implementing and then performance managing restorative home care services in New Zealand has been developed, using the Health of Older People Strategy as the common vision. Performance measurement using agreed critical success factors then provides technical information that enables people to benchmark services as part of a shared learning process for quality improvement.
Acknowledgements

The advisory team for me during this study has been extremely supportive and patient. I owe an enormous debt to Associate Professor Matthew Parsons. If not for meeting him in 2001, I probably would not have even started this often exciting and sometimes arduous journey. He has been a very knowledgeable, kind, encouraging, and sometime stern(ish), primary supervisor. I thank him for his forbearance and support. Associate Professor Paul Rouse has been hugely helpful in helping me engage with management literature, and focus on the management theories of most import to this study. His forthright comments have kept me on track.

The District Health Boards involved were extremely gracious in allowing me to become involved in their work. I hope the people associated feel they received some benefit. To all the people who engaged with the research, my thanks to you, and best wishes for both success and enjoyment in what is often a very difficult environment. There are many wonderful emotionally committed people involved, and I hope that my work may help slightly.

The School of Nursing has been as supportive as one could wish as I have moved towards completion. My particular thanks go to my colleagues in the Applied Ageing Research Group, who have managed to cope with my mutterings and distraction.

Of course, my major support system has been my family, particularly my wife, Shereen Moloney. She was certainly worried at one stage that trying to finish this thesis would kill me, so it will be great to move on to the next stage of our life together. For Willoughby, Nicolas and Eleanor, it is great to see that since I started this they have all focused on their own academic careers. I hope my example helps them get to this point more quickly than I did.
Contribution

I, the researcher, undertook all aspects of this study under the guidance of my supervisors. This involved choosing an appropriate study design and arranging engagement with the stakeholders within District Health Boards. I personally performed all interviews and ran all focus groups, undertook all analysis, and drew the presented conclusions.
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Chapter 1: Introduction

When people share beliefs and values, they can coordinate their efforts; they just know what they have to do.

(Glouberman and Mintzberg 2001)

The purpose of this thesis is to provide planners and funders of District Health Boards with a consistent approach or pathway they can follow in the development and implementation of home care services for older people. The implementation pathway provides planners and funders with a problemistic search approach (Cyert and March 1963), assisting them to set goals and then use performance measurement to receive feedback on success and risks, using benchmarking information to increase dialogue focused on quality improvement. The context for the development of the pathway was home care services for older people. Older people were a focus because the New Zealand population is ageing, in line with much of the rest of the world (Ministry of Health 2002; Christensen, Doblhammer et al. 2009). Demographic projections for New Zealand indicate that the percentage of people 65 years and over will increase from 12.4 percent to over 20 percent by 2020 (Ministry of Health 2002). In a parallel trend, there is an ever-growing number of people with long term conditions, mainly due to this ageing population having a heavy burden of lifestyle-related illness yet increasingly longer survival rates (National Health Committee 2005). Even though late-life disability is declining, co-morbidities are now the norm (Starfield, Lemke et al. 2003; Schoeni, Freedman et al. 2008). The implications of these demographic shifts are far reaching, since it is predicted there will be a fourfold increase in those aged 75 years and above over the same time period (Ministry of Health 2002).

---

1 Problems are either identified by failure to achieve a certain goal or by the threat of failure in the upcoming future. As long as a specific problem is not solved, an organisation will continue to search for a satisfying answer as the declared goal. Thus problemistic search is undertaken as long as actual performance is below a certain aspiration level (Cyert and March 1963).
Home care services were the focus because long-term care for older people and people with chronic conditions is shifting from a concentration on residential care to assisting people to stay living in their communities (Kane and Kane 1988; Booth and Mor 2007). Good quality home care can work to improve the quality of life of the older person while being considerate of the stress levels of any family carer (Banks 1999; Milligan 2004). The Health of Older People Strategy (Ministry of Health 2002), which is the New Zealand Government direction to the health sector on how to support positive ageing, has a major focus on the development of community health services that support older people to age well at home. Internationally, governments have been progressively shifting resources into community care. Evidence has shown that this can lead to both reduction in costs and improvements in quality of care, as well as being what older people want (Mottram, Pitkala et al. 2002). A restorative model of home care that aims to assist older people to remain active is therefore being adopted in New Zealand (Parsons, Anderson et al. 2005).

New Zealand has a mainly publicly funded health system, with the funding of services being controlled and managed principally by 21 regionally placed District Health Boards (DHBs). Stakeholders interested in the health system’s optimal performance include the government, governing bodies, health care providers and managers, special interest groups, and everyone who is a user or potential user of health care services (Green, Kagolovsky et al. 2000). Each DHB has its own planning and funding division, responsible for the planning and funding of services for older people, and systematic review and audit of funded services to ensure they are being delivered and that they are financially viable, clinically safe and of a high quality (Ministry of Health 2003). There will be considerable challenges to such a publicly funded healthcare system in the next decade, given the ageing population, technological advances, rising patient expectations, and healthcare costs outstripping inflation, to name but a few (OECD 2001; Christensen, Doblhammer et al. 2009). The health workforce is also under pressure, as not only is it too ageing, it is not increasing at a rate that meets current, let alone future, demand (Ministry of Health 2007). Along with these pressures, DHB planning and funding managers carry a responsibility to manage the development of effective home care services for older
people, and since the publication of the Health of Older People Strategy, the
direction of development has been determined for them.

However, achieving successful change in an organised vision driven manner is
difficult (Kee and Newcomer 2008). This is especially true for the health sector,
which consists of networks operating across organisational structures. People work
across boundaries that exist among professional groupings as well as between the
primary and secondary health care sectors (Powell 1990; Glouberman and Mintzberg
2001; Marshall and Grant 2008). Within the management literature, the difficulty of
management control of a workforce operating within networks has been well
recognised. Staff often cannot be closely supervised and what is required differs with
each patient (Simons 1995; Papadopolous and Merali 2008). The difficulty of
management control is a key issue in the health sector where much of the workforce,
for example doctors, nurses, and physiotherapists, have professional autonomy.

Simons (1994, 1995) explored how managers can control the way their workforce
operates in an environment in which they are empowered to operate with little
supervision (Glouberman and Mintzberg 2001). This thesis applies his idea that key
stakeholders, including workforce, must be motivated by a vision. The major focus
of this thesis has been on developing a process for ensuring there is a shared vision
that is then operationalised, building on the Theory of Communicative Action
(Habermas 1981; Habermas 1987) as developed in the Sheffield V-Model (Sheffield
2005). The V-Model uses a small number of general systems concepts to develop a
communication approach that aims to reduce conceptual confusion or uncertainty
amongst participants. To enable dialogue to be what Habermas terms ‘valid’
communication, the V-Model requires the collection of technical data to triangulate
with people’s personal and social worlds. To enable the collection of relevant data,
this thesis developed a performance management and measurement system, mainly
through modification of the balanced scorecard (Kaplan and Norton 1992; Schmidt,
Bateman et al. 2006). The research methodology used was a form of action research
developed by management Harvard Business School Professor Robert Kaplan
(Kaplan 1998). Innovation action research requires an ongoing iterative process of
developing information and then testing it with the people involved in the research.
Chapter 1: Introduction

The researcher is an active participant in the process, rather than a distant observer. The research process had two stages: Phase I involved working sequentially with three DHBs to develop an implementation pathway designed around principles of communication, management control, performance management and evaluation. At the end of this phase, a national focus group of DHB Health of Older People Portfolio managers confirmed that the core tenets of the approach were acceptable to them, and that they considered the approach useful. Phase II involved the development of the implementation pathway into a development and benchmarking approach called IN-TOUCH (Integrated Networks Towards Optimising Understanding of Community Health).

There are six chapters. Chapter One introduces the thesis, Chapter Two presents the literature review, with a focus on two areas: the health issues arising from an ageing population and business approaches to implementation, performance management and performance measurement. Chapter Three covers the methodology chosen for this research. Chapter Four presents the methods, Chapter Five the results, and Chapter Six the discussion. The conclusion is that the implementation pathway developed in this thesis is useful for DHB planners and funders. Relationships between the different stakeholders in home support services are shown to be fraught with misunderstandings that jeopardise service development and service quality. The implementation pathway developed in this thesis and the IN-TOUCH benchmarking programme are shown to be products that will assist people who want to develop community services for older people. They also have sufficient credibility with DHB Health of Older People portfolio managers that they will actually be used. This has been demonstrated by the ongoing use of IN-TOUCH in a number of DHBs.

1.1 Study definitions

In this study, it will become clear that words can have different interpretations and meanings, even in the same setting. Therefore, key words are defined at this stage, so that readers gain a clear understanding of the area of interest. ‘Older people’ are defined by the Oxford English Dictionary as advanced in age; far on in the natural period of existence. People’s ageing is said to be a natural process (Binstock & George, 1990). The World Health Organization (WHO) had difficulty defining a
specific age as ‘old’ because ‘old’ is a social construction (World Health Organisation 2002). Old age does not start specifically at any particular age as the changes of age are varied and complex (Tinker, 1993). In New Zealand, people are eligible for the old age pension or superannuation at 65. ‘Young old’ has been defined as being aged between 65 and 79, with those aged 80 and over being termed the ‘older old’ (Cornwall and Davey 2003). This distinction is shown later to have importance for health services as it is the projections that the number of older old will increase that are causing them the most concern. It is anticipated that this increased older population will also mean an increase in the number of people with complex needs. Complex needs are those resulting from multiple, usually interrelated, problems over several different physical, mental, and social dimensions of health and well-being as the individual shows signs of functional decline or frailty (a vulnerable state of health), and is at risk of hospital admission (New Zealand Guidelines Group 2003).

‘Ageing-in-Place’ is a concept developed by health and social policy ministers from Organisation for Economic Co-operation and Development (OECD) countries as they sought ways to cope with the increasing older population, many with complex needs. The concept refers to older people who require support to be able to continue to live in their own home, or where this is not possible, to enable them to live in a sheltered, supportive environment which is as close to their community as possible (OECD 1994). The concept does not necessarily mean the older person must stay in the family home permanently; it can mean moving to a more suitable, perhaps smaller home nearer to facilities such as shops, while maintaining links with family. One of New Zealand’s ageing-in-place strategies is to encourage new initiatives which support older people in their own homes. These include funding for increased levels of support services, rehabilitation, and case management, which all aim to enable people to stay within the community (Ministry of Health, 2001a; Office for Disability Issues 2001; Ministry for Social Development 2001).

‘Assessment and service co-ordination’ are key parts of the decision process of any ageing-in-place initiative. They are used to determine older peoples’ goals, abilities, and needs. Where necessary, the assessment provides the information needed to develop a support package which meets older peoples’ goals and needs (New
Zealand Guidelines Group 2003; Ministry of Health, 2005). Assessment and service co-ordination teams are funded by the District Health Boards (DHB); these needs assessment and service co-ordination (NASC) services are either situated within acute public hospitals or are separate entities within the communities. NASC workers coordinate and manage the allocation of home care services on behalf of DHBs, working within allocated budgets (New Zealand Guidelines Group 2003). Formal support services are funded by the DHB, Accident Compensation Corporation (ACC), the Ministry of Social Development, or privately. A second option is informal support from family and friends. The Ministry of Health (MoH) has defined ‘support’ as assistance in home services. This includes personal support such as household management, as well as respite care, environmental support such as equipment, home, or vehicle modifications, and residential care (Ministry of Health 2002).

This thesis concentrates on what have traditionally been called ‘home care’ services, contracted by DHBs to provide functional replacement; that is, to perform functions the person has lost the ability to perform, even temporarily. There have traditionally been two categories of home care: household management, in which tasks such as household cleaning and cooking meals are performed, and personal care in which personal hygiene, such as showering and toileting is assisted (Capital & Coast District Health Board 2005). Throughout this thesis, the home-based support services sector is referred to as home care. In New Zealand, home care providers are usually for-profit or not-for-profit organisations that are not part of the DHB. Most DHBs contract with a number of home care providers, usually at least three but sometimes up to six.

Home care can include planned early discharge with home care, rehabilitation at home (with or without planned early discharge), specialist nursing outreach services at home, specialist geriatric services delivered at home, ‘hospital at home’ – hospital level 24-hour nursing and specialist medical input at home either after hospital discharge or to avert hospital admission. Also included are specific high-tech techniques and equipment used at home; e.g., intravenous therapies and renal dialysis, and quick response teams and primary-care-based preventive interventions
to avoid or reduce acute hospital admission (Wainwright 2003). With so many different service options available, an ‘integrated continuum of care’ approach to health service delivery is important. This has been defined in New Zealand as an older person who is able to access needed services at the right time, in the right place, and from the right provider (Ministry of Health 2002). Providers would work closely together and, where appropriate, with families, whanau,² and other informal carers. Services and programmes in the continuum extend beyond the scope of the home care providers and might include health promotion, preventive care, specialist medical and psychiatric care, rehabilitation, community support services, equipment, respite care, and residential care (Ministry of Health 2002).

Many older people require ‘long-term care’; this has been defined by the Institute of Medicine (Wunderlich and Kohler 2000) as being a variety of ongoing health and social services provided over a sustained period of time for individuals who need assistance on a continuing basis because of physical or mental disability. The services can be provided in an institution, the home, or community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies (Ikegami and Campbell 2002). This concept is important because many older people are users of both health and disability support systems and require not only curative and rehabilitative health care, but also long-term care (OECD 2003). The very nature of long-term care can be seen as the attempt to assist people by maintaining the best possible level of function, alleviating suffering, reducing discomfort, improving the limitations caused by disease and disability, and maintaining the best possible quality of life (Larizgoitia 2003).

In New Zealand, the Health and Disability Services Act (2000) has ensured that long-term care is integrated into the health care system. The Act established District Health Boards (DHB) that have responsibility for the well-being of their populations.

² Whānau is a Māori-language word for extended family, now increasingly entering New Zealand English, particularly in official publications; (ii) An extended family; (iii) Family, the key building block and the basic unit of Māori society. The whānau could consist of up to three or four generations living together (en.wiktionary.org/wiki/whānau, accessed 23 December 2010).
Responsibility for disability support services remained with the Ministry of Health until 2003, but had been a responsibility of the health system since the health reforms of 1993 removed funding and responsibility for disability support services from Vote Social Welfare to Vote Health (Bray 2003). With the devolution of funding for disability support services for older people to DHBs in October, 2003, New Zealand clearly chose to strengthen the connection of the medical and long-term care systems for older people within the health system. The reasons given for doing this were that health and disability support programmes for older people were seen to be planned, funded and provided in a piecemeal fashion that resulted in service gaps and overlaps in some areas and inconsistent access criteria. This created an inefficient and confusing system for older people and carers trying to identify their health and disability support options. Opportunities for regaining health or improving quality of life were lost because of the lack of focus on integrated community, primary, and secondary services (Ministry of Health 2002).

In New Zealand, District Health Boards (DHB) are a major funder of health services, including home care services (Wainwright 2003); they are responsible for providing or funding the provision of health and disability services in their district. There are 21 DHBs in New Zealand which were established on 1 January 2001 when the New Zealand Public Health and Disability Act 2000 came into force. The statutory objectives of DHBs include improving, promoting and protecting the health of communities; promoting the integration of health services, especially primary and secondary care services, and promoting effective care or support of those in need of personal health services or disability support. Other DHB objectives include promoting the inclusion and participation in society and the independence of people with disabilities, reducing health disparities by improving health outcomes for Maori and other population groups, and reducing toward elimination health outcome disparities between various population groups. DHBs are expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.
1.2 Personnel involved in stakeholder groups

The personnel involved in the main stakeholder groupings involved in the research for this thesis are described below:

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Role description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB planners and funders</td>
<td>DHB staff with responsibility for planning and funding services, and then contract managing those services. For services for older people the main involvement would usually be from a Health of Older People Portfolio manager and a contract manager. In this research, the DHB Planning and Funding Disability Services General Manager and an operations systems manager were sometimes also involved.</td>
</tr>
<tr>
<td>Needs Assessment and Service Coordination (NASC) managers, assessors and coordinators</td>
<td>NASC managers fulfilled typical organisational management roles. Assessors undertook assessments of clients. Coordinators had responsibility for developing appropriate service packages, overseeing the services being delivered to their clients, coordinating between different health service providers and ensuring appropriate services were delivered. They were the main contact between the NASC and the home care provider for their clients.</td>
</tr>
<tr>
<td>Home care managers, coordinators and support workers</td>
<td>Within home care, managers fulfilled typical organisational management roles. Coordinators received initial information about clients from the NASC, and then organised the delivery of services. They would usually visit the client to verify the NASC assessment and to discuss with the client the package of care. The coordinator would then assign a support worker or workers to that client, and oversee the delivery of service, supervising support workers and liaising with the client and their family.</td>
</tr>
<tr>
<td>Disability Services Advisory Committee (DSAC)</td>
<td>DSAC is a legislatively commissioned advisory group to the executive board of a DHB. It comprises members of the executive board with an interest in disability issues, plus representatives from the disability sector.</td>
</tr>
</tbody>
</table>

1.3 This study

In this study the example or focus was on the development of new home care services for older people based on recent research evidence that a paradigm shift was needed (Tinetti, Baker et al. 2002; Parsons, Anderson et al. 2006). In Chapter 2 the literature on issues around population ageing, the concept of ageing-in-place, and the development, management and performance management of appropriate services for
older people are explored. From this exploration, the research questions are developed.
Chapter 2: Literature review

The one eyed man is king in the land of the blind

Erasmus (1510)

2.1 Introduction

This chapter begins by examining population ageing and its possible impact on the New Zealand health system and health service delivery models. The vision for a positive ageing approach to health is then explained by discussing the Health of Older People Strategy (Ministry of Health 2002) and the changing expectations of older people and their families. This leads to an exploration of how the meaning of the term ‘long-term care’ is changing as focus shifts from a medical model of health care to a social model. The need for a new restorative model of home care as part of an integrated continuum of care is examined, and then the problems of implementing new approaches to service delivery are explored. The meaning of quality in service delivery is then considered. The literature shows that success in implementing change is difficult, so models of performance monitoring are critiqued with an emphasis on finding approaches that encourage dialogue and engagement from all key stakeholders. The chapter finishes with presentation of a psychological – sociological approach to reaching agreement based on Habermas (1981).

2.2 Search methodology

Articles reviewed were accumulated through computer searches of a number of medical, nursing, psychology and management databases, with most articles being found in the MEDLINE, CINAHL, and ABINFORM@Ovid full text databases. The University of Auckland’s Philson and General Libraries were used for all manual searches, and online searches were undertaken using the Internet search engines Google (http://www.google.co.nz) and Google Scholar (http://scholar.google.com) and manually searching the Ministry of Health web page (http://www.moh.govt.nz). Key words in the literature search included ‘aged’, ‘older people’, ‘service development’, ‘home care’, ‘carers’, ‘ageing in place’, ‘performance management’, ‘management control’, ‘performance measurement’, ‘balanced scorecard’, ‘report
cards’, ‘outcome measurement’ and ‘implementation’. Publications, reports and books by the Ministry of Health and Ministry of Social Development were used as resources. People working in health and management areas, such as people working within District Health Boards, were asked for any information they had, i.e., scientific journals and publications, or grey literature that could be useful. The primary inclusion criteria were articles that referred to ‘aged’, ‘elderly’, ‘older people’, or ‘over 65’ in research or discussion on ‘ageing in place’ or ‘the ageing of the population’; secondly, articles that referred to older people and discussed levels of support, or long-term support that assisted older people to stay at home; and thirdly, articles that engaged with issues of developing, implementing, and/or managing or performance managing the delivery of a product or service, with particular attention to community or/and health services.

2.3 Demographics

2.3.1 Population ageing worldwide

Population ageing is a worldwide phenomenon, particularly in the developed world where populations have low rates of births and deaths that result in older age structures and slow or no growth (Grundy 2002). New Zealand fits into this developed world category, in which “the most pressing public health problem concerns the growing proportion of old, particularly very old people, and the possible implications of recent changes in family systems” (Grundy, 2002, p 807). This population pattern has arisen because of changes in fertility rates (women having fewer children and lower mortality rates, while fewer children die and each child has an increasing life expectancy). There has been a gain of about 30 years in life expectancy in Western Europe, the United States of America, Canada, Australia and New Zealand over the 20th century, with even larger gains in Japan, Spain, and Italy. Life expectancy is lengthening almost linearly in most developed countries, with no sign of deceleration. Best practice life expectancy, that is the highest value recorded in a national population, has risen by three months per year since 1840 (Christensen, Dobhlhammer et al. 2009). If life expectancy were approaching a limit, some deceleration of progress would probably occur. Continued progress in the
longest living populations suggests that we are not close to a limit, and further increases in life expectancy seem likely (Rau 2008; Christensen 2009).

It is the oldest-old group (aged 85 years and more) that over past decades have been the most rapidly expanding segment of the population in developed countries. For instance, data from more than 30 developed countries show that in 1950, the probability of survival from age 80 years to 90 years was on average 15–16 percent for women and 12 percent for men. In 2002, these values were 37 percent and 25 percent. In Japan, which is the country with residents having the highest chances of survival, the probability of surviving from age 80 years to 90 years now exceeds 50 percent for women. It is improvements in survival amongst the oldest-old that are the cause of the growing numbers of older people (Rau 2008).

Policy makers and funders have been reacting to such predictions for a number of years, but recent literature has begun to unpack the demographic future in more detail. This shows that such trend analysis alone cannot provide a certain basis for predicting either demand for or supply of formal or informal services. There are demographic drivers and sensitivities that have led to unexpected changes in trends. Changes in social patterns and activities and the availability of medical and social services can impact on mortality trends (Rau 2008). For instance, in 1980, remaining life expectancy for people aged 80 years was higher in the USA than it was in Sweden, France, England and Wales, and Japan. However, through the 1980s and 1990s, mortality improvements stagnated for US women, not only for the oldest-old population but also for younger elderly people (Rau 2008). This stagnation is attributed to cohort smoking patterns in this period. Investigations show that smoking accounts for important anomalies in the recent age and sex pattern of mortality change. Similar changes in mortality trends in Denmark, where life expectancy was three years lower than in neighbouring Sweden in 2000, have been attributed to lifestyle factors, especially differences in smoking behaviour (Christensen 2009). Such changes have only recently been examined in the literature, and the impact of these trends on future demand and supply is still largely unexplored.
The general picture is that people aged younger than 85 years are living longer, and on the whole, are staying independent in their daily activities for longer than were previous cohorts. There has been an assumption that exceptionally old people (90 to 100+) will inevitably be more disabled than the younger old, but this is not supported by the evidence. Findings from a number of studies suggest that the characteristics of a cohort do not change much between ages 92 and 100+ years in central domains, such as physical and cognitive functions. The levelling off in disability level for a cohort at the highest ages suggests that care costs per individual need not increase in the tenth and 11th decades of life (Christensen 2009). However, this view has to be counterbalanced by the fact that residential care entry rates for the ‘old old’ continue to increase, but with entry now being for expensive geriatric hospital care as opposed to rest home care (Ministry of Health 2007).

2.3.2 Population ageing in New Zealand

New Zealand Government projections indicate that the structure of the New Zealand population will age up to 2051. This process started in the mid-1960s when the percentage of children under the age of 15 in the population reached 33 percent with the proportion of people 65 and over being below ten percent. In 2001, the proportions of children under 15 were 23 percent, while those 65 and over were 12 percent. In 2051 the numbers under 15 will be only 16 percent, while the number of those 65 and over will reach 25 percent. In 2021, there will be more people over 65 than under 15. At the same time, the number of people between 15 and 64 will reach 67 percent in 2011, from 58 percent in 1961 and 66 percent in 2001, but then decline to 59 percent by 2040 (Ministry of Health 2002).

In conjunction with this general ageing of the population, there will be an ageing of the 65 and over population. In most of the literature, 65 years of age is defined as the beginning of being aged. By 2051, there will be 1.18 million people aged 65 and over (26% of the population), 708,000 (15%) aged 75 and over, and 292,000 (5.3%) aged 85 and over. This is a total increase between 2001 and 2051 in the 85 and over population of 485 percent, compared to a total increase in the 65 and over population of 158 percent, and the total New Zealand population of 20 percent (Ministry of Health 2002). These predictions show that New Zealand is experiencing
the same phenomenon as much of Europe, in that a gradual evolution to an older age structure is being amplified by a more recent shift to lowest-low fertility and substantial improvements in late age mortality. It is this latter trend in particular that is driving the large increases in numbers and proportions of the ‘oldest old’ aged 85 and over (Grundy, Tomassini et al. 2006).

2.4 Population ageing and the impact on health services

2.4.1 Worldwide

The major concern that the increasingly older population raises for governments in developed countries is the effect on the economy; in particular, the issues of affordability of the retirement benefit system and the health system (Ikegami and Campbell 2002). The assumptions, however, behind long-term forecasting have a dramatic impact on expectations and, therefore, judgement about what is a reasonable level of concern. One assumption often made is that as people get older they become less healthy with increased functional disability and consequently require more costly assistance (Miller 2001). Research in the latter part of the twentieth century suggested that the substantial rise in the proportion of exceptionally long-lived individuals in successive birth cohorts was the result of help given to an increasing proportion of frail and ill people into advanced old age, with huge personal and social costs (Wang, Zeng et al. 1997). There was a suggestion that the increased survival rates of frail children could lead to an increase in frail older people (Gruenberg 1997), although trends of self-reported health in the USA did not support the notion that mortality reduction is leading to worsening health of the population (Waidmann and Manton 1998). However, data from Japan, which has the highest proportion of people living to over 100 years of age, showed that centenarians from recent cohorts had worse health than previous cohorts (Christensen, Doblhammer et al. 2009). Indeed, the prevalence of both self-reported and medically recorded diseases in the older population has generally increased over time. However, cumulative lifetime health expenditures for individuals in good health at age 70 years have been shown to be no greater than expenditures for less healthy people, despite the greater longevity of the healthier older people. Health promotion efforts aimed at people aged 65 years and younger might improve health.
and longevity without increasing health expenditure (Lubitz, Cai et al. 2003). Indeed, Christensen et al. (2009) conclude their article on ageing populations by stating that although the increasing number of old and very old people is being viewed as a major challenge for health-care systems worldwide, the evidence is that while people are living longer, they are doing so with less disability and fewer functional limitations (Christensen, Doblhammer et al. 2009).

### 2.4.2 New Zealand

At first glance, New Zealand data would appear to confirm any assumption that an ageing population will lead to an increase in health expenditure. The estimated per capita health expenditure on personal health services in 2001/02 for people under the age of 15 was $949, for people 15-64 $1329, for people 65-74 years $3643, for people 75-84 $6868 and for people 85 and over $13,568. In 2001/02 69 percent ($897 million) of spending on disability support services ($1.3 billion in total) was on people 65 and over, with 63 percent ($565 million) of this expenditure being on residential care. Per capita spending on women 85 and over reached $8460 and for men $5476 (Ministry of Health 2002).

An assumption that current patterns of usage of health and disability support services will continue certainly leads to the conclusion that there will be a rapid increase in health expenditure. In 2002 there were 50,000 people in New Zealand aged 85 and over, 69.5 percent of them female. Based on current per capita expenditure, they cost the health system $377.5 million per annum. By 2051, there is projected to be 292,000 people 85 or over, 61.1% of them female. If these projections hold true and current costs per capita continue, then the cost to the health system by 2051 will be $2.13 billion per annum. This is an increase of 560 percent at a time when the overall population is only expected to increase by 20 percent. However, examination of the assumptions underlying predictions about health and social service usage show that a straight projection of current patterns into the future will not give an accurate projection of future usage and expenditure.
2.4.3 The assumptions underlying predictions

Chase examined data from the United States of America (USA), and concluded that disability among older people has declined by nearly two percent per year since 1984 (Chase 2001). Since 1950, the decline in mortality has been nearly one percent per year. Chase, following a review of extant research reported, “all of the surveys showed a healthier and less disabled elderly population by at least one measure” (p14). He explores various reasons for the change in health and disability status, for instance, declines in infectious diseases, higher education and socio-economic status, a decline in smoking, and new surgical techniques and medicines. His key point, however, is that whilst medical spending rises with age, old age itself is not associated with increased medical spending. The association is actually with disability and poor health. Therefore, if people age in a healthier way, medical spending should not increase as rapidly.

Chase analysed data from the USA Medicare Current Beneficiary Survey from 1992 to 1994, and showed that health costs are related to the number of impairments a person has and closeness to death. Healthy older people spent about US$3,000 per person on medical care annually. Proximity to death increased this amount by US$7500. As Chase (p 17) highlights, “Older people spend more because they are sicker, not because they are older.” While Chase’s data is from the USA, a review of international evidence on disability trends among older people supported his view by concluding that the most defensible conclusion is that disability rates are falling in most industrialised countries (Waidmann and Manton 1998).

However, for Australia and Canada, which has a comparable age population profile to New Zealand, and the United Kingdom, which has an older age structure than New Zealand, there has not been any consistent evidence of substantial decline or any that disability rates are rising. In Australia, there is relatively weak evidence showing little or no indication of a decreasing incidence in age-specific severe disability, although this may be explained by the number of samples being small, and with interpretation of the surveys complicated by methodological factors (Madge 2000).
Trends in New Zealand up until the turn of the century indicated that disability levels were not reducing and that the likelihood of disability and the need for long-term care increases with age. Figures using the Statistics New Zealand 2001 census population projections that are based on the assumption there would be medium birth, death, and immigration rates, along with stable rates of use of disability support services (DSS) in the 65 plus group, project a 77 percent increase in DSS from 2001 to 2021. In a further projection, with life expectancy extended five years by 2021, and assuming the costs of disability are also moved back by the full five years, the increase in cost is estimated to be 46 percent (Cornwall and Davey 2003).

There are two major views articulated in the literature about how the health system will manage with the changing demographics. One, the ‘crisis’ perspective, predicts dire consequences, and calls for major structural changes to public health services; the other, the ‘manageability’ perspective, argues that while ageing is important, its influence on the health sector will be able to be managed without placing an uncontrollable burden on either costs or service provision. Both perspectives agree that population ageing is a serious concern, and that it will be important to manage the impact of ageing on the health sector if a crisis is to be avoided (Cornwall and Davey 2003).

2.4.4 Time until death and compression of morbidity

In exploring ways of managing, awareness of the possibility that time until death may be the key cost risk to the health sector (Chase 2001) has led researchers in two directions. The first is primarily for health economists, who are exploring increasing longevity as a postponement of ageing and the subsequent cost risk to the health system. Miller proposes that time until death may be a better demographic indicator of health status than age when considering future health costs:

*From a cohort perspective, increases in longevity may be expected to lead to postponement of these costs of the final decade and final year of life. From a period perspective, declines in age-specific mortality may be expected to lead to declines in age-specific costs because declining mortality reduces the proportion of high-cost users (those near death)*

(Miller 2001, p 215)
Taking this approach yields significantly lower cost forecasts than a strict age related approach. The second direction considers whether or not the health and disability costs of the time until death can be lowered. This is relevant to health economists in making predictions, while also being a challenge to health professionals in terms of what their health interventions can achieve. The compression of morbidity paradigm proposes that by using primary prevention to reduce lifestyle health risks it is possible to postpone the age of onset of morbidity in older people by a greater amount than life expectancy is increased (Fries 2000; Shaw 2002). Fries points out that since 1980, in the USA, life expectancy for females age 65 has only increased by 0.5 years, while life expectancy of 6.1 years for both sexes from age 85 has not changed significantly. While some researchers argue that the human body is not programmed with some unavoidable sell-by date, and that people are, therefore, not programmed to die (Kirkwood 2001), Fries’ view is that while the absolute number of older people will increase markedly in the next few years, life expectancy for the average older person will increase little. Currently, this conclusion seems to be being disproved by the fact that there is no sign of a deceleration in increasing life expectancy (Christensen, Dobhlammer et al. 2009). Speculative reasons for the reduction in disability in older age are increases in the use of assistive and mainstream technologies along with declines in reports of disability as a result of heart and circulatory conditions, vision, and musculoskeletal conditions. Improvements in these conditions correspond to the expansion in medical procedures and pharmacologic treatment for cardiovascular disease, increases in cataract surgery, increases in knee and joint replacements, and expansion of medications for arthritic and rheumatic conditions. Greater educational attainment, declines in poverty, and declines in widowhood also appear to have been positive factors (Schoeni, Freedman et al. 2008).

Although Fries may have been wrong in considering that there will be little increase in life expectancy, his view of what can be defined as successful ageing is useful when considering future approaches to health service delivery. In his view, successful ageing is not about increasing the absolute length of life, but about the compression of morbidity, which mostly results from chronic processes and is concentrated in the years prior to death between the time of onset and the age of death. He reports
several studies purporting to show compression of morbidity in favoured groups, such as those with higher education, higher socio-economic status, and those with fewer life style risks (Fries 2000). Shaw (2002) also contests the view that old age automatically brings on permanent states of disability, and agrees with Fries that there is mounting evidence that morbidity and age do not rise in strict proportion to each other. Thus, most people over 65 in the UK are fit and healthy, and generally remain that way, free of prolonged morbidity or disability until they reach their seventies after which they may face increasing and accelerating health problems and disability levels until death (Shaw 2002).

2.4.5 Health expectancy measures

Health expectancy is a concept that combines information about life expectancy and prevalence of good health, and directly addresses whether the period of morbidity or disability at the end of life is shortening or lengthening. Key health expectancy measures reported in the literature are disease-free health expectancy, life expectancy in perceived good health, and disability-free life expectancy (Christensen 2009). Trends in these three measures differ. Life years with morbidity (the correlate of life-free life expectancy) have been increasing in parallel with the increase in some diseases and conditions. Life years in good self-perceived health have been generally rising, whereas trends in life years with disability have evolved differently dependent on the severity of the disability: a decrease for the most severe levels of disability and an increase for the least severe levels are reported (Christensen 2009). The European Health Expectancy Monitoring Unit has developed a common indicator of disability-free life expectancy named ‘healthy life years’ (HLY). Time trends are available for 14 European countries between 1995 and 2003. On the basis of this measure, differences in HLY across European countries and across genders within countries are large. While there is debate in the literature over just what the increase in life expectancy means, there is some evidence that life expectancy over recent decades might have added years with moderate difficulties but not years with severe difficulties; that is, there has been an increase in life years with morbidity, but mostly less severe morbidity (Christensen 2009).
Christensen (2009) raises the possibility, in agreement with Chase, that if the current positive trends in disability continue, future need for social services and long-term care may not parallel demographic projections. However, while many studies have suggested a compression of morbidity for the oldest-old, implying that the future care needs of elderly people will not follow the demographic prognoses, most of these studies have used health indicators based on disability (Parker and Thorslund 2007). Examining health-trend surveys with a focus on the health indicator used reveals that although disability measures often show improvement, there is a simultaneous increase in chronic disease and functional impairments, the health components that also require care resources. This suggests that an expansion of other health problems may accompany a compression of disability. A concept of general morbidity is not sufficient when discussing health trends and the need for care services in the population of older people; a more complex discussion is required since the different trends in disease and functional limitations suggest a parallel or increased need for resources in medical care, rehabilitation, and compensatory interventions such as assistive technology (Parker and Thorslund 2007). Home care services that initially developed as functional replacement services to support people with long-term disabilities (Wainwright 2003) need to learn to operate within a health model in which people may be restored. They certainly need to operate in a way which does not increase the dependence of the people they assist (Townsend 1981).

2.5 Policy

2.5.1 Approaches to coping with an ageing population

Ageing is expected to have a considerable but manageable effect on projected health expenditure, but future health costs due to ageing will be influenced by advances in technology, increases in life expectancy, and labour costs (Jacobszone and Oxley 2002). Although it is possible to reasonably predict demographic ageing, it is difficult to predict the future relationships between age, health needs, and advances in medical technology. The main pressures on the health system will arise from increasing expectations on the part of patients, the rising costs of care, and the availability of informal carers (Metz 2001; Wanless, 2001; Hogan & Hogan, 2002).
From the perspective of managing future health services for an ageing population, there appears to be a conjunction between factors that older people want from a health service and the factors that help them age positively. The result is that they either will not need or may limit their need for health and disability support services, thus reducing health cost per capita. The older person’s capacity to slow age-related decline in physical and mental function has only recently been fully appreciated. Research has indicated that a major part of the physical decline experienced by older adults is caused by lack of health promotion and disease prevention rather than ageing (Kennedy 2003).

The psychological and social component of ageing positively is becoming clearer. A prospective cohort study with a mean length of follow-up of seven years showed that people who believe middle age ends at or before 60 years of age, compared to those who believed middle age ended at or after 70 years of age, were at higher risk of coronary heart disease, fatal coronary heart disease and non-fatal myocardial infarction with poor physical and mental functioning during follow-up. The hypothesized explanation was that perceived end of middle age acts as a general summary of the subjective rate of ageing (Kuper and Marmot 2003). Another study explored the relationship between depression in older people and unhealthy lifestyles. The finding was that people with emerging depression were significantly more likely to concurrently adopt a sedentary lifestyle, irrespective of their somatic disease status, resulting in a decrease in physical activity, as well as being associated with an increase in excessive alcohol use and an increase in cigarette consumption for those who were already smokers (Van Gool, Kempen et al. 2003). Included in the ageing population are a number of people with chronic conditions, as people increasingly survive diseases that were fatal some decades ago (Larizgoitia 2003). On average, people with chronic diseases have been shown to be up to two times more often depressed than those without such a condition. This demonstrates that the mental health status of an older person is important if people are to be assisted to maintain healthy lifestyles stopping a possible downward spiral of depression, unhealthy lifestyles, and the deterioration of chronic disease.
A United Kingdom review of quality of life and the concepts of ‘positive’, ‘successful’, or ‘robust’ ageing argued that there are several problems with the concept and definition of successful ageing, with many definitions being tautological, or involving reference to other poorly defined concepts. However, such concepts emphasise the multidimensional nature of well-being in old age. Many batteries of measures used as proxy measures of quality of life for older people have a negative pathology focus and concentrate on impairments in mental, physical and social functioning, thereby underestimating other areas of life also regarded by older people themselves as important. Empirical research has shown that alongside psychological well-being and good physical functioning, older people value having relationships with others, health, and social activity, and that they struggle with loss of independence (Grundy and Bowling 1999; Netten, Ryan et al. 2002).

2.5.2 The New Zealand Government response

The Foreword to the New Zealand Health of Older People (HOP) Strategy (2002) states, “We want sustainable health and disability support services that can meet the needs of current and future generations of older people and support them to age positively” (p3). The two key concepts in this statement are sustainable and age positively. The issue of cost management so that the health system is sustainable is one key part of the picture for any Government; however, relatively new for any government is this concept of ageing positively (Minister for Senior Citizens 2001).

Older people who receive assistance from health and disability support services measure the outcome of the support against its usefulness in assisting them with their control over daily living, safety, personal care, food and nutrition, and social participation (Netten, Ryan et al. 2002). There is no commonly agreed definition of positive or successful ageing, but in a comprehensive review of larger quantitative studies, the majority of definitions were found to be based on the absence of disability with lesser inclusion of psychosocial variables (Depp and Jeste 2006). General predictors of successful ageing have been described, such as (i) avoiding disease and disability, (ii) maintaining physical and mental function, and (iii) continued engagement with other persons in productive activities (Rowe and Kahn 1998). However, Depp (2006) found non-smoking, and the absence of disability,
arthritis and diabetes to be the most significantly correlated factors across definitions with only moderate support for greater physical activity, more social contacts, better self-rated health, absence of depression and cognitive impairment, and fewer medical conditions. They also found that gender, income, education and marital status were not generally considered factors in successful ageing.

The importance of the concept of successful ageing in the HOP Strategy is it recognises that while the key expense for the New Zealand health system are those people 75 years and over, the health and disability drivers of costs for this age group are dynamic; that is, they are able to change or be changed (Chase 2001; Christensen, Doblhammer et al. 2009). An active ageing strategy focuses on reducing the prevalence of disability with a greater emphasis on prevention. It will consider that ageing is not a purely demographic phenomenon, but also a dynamic process which social policy and care systems may certainly influence (Jacobzone, Cambois et al. 1998). Decisions taken now in terms of the balance between encouraging healthy ageing, providing care that does not create dependence but assists recovery or maintenance of health, and support for families and informal care will therefore largely determine the impact the ageing population has on the ability of New Zealand to manage the financial and health implications.

The HOP Strategy stated that the Ministry of Health was looking to work with DHBs to develop and assess timely community-based options to support older people to age in place. In the New Zealand Positive Ageing Strategy (Office for Senior Citizens 2001), to which the HOP strategy was a health sector response, ageing in place was defined as the ability of people to “make choices in later life about where to live, and receive the support to do so” (Ministry for Social Development 2001). Ageing in place refers to ability to remain dwelling in the community, including in retirement villages; residential care in the form of either rest homes or hospitals is specifically excluded (NZIRA, 2005)(OECD 1994). The key components of the New Zealand Positive Ageing Strategy definition are choice, location, and support.
In order to support the implementation of the HOP Strategy, the New Zealand Ministry of Health supported various ageing in place initiatives in various parts of the country. While some of these initiatives were small, single provider, single service programmes designed to fill gaps in existing services, others were based on a key worker case management model aimed at coordinating packages of care. The Ministry was keen to support care management approaches because the HOP Strategy also called for integrated care to improve the functioning of health services in the community (Ministry of Health 2002). There will be discussion on issues re integrated care later in this Literature Review.

2.6 Service configuration that will support the aims of the Health of Older People strategy

2.6.1 Long-term care: a medical system or a health system?

When considering a health and disability support system for older people, the distinction between the medical system and the health system becomes important. A case can be made that long-term care should be regarded as completely separate from the health care system because medical staff are oriented towards curing acute illness, even though an increasing share of health expenditure is being spent on managing chronic diseases such as hypertension and diabetes. Having medical staff in charge of long-term care could, therefore, result in over-medicalisation, for example during palliative care, or under-medicalisation, during rehabilitation. Doctors’ professional opinions are vital for medical care, but not as important in choosing among or assessing the quality of long-term care alternatives. Medical care is hard to ration because withholding a treatment may be a life or death matter. Long-term care is more a matter of levels of comfort and unpleasantness than life versus death. There is a risk that including long-term care within the health care system will lead to resources being shifted over to other parts of the health sector such as acute care, or that high-cost practices from other parts of the health system will be introduced inappropriately (Ikegami and Campbell 2002).

Underlying differences between health services and disability support services can frustrate the integration of medical and long-term care systems. The two key issues in countries such as the United States and the United Kingdom are that (1) health
care benefits for older people are universal national entitlements, whereas long-term care benefits are an individual’s own responsibility until they have reduced their assets to a point where they are entitled to service benefits, and (2) access to health care is based on medical need as determined by doctors, whereas access to publicly funded long-term-care benefits is based on functional status, normally determined by nurses or social workers (Leutz 1999).

However, in New Zealand, the Health and Disability Services Act (2000) has ensured that long-term care is integrated into the health care system. The Act established the DHBs that have responsibility for the well-being of their populations. When responsibility for disability support services for older people was devolved from the Ministry of Health Disability Services Directorate to DHBs in 2003, New Zealand clearly chose to strengthen the connection between the medical and long-term care systems for older people within the health system. To further strengthen the health/disability connection, DHBs were required to be significantly advanced in their plans for delivering an integrated continuum of care for older people before they were able to receive the devolved funding. In other words, the desired health system for older people was described not as a medically dominated model, but one in which all necessary elements are focused on “improving health status, promoting quality of life where health cannot be restored, reducing inequalities, and promoting participation – in social life and in decisions about health care and disability support provision” (Ministry of Health 2002, p 6).

### 2.6.2 Older people with high and complex needs

Positive ageing was well presented by Sue Lawley, presenter of the 2001 Reith lectures, who when asked if she wanted to live to a hundred, said “Only if I can remain mentally alert and in reasonable physical shape” (Lawley 2001). Much of the HOP Strategy is aimed at trying to compress co morbidity by reducing the number of people who age with health or disability issues. It is this group who make high and expensive demands on the health system.

The New Zealand health system also has to identify how to assist the ‘young old’ and ‘older old’ who have high and complex health and disability support needs. With the
current and next cohorts of older people it might be expected that the complex chronic and functional limitations common in the older population will place them at risk of need for extensive health and disability support. An exploration of the risk in the USA showed between 34 and 50 percent of patients over 64 years of age experience functional decline unrelated to their primary diagnosis during hospitalisation. This, together with shorter hospital stays, is resulting in sicker and more functionally impaired older people going home, sometimes to be cared for by other older people, thus increasing the likelihood of post-discharge problems and costly re-hospitalisations (Rosswurm and Lanham 1998).

People with long-term conditions and disabilities are an especially vulnerable group. The nature of the person’s condition is often incurable, unpredictable, and may be costly. There may be difficult challenges for the older person and family in organising care, controlling symptoms, following treatment regimes, coping with changes and daily intrusions, preventing and managing crises, maintaining normal relationships, and remaining independent. The provider of service faces demands including: obtaining comprehensive assessments, putting together service packages, monitoring changes in health status, working within existing financial restraints, and coordinating care from a mix of providers through periods of acuity, maintenance, rehabilitation, and transition (Kodner and Kyriacou 2000).

The Audit Commission Report for the UK (Audit Commission 2000) stated that a range of services that are well-integrated are needed if older people are to be effectively assisted to stay out of hospital or residential care. Kodner and Kyriacou (2000) observe that ‘integration’ was a buzzword of the 1990s, but that understanding the term ‘integrated care’ is difficult as it has many meanings, and there has been no sound analytic paradigm by which to understand or evaluate such care. Integration has been defined as a search to connect the health system (acute, primary medical, and skilled) with other human service systems (long-term care and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency). This integration can occur at the policy, finance, management, and clinical levels (Leutz 1999).
Three levels of integrated care have been identified: (i) linkage, (ii) co-ordination, and (iii) full integration. The three are part of a continuum from linkage within the context of existing fragmented systems to complete overhaul and consolidation of responsibilities, resources, and funding (Leutz 1999). Kodner and Kyriacou developed an evaluation model, based on the work by Leutz, which identified fifteen principal features of integrated care. They compared two American programmes against these features using information gained from previous research on those programmes. The model they used recognised that the two programmes appeared to improve outcomes, but the authors themselves raised two major drawbacks with the evaluations: 1) the data was not gathered and analysed in a way that enabled the programmes to be compared; and 2) the evaluations did not clearly identify what works and why. However, they did identify elements related to the efficiency and effectiveness of fully integrated systems for frail older people. These elements are described in Table 2.

Table 2: Elements of integrated care

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<th>Elements</th>
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<tr>
<td>Longitudinal care management – spanning time, setting, and discipline</td>
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<tr>
<td>Intensive, interdisciplinary team care</td>
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<tr>
<td>Geriatric philosophy and focus – including a central role for the primary care doctor</td>
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<tr>
<td>Organised provider and clinical arrangements to achieve horizontal and vertical alignment</td>
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<tr>
<td>Appropriate targeting – serving the right population and keeping the size of the patient population within manageable limits</td>
</tr>
<tr>
<td>Mechanisms to pool funding streams to assure administrative and clinical flexibility</td>
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Source: Kodner and Kyriacou (2000)

When considering the importance of integration of care, it is noteworthy that a decade after Kodner and Kyriacou’s work (Kodner and Kyriacou 2000), the future of integrated care is still being debated (Stein and Rieder 2009) with particular emphasis now being placed on considering how to achieve it. A recent study involving literature searching, a Delphi study, and concept mapping identified 101 elements of integrated care, with an element of integrated care being defined as an activity that
focuses on the development (realization, improvement, innovation or sustainability) of integrated care. That is, the emphasis has shifted from identification of the core components of the actual integrated service to a concentration on factors affecting implementation (Minkman, Ahaus et al. 2009). However, Minkman et al (2009) acknowledge that the levels of integration as defined by Leutz in 1999: linking, coordinating and full integration – are mirrored in the descriptions they received from their expert panels in 2009. Kodner and Kyriacou (2000) concluded that while each of the factors in Table 2 are essential on their own, the synergy among and between these critical elements is what makes fully integrated care possible, and the existence of a single, accountable, organisational structure allows for their optimal impact.

2.6.3 The gap between the ageing in place ideal and the long-term care reality

Historically, long-term care has not been a main concern of health policy-makers. There has been a focus on medical specialised care, and families have always been and will be expected to remain the main providers (Larizgoitia 2003). Long-term care in Europe and Australia has equated to residential care (Mykta, Loan et al. 1997; Royal Commission on Long Term Care 1999). A similar pattern prevails in New Zealand where $565 million of the $897 million spent in New Zealand on long-term care of older people was spent in residential care (Ministry of Health 2002). This is in stark contrast to the definitions of long-term care that, at least since 1988, have developed with a focus on ageing in place (Kane and Kane 1988; Larizgoitia 2003).

The pressures on the health system that result from the ageing population have also been exacerbated by a trend to shorter lengths of stay in hospitals. As the Audit Commission (2000) in Great Britain has noted, health and social services have been locked into a vicious circle (Figure 1). The Audit Commission report (Audit Commission 2000) noted: "Effective rehabilitation can help people to stay at home, or return home, after hospital, and reduce admissions to residential and nursing homes" (p 1). The HOP Strategy picked up on this approach and combined it with the need for integration. In Action 8.1 it stated: "The Ministry of Health will fund a range of health and disability support services to provide flexible, coordinated
support for older people to age in place" (p 58). Then in Action 8.5, it stated: "Long-term support providers (in the community and residential care) will build in opportunities for appropriate health promotion, disability prevention and rehabilitation" (p 62).

To age in place was defined by the Ministry of Health as the ability to make choices in later life about where to live, and to receive the support needed to do so. A key component of implementing ageing in place is the development of services that support older people to continue to live safely in the community (Ministry of Health 2002). Three broad trends identified in long-term care for older people across Europe, Australia, Canada, and the USA are a move away from institution-based care, the enhancement of home-based care, and the development of mechanisms of coordination and case management (Challis 1992).

For those older people with high and very high needs, the move to community-based care raises issues of coordination to a higher level than they are within an institution where inter-professional coordination is the main issue. In the community, there is a
need for interagency coordination and case level coordination (Challis 2003). Case level coordination is also called case or care management. Care management has a pivotal role in the integration of social and economic criteria at the level of service provision, the point at which the balancing of needs and resources, scarcity and choice must take place (Challis 2003). Therefore, care management processes are a necessary component at the heart of the integrated continuum of care that is called for by the HOP Strategy. Six factors behind the development of the care management approach have been identified: de-institutionalisation, the decentralised nature of community services, growing numbers of clients with multiple needs living at home, fragmentation of care services, a growing awareness of the importance of social supports and carers, and the need for cost containment (Moxley 1989).

2.7 What sort of community health services are needed?

2.7.1 Integrated care

The concept of an integrated continuum of care covers the whole range of services provided for older people, from health promotion and primary care to rehabilitative and restorative approaches. Traditionally, home care has consisted of a combination of household management and personal care. Intermediate care includes early treatment and rehabilitation to prevent disease or disability, and slow-stream rehabilitation or convalescent care following discharge from hospital. Services can be delivered in hospital, day hospital, or at home, and can cover high intensity to low-level services (Godfrey, Keen et al. 2005). In practice, the various types of services under community-based care and intermediate care may overlap.

Wanless (2006) summarises an integrated continuum of care in the following diagram (Figure 2). Low-level services usually include home care such as household management and personal care. There is some international evidence that low-level services provided to older people with lower levels of need, usually provided in the community, can delay entry into hospital or residential care. If people are moved too quickly to the intensive end of the spectrum, cost-effectiveness is an issue. If people remain at the low intensity end for too long, safety and risk become issues (Wanless 2006).
Community-based services are usually provided within older people’s homes or within their local community. Key features of community care include the development of needs-driven packages of services provided in the locality of residence of the older person (Litwin and Lightman 1996), and may involve formal or informal care and support.

### 2.7.2 Control over daily living

Choice, autonomy, and independence are all closely interlinked (Netten et al., 2002). Autonomy, or the freedom to determine one’s own actions and behaviour, involves the ability to choose between options for oneself. This has been differentiated from independence which infers being able to act on one’s own without dependence on others (Baltes and Baltes 1993). Consultation forums with older people, held to contribute to the New Zealand Housing Strategy (Davey, De Joux et al. 2004), found that older people valued their independence and tended to support intimacy at a distance with their families.

The concept of independence can be problematic because of its varying interpretations in the field of disability and care. In this thesis, independence is being used in the sense of being self-reliant in managing one’s own life. Self-reliance is, in fact, not possible for many older people or people with chronic conditions. However, this is not the same as being dependent and losing control. Recent writing emphasises the interdependence and reciprocity within supportive relationships which incorporates the notion that being able to give allows one to accept help.
(Godfrey, Townsend et al. 2004; Fine and Glendinning 2005). In their development of a measure of social care outcomes, Netten et al. have chosen the domain of ‘control over daily living’ in preference to ‘autonomy and independence’ as they have found this phrase is more meaningful for older people (Netten, Ryan et al. 2002). This idea fits well with Townsend’s (1984) view that services need to move beyond a model of structured dependency which forces older people into positions where they lose control and are made dependent.

2.7.3 Location

Even in very late life, the majority of people live in their own homes and want to remain there for as long as possible (Keeling 1999). In providing a context for their lives, the place in which people age has a special significance. Home is a familiar place and a treasure chest of memories. It can be an expression of one’s personality, hobbies and skills. Home provides a sense of identity and a face to the community (Gee 2000). The promotion of ageing in place with its implications of living independently does not simply mean living in a conventional family/couple-based household. A variety of new housing and household types are emerging. These include shared housing and retirement village options (Keeling 1999).

2.7.4 Support

Older people are currently higher users of health services when compared to other age groups, and this is expected to continue even with improvements in the wellbeing of many older people (Christensen, Doblhammer et al. 2009). With the exception of dental care, the increasing use of health services by older people directly correlates to advancing years. People in the oldest age groups have more visits to their general practitioner, receive more prescription items and admissions to hospital than people in younger age groups. The prevalence of ill-health and disability with age makes support and care needs increasingly important (Dwyer, Gray et al. 2000). If principles set out in the HOP Strategy (2002) are to be adhered to, a range of preventive and home-based services is required. These should be accessible, appropriate, and based upon holistic needs assessment (New Zealand Guidelines Group 2003).
Research that sought the views of disabled people using home care in four major centres in New Zealand recommended the following improvements for service delivery: client-centred flexible services with a back-up support system, access to quality information, appropriately trained support staff who would be monitored, funding to secure the quality support required for disabled and older people to secure lives of their choice in the community (Jorgensen, Arksey et al. 2009). The research, which used one-on-one interviews with a set of open-ended questions, uncovered dissatisfaction with the way the people receiving the service were treated in their own homes. People thought they were insufficiently involved in decision-making, cultural differences were insufficiently respected, and they had little control over their everyday lives. In this particular study, less than 33 percent of participants were over 65. Notwithstanding, in a wider perspective these services are used mainly by older people, and so the aforementioned issues are relevant to ageing in place.

Community care for older people with complex health needs raises issues around risk aversion and societal expectations of safety. Health professionals and policy makers face ethical dilemmas in determining how to manage risks. They need to balance threats to safety which may arise from reduced competence and capacity against older people’s requirement for autonomy. A sense of security is important for older adults, but often the perceived threat of harm outweighs the actual risk of harm (Kane and Levin 1998). In one study, older people themselves have been found to consider worry about safety as more of an issue than the actual level of risk. This study used a Discrete Choice Experiment method, which involved presenting choices to 347 individuals and asking them which they (least) preferred. The instrument consisted of five domains (control over daily living, food and nutrition, personal care, safety, and social participation), each with three levels, giving a total of 243 possible outcome profiles or situations. Safety was found to be the least important domain, with sense of control being the most important (Netten, Ryan et al. 2002).

Although some legal protection is offered through the Protection of Personal and Property Rights Act 1998, older frail people are vulnerable to neglect and physical, psychological, and financial abuse. In making provision for the support of older people, whether living in the community or in residential care, a balance needs to be
found between risk aversion and protection from harm. The need for a holistic, inclusive and flexible approach to support older people was the fundamental message put forward in the Health of Older People Strategy (Ministry of Health 2002) and the New Zealand Positive Ageing Strategy (Office for Senior Citizens 2001).

2.7.5 Restorative care

Disability has been shown to be dynamic for many people as they age. While deterioration is more usual than improvement, there is improvement after disability for some people (Grundy and Glaser 2000; Chase 2001; Parsons, Anderson et al. 2006). Restorative care aims to maximise people’s ability to function, thereby sustaining their independence as long as possible, enhancing their quality of life, and reducing the level of support required (Tinetti, Baker et al. 2002; Resnick, Simpson et al. 2006). Most of the research on restorative care has been in the residential care sector, with positive outcomes for older people reported (Field 2004; Resnick, Simpson et al. 2006; Peri, Kerse et al. 2008). In New Zealand there has been one trial which identified restorative elements that are necessary if the quality of home care is to be improved (Parsons, Anderson et al. 2006). This randomised controlled trial compared an intervention involving restorative home care with usual care for older people having high and complex needs (n=113). It showed an improvement in activities of daily living and a reduction in residential home admissions. Being dependent in any three activities of daily living has been shown to be a predictor of residential care admission (Gaugler, Duval et al. 2007), supporting the finding that if improvements can be made, it will increase the ability of the older person to remain at home. Functional difficulty is also recognised as one of the eligibility factors for receiving home care (Wainwright 2003). Despite this, older people with functional disabilities have not typically received home care to address performance difficulties unless an acute medical episode or hospitalization triggers a referral for therapies (Vladeck BC and NA. 2006). Most approaches to home care that support older people to stay at home have paid insufficient attention to any rehabilitative potential that an individual may have, with services being either brief or purely focused on functional replacement (Gitlin, Winter et al. 2006). One view is that traditional home care operates out of a dependency model, in which the duties of the nurses and home care staff are heavily prescribed, with older people expected to be not only
grateful, but also passive recipients (Townsend 1981). This means that home care services have tended to lean towards a dependency model of service provision that provides for the person, rather than focusing on activity, supporting the functioning of the older person, and working to enhance the older person’s sense of control and independence (Hallberg and Kristensson 2004; Baker 2006; Lewin, Vandermeulen et al. 2006; O’Connell 2007; Glendinning, Clarke et al. 2008).

2.7.6 Provider provision of home care – changing from reactive to proactive models

Home care services have not, therefore, promoted the development of healthy lifestyles and daily routines, social support, exercise, and autonomy and control, even though there is now strong evidence that it is possible to effectively provide support to improve health status, and rehabilitate or re-enable occupational and social function in older adults, even if frail and with chronic illness (Landi, Gambassi et al. 1999; Stuck, Walthert et al. 1999; Parsons 2002; Peel, Bartlett et al. 2004; Parsons, Anderson et al. 2006). For instance, home care staff may hold a view that bed rest can be beneficial for an older individual with illness, despite the considerable evidence to the contrary (Baker 2006). They may also make the situation worse by having too great an emphasis on task completion with a tendency to do as much as they can for the client, rather than trying to assist the client to do things for themselves (Ryburn, Wells et al. 2009). Essentially, older people lose the motivation to do things for themselves and become dependent on continuous professional management of care because they have accepted the world view that they are limited by being aged or unwell (Verbrugge and Jette 1994; Baltes 1996; O’Connell 2007). The limitations to the evidence are that few studies look at long-term outcomes (more than one year). Although there is some evidence that highlights improvements in function and decreased use of services, there is little evidence about which client groups are likely to most benefit from a restorative approach to home care and what the duration, timing and intensity of an effective service might be.

The key to providing effective home care interventions for older people is to identify those most likely to benefit from assistance. Assessment of older people is more than just a series of measurements; a meta-analysis has shown that it is an important
intervention in its own right which influences the health and social outcomes for older people with high support needs, as well as their family and carers (New Zealand Guidelines Group 2003; Stuck and Bern-Ziegler 2003). However, the assessment must be followed by intervention to address any issues identified (Burns, Nichols et al. 2000; Aminzadeh and Dalziel 2002); this includes a process to ensure adherence to the plan by both the older person and the professionals and support services involved (Reuben, Frank et al. 1999). A review of the literature on patterns of predictors of patient and primary care physician adherence to treatment plans recommended by outpatient comprehensive geriatric assessment programmes found strong evidence that comprehensive assessment that is not followed by the implementation of individualised care plans can have harmful effects (Aminzadeh and Dalziel 2002). Such intervention when coordinated and combined with home care has been shown to reduce hospital usage (Landi, Gambassi et al. 1999).

A care pathway for the older person that includes a restorative home care plan is developed from an assessment by a multidisciplinary team. This pathway develops the plan which will be followed by all services right through to the home-based services, so there is a continuum of care across each service. A care plan for home-based older people is developed by a multidisciplinary team to enable them to remain in their own home as long as they wish or as long as possible. This restorative approach contrasts with the traditional task oriented ‘do for the person’ approach (Tinetti, Baker et al. 2002); through good assessment and care planning it aims to reduce the susceptibility to dependency that occurs with the introduction of home care. There is an imbalance however between the amount of care required to stimulate, rather than suppress, independent function, especially at the beginning of an intervention when intensive support may be required under a restorative model (Baker, Gottschalk et al. 2001). Ideally, this support will be reduced over time, so the total amount of health resources required over a long period of time becomes equal to or less than the restorative model. In the traditional model, this support remains constant or increases over time. The temptation for a funder, however, is to constrain upfront expenditure (Wainwright 2003). Baker, Gottschalk et al. (2001) have also pointed out that many paid and informal caregivers, as well as patients, are not aware that being sedentary does not help the person recover, and in fact is
hazardous. Her research showed that home care assistants need to learn that ‘doing for’ a person is unhelpful to that person, even if, in the short-term it is efficient, because it leads to physical deconditioning, decreased confidence, and increased dependence.

During the 1990’s, Tinetti and colleagues (Tinetti, Baker et al. 2002) used a case-controlled trial of home care services to evaluate restorative models of care that were interdisciplinary and included utilising and integrating knowledge and principles from geriatric medicine, rehabilitation, nursing, and goal attainment. The key results showed that adherence to treatment plans is more likely if the person is involved in setting their own goals, and then working out how to achieve them. The key characteristics of the restorative approach were identified as: i) training all the workforce – nurses, doctors, health care assistants, and allied health professionals – in the issues of goal attainment, rehabilitation and geriatric medicine; ii) developing an integrated, coordinated, interdisciplinary approach in home care; iii) refocusing the workforce to work with the person to maximise function and comfort rather than doing things for them. A care pathway that is developed from an assessment by a multidisciplinary team with the intention to provide a restorative approach for an older person will produce a plan that will be followed by all services right through to the home-based services and create the continuum of care across each service (Parsons, Anderson et al. 2006).

Table 3 highlights the core elements of the restorative home care approach. Goal facilitation increases the client’s involvement in their own plan of care, and in a New Zealand setting has been shown to improve outcomes (Peri and Kerse 2004). There are a number of studies showing that older people who exercise improve muscle strength, balance, quality of life, and functional performance (Keysor and Jette 2001; Rejeski and Mihalko 2001), and that this exercise can be achieved through working on muscle groups used in everyday activities (de Vreede, Samaon et al. 2005; de Bruin and Murer 2007). Training and supervision for support workers has been shown to have a positive effect on older people in residential care (Smith, Kerse et al. 2005). If the expected level of care for older people at home is to be delivered, it is imperative that home care workers receive effective training as well (Hockenstad
In one study, 30 home care workers were interviewed, with the finding that inadequate training was a key factor in training and recruitment (Stone and Wiener 2001). While the evidence specifically related to the training of home care workers is not robust, the evidence from residential care shows that training can have an impact, while the identification of the skill base necessary for a restorative model shows its importance if effective implementation of the model in home care is to be achieved (Parsons, Dixon et al. 2004). Health professional training is important as nurses are increasingly taking on the role of coordinators of home care services and care managers. The importance of training coordinators was emphasised in a recent study, as these people operate in a supervisory role with care workers (Brannon, Barry et al. 2007). The importance of the care management and comprehensive geriatric assessment factors are discussed elsewhere in this literature review.
## Table 3: Elements of restorative home care

<table>
<thead>
<tr>
<th>Restorative care element</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal facilitation</td>
<td>A key concept of restorative care is to create a support programme based on the goals and aspirations of the older person.</td>
</tr>
<tr>
<td>Functional and repetitive Activities of Daily Living (ADL) exercises</td>
<td>Functional exercises involve working on muscle groups used in everyday activities. Restorative home support incorporates this approach into all programmes, and the support worker motivates the older person to undertake the exercises.</td>
</tr>
<tr>
<td>Support worker training and enhanced supervision</td>
<td>Restorative home support relies on support workers to collaborate with older people to maximise their independence; this is a shift from the current home care model which focuses on providing care. Therefore, support workers receive experientially-based adult training in such restorative care techniques. In addition, restorative home support adopts enhanced health professional integrated supervision via coordinators. Contact in both a team environment and one-on-one in the presence of a client occurs regularly.</td>
</tr>
<tr>
<td>Health Professional training</td>
<td>The role and competencies of the coordinator change greatly with the evolution of restorative home support. Roles and duties may include: delegation and supervision of non-regulated staff, comprehensive assessment, care management, goal activity analysis and grading, and expertise surrounding community integration for older people. Given the clinical and academic expectations of these positions, post graduate education is recommended.</td>
</tr>
<tr>
<td>Care management</td>
<td>Restorative care utilises care management in which the intensity varies according to the level of service input; specifically, a higher level of care management is present when the service focuses on older people at risk of residential care.</td>
</tr>
<tr>
<td>Comprehensive Geriatric Assessment</td>
<td>Similar to care management, the level of service delivery impacts on the assessment system utilised. Older people with high and complex needs may require a more comprehensive assessment, in contrast with those older people with lower needs who may require a less extensive assessment.</td>
</tr>
</tbody>
</table>

Source: Parsons, Anderson et al. (2006)
2.7.7 A needs assessment and service coordination function

The Assessment Processes for Older People Guidelines (2003) reported that a major barrier to the effectiveness of programmes of assessment and support for older people is the incomplete implementation of the recommendations that result from assessments made both by the older people themselves and by health professionals. The report stated strongly that to be effective, an assessment programme must operate on the principle of working together, or concordance, where the older person being assessed, their family/whānau, their carers, and all professionals involved in their care and support are actively involved. One of the key factors identified for this mismatch between the recommendations of the treatment or care programme and its implementation was a lack of understanding by the health care professional and the older person of the difference in their priorities and beliefs about health care issues. Working together is based on the idea that the work of the health practitioner and the older person is a negotiation between equals, and that the aim is a therapeutic alliance between them. The strength of this alliance lies in an assumption of respect for the older person’s concerns and aims.

From this, it can be seen that for the restorative care approach to work well, one of the key roles of the needs assessment and service coordination (NASC) function is to enter into a partnership with the older person (and their family) to identify the older person’s concerns and aims, and then to work with them to develop a package of support that will assist them to feel relaxed about their concerns and achieve their aims (Minister for Disability Issues 2001; New Zealand Guidelines Group 2003). One of the mechanisms that is being used by people undertaking the NASC function to achieve a partnership with the older person is the TARGET tool, developed by The University of Auckland to assist assessors and home-based support providers to have a dialogue with the older person about what they want from the rest of their life. From the goals established in this dialogue, the NASC worker then puts in place a number of therapy and support programmes for the older person. However, that is not the end of the NASC role.

The ASPIRE evaluation of programmes for older people in New Zealand (Parsons, Andersen et al 2006) showed very clearly that coordination of the services an older
person receives is important to stop duplication and to prevent services not actually being delivered. The study shows a care management role is needed for people who are interacting with a number of health professionals and service providers to ensure that the agreed plan is being actioned efficiently and effectively. ASPIRE was set up in 2004 to evaluate the effectiveness of three of the significant ageing-in-place programmes within New Zealand: (1) The Coordination of Services for the Elderly (COSE). This was a community-based needs assessment and service co-ordination initiative. The aim was to avoid duplication in service provision. A key worker was assigned to several general practice teams and identified resources within communities. This offered older people a greater choice of service support and facilitates safely staying in the community. COSE represented an evolution of the NASC role. (2) The Promoting Independence Programme (PIP). The programme was for people who would not be able to maximise their potential for recovery within the average hospital stay. Referrals to the programme were made by medical consultants, general practitioners, NASC and other similar agencies. A key worker was assigned to each older person and they initiated and co-ordinated the person’s rehabilitation process. The process also involved a team of healthcare workers including registered nurses, occupational therapists, physiotherapists and speech therapists. Older people received up to 8 weeks of facility based rehabilitation or, if able to receive services in the community, up to one year of rehabilitation from the time of the health event. Hand over to home care providers occurred after that period. PIP did not replace NASC; instead it integrated with current practice. (3) Community FIRST (Flexible Integrated Restorative Support Team). This offered a different approach in the form of restorative home support, which usually involved the integration of physical activity into the routine delivery of services. It used a multidisciplinary team (primarily registered nurse, physiotherapist and occupational therapist) and delivery was based on several levels of support depending on the needs of the older person. It offered a replacement for current home care provision.

The objectives of ASPIRE included: assessing the effectiveness of the ageing-in-place initiatives as compared to usual care in preventing (or delaying) the time before a community-based older person requires permanent residential care; determining the impact of the ageing-in-place initiatives on an older person’s independence and
health related quality of life compared to similar measures in those receiving usual care.

The researchers conducted randomised control trials of a sample of patients using the three ageing-in-place initiatives, compared to the usual care resulting from NASC assessment. There were 569 participants in the trial. Initial interviews were conducted before people participated in the trials. Interviews were repeated at three months, six months and then every six months to an average of 18 months.

There was a significant effect of a 31 percent relative risk reduction (RR\(^3\) =0.69, 95% CI 0.53, 0.91) of improved survival over two years. Furthermore, older people who used one of the three initiatives experienced a significant 34 percent (95% CI 0.47, 0.92) risk reduction in residential care placement [3]. Predictive modelling using the same data set identified a number of factors that increase the likelihood of older people being hospitalised or entering residential care. Factors associated with increased risk of residential care included functional decline, social isolation, negative mood, caregiver stress, inadequate meals or dehydration. Factors associated with increased risk of hospitalisation included a lack of medication review, negative mood and previous hospitalisation.

### 2.7.8 Service deliverers

Care and support services in New Zealand are provided by organisations in the public and private sectors, including local and national government agencies, and religious and welfare organisations. Since the 1990s, services have been increasingly delivered by commercial businesses (Ministry of Health 2007). In the United States of America, long-term care services such as home care are funded from one of four sources: out-of-pocket payments, private long-term care insurance, Medicare, and Medicaid. Out-of-pocket expenditure accounts for 28 percent of long-term care

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\(^3\) Relative Risk - is a ratio of the probability of the event occurring in the exposed group versus a non-exposed group.

\(^4\) Confidence Interval - an estimated range of values which is likely to include an unknown population parameter.
costs. In New Zealand, long-term care is funded through both government and out-of-pocket expenditures, but there does not seem to be any research that has clearly identified exactly how much is spent or from which source (Booth and Mor 2007). In 2004, 942 (93) organisations in New Zealand were identified as providers of either residential care or home care funded by the Ministry of Health or the Accident Compensation Corporation. It was estimated that 9.9 percent of these provided only home care, while a further 23 percent (216) provided a combination of home care and residential care (Parsons, Dixon et al. 2004). This makes 309 organisations providing home care that is funded through means other than or in combination with personal client contribution. However, DHBs have tended to restrict their contracts to three or four providers, some of which are national, so the number of home care organisations that would be affected if DHBs adopted the implementation pathway for home care service developed in this thesis is considerably less. It also has to be recognised that while statutory and independent organisations have a role to play, most care is actually provided by family, friends and neighbours (Milligan 2004).

2.7.9 Working out what older people want

If improvement in the health care system is contingent on care being seen through the eyes of those who use the health system (Royal Commission on Long Term Care 1999), then it makes sense that consumers must become the co-architects of future health care delivery systems (Berwick 1997). Understanding what is wanted by the consumer becomes essential if consumer satisfaction is defined as the function of the difference between what consumers expect and what they receive (Jennings and Staggers 1999). The necessity of listening to consumers about what matters to them comes to the fore. Stollerman (1998) refers to the seven Cs for what consumers value most from their health care: competence, communication, cognisance, caring, contact, coordination, and continuity (Stollerman 1998). This may mean a very different definition of quality for clinical staff who are focusing on treatments and medications. It is therefore important that the consumer’s perspective on health care be incorporated into performance measurement, taking into consideration holistic outcomes, with indicators that extend beyond disease boundaries to show how well a person is living with a particular problem. These indicators would include the
person’s functional status, health status, mental status, and quality of life. Additional holistic indicators show patient satisfaction and symptom management (e.g., pain, fatigue, and nausea). Holistic outcome indicators have tremendous significance in current outcomes literature with health-related quality of life (HRQL) measures exemplifying the emphasis on the patient’s interpretation of outcomes (Jennings, Staggers et al. 1999).

While the satisfaction of the health care consumer may be vital, information from satisfaction surveys provides only modestly useful information because there are consistently inflated means and a lack of variability in scores (Jennings and Staggers 1999). Data analysis is the key problem as there appears to be an asymmetric nature to satisfaction; therefore, more incisive analysis is necessary. The asymmetry can be explained by the fact that negative performance appears to have a more profound effect on satisfaction than does positive performance (Mittal and Baldasare 1996). Hence, identifying and remediying those factors which have a negative effect on satisfaction will provide a much higher return on investment than further improving those aspects that already provide satisfaction. The aspects of satisfaction most closely related to quality can be determined by discriminant analysis (Dansky 1996). In this way, the focus can be on measures of satisfaction that concentrate on variables that have value for performance improvement.

2.7.10 Social support

Social support has been shown to be critical for frail older people, who often depend on others, with caregivers being able to enhance the understanding of prescribed actions and provide direct assistance to the older person to facilitate adherence (Aminzadeh 2000). Older people with strong support networks are less likely to enter residential care (Bear 1990). Research has found connections between social networks and a range of feelings such as sense of morale, notions of self-worth, and life satisfaction; there is also a range of behaviours, most notably in this context, older peoples' utilisation of health and social services. Social support networks can assist older people with the implementation of health and disability care plans (Litwin 2001). The importance of this was shown in the literature review for the
development of the New Zealand Guideline on Assessment Processes (New Zealand Guidelines Group 2003). There were a number of articles showing why comprehensive geriatric assessment did not produce good outcomes, one reason being that older people themselves failed to implement the intervention, often as a result of poor communication between the person and the health professional, and another being they thought the intervention was too complex or difficult (Reuben, Frank et al. 1999; Aminzadeh 2000; Anderson, Ory et al. 2000).

Litwin (2001) undertook a research project (Wenger 1991; Wenger 1994; Wenger 1996; Wenger 1997; Litwin 2001) which validated findings that the classification of network types allows outcomes for the older person to be related to their interpersonal environments. Five network types were derived across a range that extended from isolation or having just family relationships to having a wide social network. Respondents in diverse or friends networks reported the highest morale; those in exclusively family or restricted networks had the lowest. Wenger found that different network types are associated with different types of presenting problems. Assessment of the strength of support networks would, therefore, seem important for predicting community care outcomes, but many of the tools available to measure the strength can be too elaborate to be useful in day-to-day practice. Wenger’s own measurement approach was not found to be useful in a New Zealand study of the factors influencing residential care entry (Parsons, Anderson et al. 2004).

2.8 Achieving a high functioning service

The sections above have explored the issues for health services that are raised by an ageing population, particularly with the predicted growth in the old-old. What has been shown is that older people want a sense of control (Netten, Ryan et al. 2002), that a restorative model is a shift from a dependency model and aims to put older people in control of their own plan of care, and 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. 2006; Resnick, Simpson et al. 2006). While many studies of restorative care have had methodological flaws, often with small samples or concentrating on older people with high and complex needs (King
2010), the fact is there is a useful conjunction between what older people want and the delivery of services that appear to lead to better quality health services in terms of achieving better outcomes for older people. But understanding what has to be done is very different from achieving its successful implementation with services that deliver programmes that fit with the evidence (Anderson, Ory et al. 2000; Birch 2002; Fixsen, Naom et al. 2005). The interplay of the concepts of quality, evaluation, and performance management and measurement in the implementation of evidence-based practice is explored in the next section of this literature review.

### 2.8.1 The concept of quality

Quality of care has been defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes that are consistent with current professional knowledge (Lohr 1990). The purpose of defining the quality of care provided to individuals living with chronic illness, disability, or limitations due to ageing who have their long-term care needs met in the community, most often at home, can be regarded as an essential step toward defining what a system of care should look like (Birkel 2009).

However, a commonly accepted definition of quality is, in fact, lacking (Jennings and Staggers 1999). Quality requires a judgement, which means that quality is, in essence, subjective and can mean different things to different people (Joint Commission on Accreditation of Healthcare Organizations (JAHCO) 1993). The point Jennings and Staggers make is that there is no single, comprehensive measure of quality. In fact, there are a large number of performance measures from which to choose. They argue that an integrated view of quality is necessary, and examine three key components of quality plus their interrelationships. The three key elements are structure (having the right things in place), process (doing the right things), and outcome (having the right things happen). This is a derivation of the Donabedian model of structure, process and outcome, in which structure refers to the infrastructure of the healthcare system and includes such factors as availability of equipment and qualifications of staff; process relates to the details of care such as diagnostic tests and interventions; and outcome is the end result including the traditional measures of mortality and morbidity as quality of life measures.
(Donabedian 1966). Assessment of quality of care should, therefore, include every aspect of a patient’s journey through the healthcare system because it needs to deliver an overall broad impression of health care delivery as well as the outcomes (Suliman, Ashrafian et al. 2010).

What this means is that there is a danger if performance measurement activities have a major or sole focus on the measurement of outcomes, because positive outcomes do not guarantee quality (Jennings and Staggers 1997; Jennings and Staggers 1998; Jennings and Staggers 1999). An example is when a shorter waiting time in an emergency room is not a good outcome for a person who would have been better managed on an ambulatory basis (Lansky 1996). Processes, inputs, outputs and outcomes are all inextricably linked when considering performance (Jennings and Staggers 1999).

Service quality can be defined in terms of objective factors, such as frequency of missed or late contacts with clients. This approach is adopted by many public services in reporting to regulators (Heritier 2000). It can also be defined in terms of subjective factors such as the perceptions of the users of the services (Francis and Netten 2004). In the specific field of home-care quality, a variety of characteristics that are most valued by those in receipt of home care include continuity of direct care staff so that service users and care workers can form trusting relationships (Edebalk, Samuelsson et al. 1995), communication about changes in who is coming and when (Raynes, Temple et al. 2001), flexibility of the service in recognition of users’ fluctuating needs (Henwood, Lewis et al. 1998), reliability (Qureshi and Henwood 2000), staff attitudes (Qureshi and Henwood 2000; Sinclair, Gibbs et al. 20000 and skills or competence of care workers (Raynes, Temple et al. 2001).

### 2.8.2 Evaluation or performance management?

Ageing populations are only one of the factors leading to increasing demands on resources, alongside other factors such as technological developments and increasing public expectations. Choices must be made between claims on resources, both within health and between health and other Government funded sectors such as housing, benefit payments, etc., each of which produces some positive outcomes.
The fiscal consequences of increasing expenditure on health care may not be supported by electorates. Therefore, there is an incentive for governments to establish evidence-based decision making as a normative approach, showing conscientious, explicit, and judicious use of current best evidence (Sackett, Rosenberg et al. 1996). This may be a useful way of managing their electorates when justifying hard resource decisions (Kerridge, Loew et al. 1998). The need for governments to manage a budget for the health of the whole population has coincided with the rise of evidence-based health economics, as the need to make choices where there is scarcity forces a funder to consider the economic principle of opportunity costs (Birch 2002; Donaldson, Mugford et al. 2002).

While governments are increasingly shifting resources into community care and expecting both reduction in costs and improvements in quality of care, a Cochrane Review of the effects on health outcomes of institutional versus at-home care for functionally dependent older people came to the conclusion that there is insufficient evidence available to estimate the likely benefits, harms, and costs of either form of care (Mottram, Pitkala et al. 2002). In terms of what approach to take if the effect of an intervention is unknown, Gray opines that there are only two options: the first is to stop them starting; the second is to promote the conduct of randomised controlled trials for both new interventions and for interventions already in practice (Gray 2001). However, the technical method chosen for the evaluation of an intervention is only one of the aspects which need to be considered if the evaluation is to influence behaviour. Evaluators are naive if they assume that others will use only evaluation information to judge value, and that judging value will then automatically lead to action (Ovretveit 1998). As J.M. Keynes stated:

*There is nothing a politician likes so little as to be well-informed; it makes decision making so complex and difficult*

(Cited in Gray 2001, p 287)

Gray (2001) believes that two necessary pre-conditions for the fostering of evidence-based healthcare have emerged: first, a whole population approach where a commitment to improve the health of the whole population makes it possible to
show evidence of the effectiveness of an intervention; and second, a fixed budget for healthcare.

Making service delivery choices requires information on both resource use and benefits from alternative courses of action. Evidence-based healthcare is not just about economics. There are three main ways in which research evidence can be used: to improve health services policy-making, purchasing and management; to improve patient ability to choose from treatment options, if they wish to, on the basis of the best current knowledge; and to improve clinical practice so that clinicians use the best evidence available, in consultation with the patient, to decide upon the option that best suits the patient (Gray 2001).

2.8.3 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. Table 4 presents a summary table of effectiveness, efficiency, and equity performance criteria (Aday, Begley et al. 1998).

Given the clarity of the questions for each criteria and each level, it might be expected that there would be clear answers. However, although the stakes are high, information that would enable the performance of health care organisations to be evaluated is lacking (Green, Kagolovsky et al. 2000). A number of performance evaluation frameworks have been put in place, but there has been little information on their relative weaknesses and strengths. Green, Kagolovsky et al. (2000) appraised different evaluation models for their compatibility with a systems approach. Their conclusion was that many of the health evaluation systems in Canada were hospital-focused, for-profit sector focused, and ill-suited for application.
in a community setting in many but not all aspects. Their key recommendation was that an evaluation approach grounded in systems theory and process-improvement theory would assist the development of integration of health care and facilitate a continuum of care.

Table 4: Summary Table of Effectiveness, Efficiency and Equity performance criteria

<table>
<thead>
<tr>
<th>Level</th>
<th>Performance Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Micro-level (Clinical)</strong></td>
<td><strong>Effectiveness</strong></td>
</tr>
<tr>
<td></td>
<td>Clinical effectiveness: Does healthcare contribute to improving the health of individuals?</td>
</tr>
<tr>
<td></td>
<td><strong>Efficiency</strong></td>
</tr>
<tr>
<td></td>
<td>Production efficiency: Is healthcare being produced at the lowest cost?</td>
</tr>
<tr>
<td></td>
<td><strong>Equity</strong></td>
</tr>
<tr>
<td></td>
<td>Procedural equity: Are the procedures for allocating healthcare fair?</td>
</tr>
<tr>
<td><strong>Macro-level (Population)</strong></td>
<td><strong>Effectiveness</strong></td>
</tr>
<tr>
<td></td>
<td>Population effectiveness: Is the health of the population improved?</td>
</tr>
<tr>
<td></td>
<td><strong>Efficiency</strong></td>
</tr>
<tr>
<td></td>
<td>Allocative efficiency: What mix of investments produces improvements in the population’s health?</td>
</tr>
<tr>
<td></td>
<td><strong>Equity</strong></td>
</tr>
<tr>
<td></td>
<td>Substantive equity: Are subgroup disparities in health within the population minimised?</td>
</tr>
</tbody>
</table>

Source: (Aday, Begley et al. 1998)

Alongside this sort of critique of the usefulness of current health system evaluation frameworks, there have also been issues raised that the role of evaluation has been marginalized (Duignan 2002). During the 1990s, performance management measured a range of indicators and used them for holding programmes to account with little regard to attributing causality, or to the real life complexities of evaluation. In 2001, the American Evaluation Association annual conference was titled ‘Mainstreaming Evaluation’. Duignan interprets this as meaning that people within organisations will become more evaluative about what they are doing; that is, evaluative or evaluation capability will be built into programmes, organisations, and policy development, so that organisations, policies, and programmes gradually develop more effective and efficient ways of operating. Duignan states that this means the evaluation profession must give evaluation away, so that people themselves have evaluation as a central task they own, and that they may or may not involve external evaluators in what is a core task for their business as a whole.
This sort of approach fits with evaluation models promoted for community-based health prevention and health promotion programmes. Five principles that address both formative and summative aspects have been proposed to help with evaluating the complexities of community programmes (Goodman 2001):

1. Evaluation should include an assessment of programme theory. This means that any programme should have a theory of causation or action or logic model, defined as a succinct, logical series of statements that link the problems a programme is attempting to address, how it will address them, and what the expected result is (Kumpfer and al 1993). Logic models become templates for comparing the consistency of the desired programme with the programme that is implemented.

2. Evaluation instruments must be contoured to each individual community. While standardised instruments are necessary, instruments must take account of the language skills, age appropriateness, cultural relevance, and attention span of local audiences in order to reduce culturally induced bias (Kumpfer and al 1993).

3. Evaluation approaches should be guided by the questions asked, and often require both a quantitative and qualitative orientation. For a focus on questions that ask who, what, where, and how much, quantitative inquiry may be the best approach; for a focus on questions that ask why or how, qualitative methods may be needed.

4. Evaluation should be informed by social ecology and social system concepts. This conceptualises evaluation across two dimensions: first, the multiple social levels at which programme interventions are directed (intrapersonal, interpersonal, organisational, and public policy); and second, the stages development programmes may be at (initial, establishing organisational structure, building capacity for action, implementing, refining, and solidifying).

5. Community evaluation should involve local stakeholders in meaningful ways. This principle posits the evaluator or evaluation process as having a role as a coach, collaborator, and builder of capacity (Goodman 2001).

Ovretveit (1998) suggests that there are four approaches to evaluation, dependent mainly on the purpose of the people being evaluated (Table 5). The evaluator role is determined by the methods, which are chosen to suit the purpose. The purpose affects whether the focus is on outcomes, outputs, or processes, or a combination of these.
Table 5: Four evaluation approaches

<table>
<thead>
<tr>
<th>Factors</th>
<th>Primary users</th>
<th>Purpose</th>
<th>Focus of study</th>
<th>Methods</th>
<th>Evaluator role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental</strong></td>
<td>Scientists, health professionals</td>
<td>Discover evidence of effect and causes</td>
<td>Outcome</td>
<td>Hypothesis testing; measurement of outcome; control and quantification of variables; statistical analysis</td>
<td>Independent external detached scientist</td>
</tr>
<tr>
<td>Economic</td>
<td>Managers, policy makers</td>
<td>Calculate resources used and benefits</td>
<td>Inputs, activity, outputs, and outcomes</td>
<td>Quantitative and specialist measures of outcomes</td>
<td>Independent external detached scientist</td>
</tr>
<tr>
<td>Developmental</td>
<td>Managers and people working in the service</td>
<td>Help providers to improve in the short-term</td>
<td>Process</td>
<td>Primarily quantitative</td>
<td>Independent collaborative or self evaluation</td>
</tr>
<tr>
<td>Managerial</td>
<td>Managers and supervisory boards</td>
<td>Accountability and performance management</td>
<td>Inputs, process, and outputs</td>
<td>Quantitative and qualitative</td>
<td>Inspectorial, detached, quasi-independent</td>
</tr>
</tbody>
</table>

Source: Ovretveit (1998)

If an evaluation is to be useful, that is, if the evaluation is to have some impact on future purchasing and management of health services, it would seem useful for it to try to encompass all four perspectives. Ovretveit has a chapter titled ‘Why are evaluations not used more?’ in which he suggests solutions to the finding that evaluation, and indeed most research, has not had a great practical impact. The evidence is from the late 1980s and early 1990s, at the beginnings of the evidence-based medicine movement. Lessons from Ouvreit that are relevant for an evidence-based health approach are: policy makers and health clinicians are influenced by many factors apart from information; homeostasis or inertia in health services can be difficult to overcome; the findings from research may be poorly communicated; and those who need to be involved in the change process are often not involved in the evaluation.
If the implementation framework developed in this thesis is to be both useful and used, the factors raised in the above section will need to be considered and solved during the development of the implementation framework that is the focus of this thesis.

### 2.8.4 The evaluation of integrated health services

An integrated health delivery system has been defined as “a network of organisations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically accountable for the outcomes and health status of the population served” (Leggatt and Leatt 1997, p 11).

Internationally, there has been a major focus on the provision of integrated care for frail older people and populations with complex, chronic, disabling conditions in the belief that integrated care strategies offer the potential to improve service coordination, the quality of outcomes, and efficiency (Dansky, Dellasega et al. 1996; Coleman, Grothaus et al. 1999; Landi, Gambassi et al. 1999; Kodner and Kyriacou 2000; Wieland, Lamb et al. 2000). Kodner and Kyriacou (2000) compared two American programmes using information gained from previous research on those programmes. They developed an evaluation model that identified fifteen principal features of integrated care. The model they used indicated that the two programmes appeared to improve outcomes, but there were two major drawbacks with the evaluations: the data did not enable the programmes to be compared, and the evaluations did not clearly identify what worked and why.

If programmes cannot be compared, it is problematic whether integrated care providers can be held clinically accountable for the outcomes and health status of the population they are serving. While there is no specific reference to accountability in the HOP Strategy, accountability lies with DHBs as they work to achieve the goals set in their Annual Funding Agreements with the Crown. Among those goals is the establishment of an integrated continuum of care for older people by 2010, which is when all DHBs were expected to have implemented the recommendations of the HOP Strategy. The evaluation of the performance of ageing in place initiatives for older people needs to deliver useful information to funders regarding cost-
effectiveness, and allow outcomes from different programmes to be compared so that both providers and funders can be held accountable. The evaluation also needs to provide information that will enable ongoing performance improvements within the system (Leggat and Leatt 1997).

The Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) evaluation of ageing-in-place initiatives sought to provide sufficient information that there can be a more solid answer than “may be a cost-effective option”. It also aimed to enable the three initiatives to have their outcomes compared (Parsons, Anderson et al. 2006). ASPIRE was a useful start, but it did not solve the accountability dilemma for other providers. To be able to provide funders with regular reports on the outcomes of their programmes, providers need a performance management approach that enables them to evaluate their programmes with reasonable ease and accuracy, and without prohibitive compliance costs.

2.8.5 Using evaluation to provide information that supports continuous quality improvement to providers

In work for the United States Department of Veterans Affairs, Zimmerman, Daley et al. (1997) define outcomes in a health service as “the results of specific health care services and interventions” (p 1). Among possible uses of the measuring outcomes they describe using this data for quality improvement processes, establishing performance benchmarks, tracking and comparing provider performance over time, and allowing providers to identify those treatments and conditions where they excel.

The Department of Veterans Affairs has been using outcomes measurement to promote a culture of continuous quality improvement. In particular, they have developed performance indicators to assess the efficacy and efficiency of their programmes, and concentrate on five domains of value: 1) cost/price, 2) technical quality, 3) customer satisfaction, 4) patient function, and, 5) access to care. They have established provider, service line, facility, network, and system-wide benchmarks and performance measures for these five domains of care as well as performance monitoring systems and mechanisms for the dissemination of best practices system-wide. They also explore the use of report card measures, especially
for chronic diseases. Report cards are defined as tools that supply data for specific measures of health care quality and utilisation, patient satisfaction, and other areas of interest, thus enabling policy makers, purchasers, and patients to compare and understand provider performance (Zimmerman, Daley et al. 1997).

Zimmerman et al. (1997) argue that using outcome measurement is meant to bring the focus of the entire health care delivery system back to the patient, with a rigorous and continuous evaluation of the processes of care though outcomes measurement and analysis ultimately improving the quality of care. The focus on patient outcomes aims to avoid the issue of collecting the right data in the right way, as many organisations focus on the wrong performance improvement areas, or require too much data collection, or the results are not statistically significant so may not result in appropriate actions. Data may be too detailed for users to understand; there may be redundancy of effort through multiple parties collecting the same information; and interpretation of the data may be poor. This is called being data-rich but information poor (Behrens and Oldenkamp 2000).

Total Quality Management (TQM) or Continuous Quality Improvement (CQI) systems are aimed at chains of processes to ensure that care delivery is performed in a satisfactory manner. These processes provide a framework for management and staff to critically appraise everyday practice, identifying gaps and deficiencies, so they can scope out actions they need to take to improve performance. ‘Product’ is the focal point for organisation purpose and achievement (Creech 1994); however, as noted in the ISO (International Standards Organization) model (International Organization for Standardization 2004), the desired outcome is determined by the service provider or manufacturer, and the system then ensures that the outcome can be achieved in a consistent and effective manner. If the service provider or manufacturer determines that their desired outcome is a low-cost, poor quality service or product, then ISO or TQM will help them efficiently achieve that outcome.

Assessment of the actual outcomes of care remains a necessary instrument to measure the achievement of care, as well as to render providers accountable for their
performance so that further corrective action can be adopted on a more empirical basis (Larizgoitia 2003). TQM and CQI were considered as noun forms, rather than as verb forms (Batalden and Splaine 2002). Quality was viewed as something achieved as a steady state, rather than something dynamic that required ongoing involvement and action at all levels of an organisation. Those who worked in health during the twentieth century learned that health care is a system. Now, the work of many such as W. Edwards Deming and Joseph Juran in the manufacturing and service industries that focused on the creation of learning systems in daily work has begun to migrate into the delivery of care in health settings. From their perspective, there are two imperatives for health care in the twenty-first century: redesigning care and improving service. The redesign 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. At the level of delivery of care, there is a microsystem, a small replicable unit of service organisation where the core competency of the health service providers meets the customer who is the beneficiary of the services (Batalden and Splaine 2002). The beneficiaries of care are members of the same system or work unit as the providers, and information and information technology are also integrated as full members of the work system (Quinn 1992). 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).
There is thus a need to measure the outcomes of integrated health delivery systems in a way that supports continuous quality improvement without falling into the abyss described by Behrens and Oldenkamp. This has led people like Leggat and Leatt (1997) to embrace the balanced scorecard (Kaplan and Norton 1992) as a model for evaluating integrated health systems. The development of the balanced scorecard approach within health and long-term care systems, and the reasons for utilising this approach in the implementation framework, are discussed later in this literature review.

2.8.6 Making data collection tolerable and meaningful

Often data collection does not reflect the values of the organisation (Eccles 1991), but what was currently available rather than what ought to be measured (Jennings and Staggers 1997). Health professionals can be frustrated by demands to collect, review, and critique data, especially if the findings are not used systematically to inform decision making (Couch 1993). The greatest lesson that was learned from the State of Virginia’s experience with the Virginia Performance Outcomes Measurement System was that less is more (Blank, Koch et al. 2004). Measuring a large number of performance and outcome indicators requires a large investment of resources. It is critical that these limited resources be devoted to indicators that provide the best cost-benefit – that is, indicators that can be measured reliably, at low cost, and with the greatest utility.

O’Leary advocated that data collection should focus on those things that matter rather than the total universe of measures, emphasising that unless performance improves, data collection is not useful (O’Leary 1993). While sound decision making depends on sound data, it is also the case that performance measurement can be simply a means of compiling data. Synthesis and analysis to create meaning is necessary (Jennings and Staggers 1999). Monitoring, analysing, and formulating useful information out of all the individual bits of data is a vital part of the data process (Hierholzer 1991). For this, an understanding of both human cognitive science and the information flow of clinical processes is required. Aspects of human cognitive abilities, such as the ability of a human being to excel at pattern matching,
but to be less adept at discerning details about objects and concepts, must be used in
designing data presentation (Pinker 1997; Jennings and Staggers 1999).

Having an electronic and automated system is essential (Marr and Neely 2003). According to de Waal (2001), one of the seven performance management challenges organisations need to address is embracing information transparency in order to have the right information available at the right time, to make the best decisions, and to take actions. Classe (1999) notes that paper and pencil, or simple spreadsheet tools are everything you need to start applying the balanced scorecard approach to performance measurement, but if you decide to make the method an integral part of the business, automation will usually be necessary. Sharman and Kavan (1999) add that paper-based measurement systems are too slow, cumbersome, labour intensive, and unreliable.

A report on the use of a balanced scorecard in the Houston, USA based St Lukes Episcopal Health System (Wyatt 2004) identified that the information needed for reporting purposes was scattered in different databases. The system for collecting the information was so cumbersome that managers were not able to know until well into the following month whether or not they were meeting their targets. While developing a report card system based on a balanced scorecard enabled them to know what information they should be tracking, usefully applying the information was difficult because of the time delay in receiving it. St Lukes developed a single portal solution, which enabled managers to view key performance indicators such as staff turnover, client wait times and supply expenses through a series of visual dashboards. Combining the balanced scorecard approach with a visual dashboard is analogous to the visual cues used by a fighter pilot: the dashboard supplies readings on altitude, speed and fuel supply as the pilot looks through the canopy to effectively complete the mission. Visual dashboards can also be set up to present current status at a glance through colour coding. What this system did was allow managers to access the information quickly in a format that also provided them with a means for drilling down to find the root cause of the problem.
2.8.7 The impact of performance measurement on behaviour

Organisations can learn from their performance by collecting performance measures, and then create aspiration levels for staff based either on their own past performance or that of other organisations. They can then change organisational activities if the performance is lower than the aspirational level (Greve 2003). Flamholtz (1983) was clear that when something became the subject of measurement it tended to influence the behaviour of people in organisations. The mechanism is simple self-regulation by attempting to reach a goal not currently met.

Organisations with performance below the aspiration levels of their managers have been shown to have higher rates of strategic change, research and development expenditure, innovation and investment. Their managers are willing to try a wide range of strategic actions to solve a problem of low performance. There is no clear delineation of high or low performance on the measures that managers use to evaluate their organisations, only rough rules of thumb; managers set their own standards for the level of performance required. The mechanisms for adjusting aspirational levels are an important part of research on performance feedback in organisations (Greve 2003).

Organisations have been criticised for making insufficient changes in response to low performance. Greve (2003) argues that organisational failure spurs change to a greater extent than organisational success reduces change. Improved performance will often cause the rate of organisational change to drop by a considerable amount, but deterioration in performance of the same size results in a barely perceptible increase in the rate of change. Managers seem prepared to believe that all is well until they have been presented with strong evidence to the contrary.

Learning Theory as presented by Kathy Sierra, a learning theorist with a background in computer-game development, shows that success in games lies in weaving the learning experience into the playing experience, so that the ‘user as hero’ finds it easy to begin and fulfilling to continue. Except for highly motivated planners and funders, a performance measurement system must be easy to engage with and fulfilling to continue with. Sierra used to operate a website with articles that could be
seen as a string of psychobabble, but which underpin some successful product and teaching strategies – e.g. “give your users an ‘I rule’ experience…a higher resolution experience”; “reducing guilt is the killer app” (Brown 2006). The relevance of this for the performance measurement as a tool to improve performance is that having a logically and evidentially sound instrument is not sufficient. People need to have an instrument that they are comfortable using – the experience of the participant in the use of the instrument is of equal importance to the soundness of the instrument. If they don’t like the experience, they will not continue with it and it will not help them learn (Mezirow 1997; Sierra 2006).

2.9 Performance monitoring

2.9.1 Performance management: the gap between the promise and the reality

Kaplan and Norton (1992, 1993) argue that a number of perspectives other than financial are needed to manage the performance of any organisation and assist that organisation to achieve an intended strategic outcome. The intention of having more than one perspective (financial) was to ensure that managers were held responsible for the long-term health of an organisation, and were not rewarded for short-term profit that was achieved by stripping out needed personnel and resource assets. By identifying other significant performance factors that were aligned to the organisation’s long-term goals, overall performance, including profit, would be improved. The four perspectives that make up the balance are described in Table 6.

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer</td>
<td>What does the customer want?</td>
</tr>
<tr>
<td>Internal business</td>
<td>What must the service excel at?</td>
</tr>
<tr>
<td>Growth</td>
<td>How can the business continue to improve?</td>
</tr>
<tr>
<td>Financial</td>
<td>How do funders perceive the service?</td>
</tr>
</tbody>
</table>

A balanced scorecard is a technique for use in strategic management. 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
nonfinancial 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). To be effective and useful, any measurement system needs to make the relationships between the objectives and the measures explicit so that, in the process of measurement, the relationships can be validated and managed (Kaplan and Norton 1997). Comprehensiveness is achieved by including measures that interact on the basis of established cause-and-effect relationships (Pineno 2002). A review of over 30 companies that successfully use organisation-wide balanced scorecard systems showed that the average percent gain across the organisations’ scorecards has been 54.4 percent (Abernathy 1997). The balanced scorecard approach has, therefore, been proven to be practical and of value for improving operational performance. Pineno (2000) argues that using an incremental approach in the development of a scorecard allows management to develop realistic approaches and to test for causality. They are assisted to determine a range of target measures based on probabilities, and then to evaluate in an ongoing way the reasonableness of the targets for future periods. An incremental approach means using sensitivity analysis to determine what effect, if any, a marginal change in one measure may have on other measures of the balanced scorecard. The measures are weighted and then a weighted average success indicator is calculated. Incremental changes to one or a series of measures are then tested to maximise the success indicator. Measures that maximise the success indicator are included in the balanced scorecard.
While there has been a large uptake of the balanced scorecard approach for performance management, a number of shortcomings have been noted (Kennerly and Neely 2000; Neely, Gregory et al. 1995). There are no perspectives concerning the employees or the competitors. Since in New Zealand we are dealing with a public health system where the government-owned DHBs control the funding and the contracting for services, the competitive perspective is not considered to be necessary for the implementation pathway. From a DHB perspective, benchmarking between providers to assess outcomes in order to improve quality has a higher priority. As noted previously, however, the workforce perspective is also important.

The balanced scorecard approach also does not specify the dimensions of performance that determine success, with there being no recognition of the importance of aspects such as human resources. One view is that there is no explicit causality notion (Rouse and Putterill 2003), although there is debate about this. For instance, one researcher stated: “Furthermore, the balanced scorecard seeks to link these measures into a model that accurately reflects cause-and-effect relations among categories and individual measures” (Malina and Selto 2001, p 52).

One concern is that while between 40 and 60 percent of large US firms had adopted a balanced scorecard approach by the end of 2000, despite all the activity, there were claims that 70 percent of the initiatives failed (Kennerly and Neely 2000). Two reasons given for this failure are: the measurement systems are often poorly designed, and they are often difficult to implement. Implementation issues cluster under three main headings – political, infrastructural, and focus. Measurement will not work when it is used for political control within a culture of blame rather than as a quality improvement tool; the infrastructure does not allow the required information to be obtained in a compliance friendly manner; and the time taken to implement and manage the system takes so long that people lose focus and interest (Kennerly and Neely 2000).

There are also formidable data quality problems in getting a large number of different organisations to report data in a standardised format so that comparable indicators
may be produced (Zelman, Pink et al. 2003). When performance management is used to develop reporting that leads to benchmarking, this becomes a real issue.

2.9.2 The use of the balanced scorecard technique in health

The balanced scorecard was developed for commercial firms and used to force managers to look at their business from the four important perspectives (Kaplan and Norton 1992; Kaplan and Norton 1993; Kaplan and Norton 1996). Potential trade-offs could be identified and provide a mechanism for ensuring the accountability of the system. One review of the use of the balanced scorecard in health care noted that its use within health was well into a growth phase, with many refereed articles published since the first one related to health care in 1994 (Zelman, Pink et al. 2003). The review concluded that the balanced scorecard is relevant to health care if it is modified to accommodate health industry organisational realities; if it includes other perspectives such as quality of care, outcomes, and access; and if it helps to meet the need for valid, comprehensive, and timely information.

One view is that in order for health organisations to connect practices, outcomes, quality, value, and costs, they must use a balanced scorecard (Castaneda-Mendez, Mangan et al. 1998). 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. Thus, the balanced scorecard concept is generalisable and is not restricted to particular organisational types such as product based organisations.

However, differences were identified between organisational and sectoral applications of the balanced scorecard within health care. The health care organisation is focused on the organisation’s mission, strategic management, programme and service improvement, and quality management. The health care sector is focused on the achievement of the mission for the health system, public accountability, improvement of programmes and services, and addressing specific political needs and concerns. The health care organisation is interested to ensure that its scorecard is comparable across time and wants to compare its performance to its
own benchmarks. Therefore, each organisation wants to choose indicators that reflect its own mission, services, programmes, and operating environment. The data is assembled internally using a reporting framework and methods determined by the organisation. For the health care sector, comparability across organisations is more 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).

Leggat and Leatt (1997) adopted the balanced scorecard framework for monitoring and evaluating integrated health programmes, changing the focus slightly for each perspective, and adding a fifth regarding community benefit. Their framework for monitoring the performance of an integrated health system is defined in the following table:

<table>
<thead>
<tr>
<th>Performance measurement</th>
<th>Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 How do patients/other customers view the integrated health system?</td>
<td>the customer perspective</td>
</tr>
<tr>
<td>2 At what must the integrated health system excel?</td>
<td>the internal business perspective</td>
</tr>
<tr>
<td>3 How can the integrated health system continue to improve?</td>
<td>the innovation and learning perspective</td>
</tr>
<tr>
<td>4 How does the integrated health system look to the funders?</td>
<td>the financial perspective</td>
</tr>
<tr>
<td>5 How does the integrated health system impact on the health status of the population?</td>
<td>the community benefit perspective</td>
</tr>
</tbody>
</table>

Source: Leggat and Leatt (1997)

The performance measurement aspect of the implementation pathway that is the focus of this thesis will be based on the balanced scorecard framework, particularly as constructed by Leggat and Leatt (1997), to evaluate integrated health systems. Ageing in place initiatives must be a form of the integrated health delivery system if
they are to be acceptable in terms of the Health of Older People Strategy. One long-term care organisation developed a balanced scorecard containing the perspectives of ‘development and community focus’, ‘human resources’ and ‘quality of care and services’ (Potthoff, Ison et al. 1999). For the implementation pathway, the main adaptation will be to address the customer perspective with the question: “Does the ageing in place initiative improve outcomes from the perspective of the individual, including the perspective of that individual’s family and whanau?” The difference is that the focus is not on the individual customer’s view of their relationship with the health system, but on the effect of that interaction on their well-being. The addition of outcomes for family and whanau comes from the research highlighted by the Health of Older People Strategy and the New Zealand Disability Strategy (2000) which both emphasise the importance of informal carers to the well-being of older people. The perspectives raised by Potthoff, Ison et al. (1999) will be the domains within the perspectives put forward by Leggat and Leatt (1997).

The issues in the health sector have been summed up as a necessity to meet service users’ expectations, to eliminate waste and allocate resources effectively, to have motivated well-trained staff, and to deliver a high standard of service (Schmidt, Bateman et al. 2006). Excellence is defined by Schmidt et al. as having a sustainable and strategic performance approach that fully meets service users’ and any carers’ expectations through a focus on processes, people, and resources, within limits and directives set by higher authorities, and by ensuring high standards for the future. In taking this focus on excellence into reviewing the balanced scorecard approach, Schmidt et al. analyse the term ‘perspective’ used by Kaplan and Norton, and decide that a different approach is needed in their area, mental health. Their argument focuses on the customer’s perspective, which describes how the customer sees the provider. In their view, this is not a suitable approach on its own for a mental health service. As they point out, mental health services often treat people who are not able to appreciate their work. The values underpinning the work of the mental health trust that Schmidt et al. are working with requires staff to enable service users and their carers to make decisions about their care. To do this, information must be shared, and all parties must be treated with dignity and respect – service users, staff, and managers. In mental health, it is important to consider how all stakeholders see
each other – managers, providers, staff, service users, carers – how each party sees their environment, and how the work of each party is seen by all other stakeholders. Their suggestion is to focus on areas rather than perspectives; the areas for them being clinical risk, finance, service modernization, and workforce. They used these terms because they wanted all areas to have a direct connection to the clinical language of the British health sector and the trust they were working with. They also wanted the names of the areas to be understandable and recognizable for all trust employees.

The next step, as suggested by Schmidt, Bateman et al. (2003), is that for a strategy to be translated into performance measures within each area, it needs to be converted into tangible statements. They recommend this be done by establishing strategic objectives by which success will be gauged. These have been called a bridge that provides the quantitative means to span the strategy of broad overall priorities and measures (Niven 2003). The strategic objectives should also motivate people to implement the strategy successfully. All strategic objectives should be derived from the goals and begin with an action verb; that is, they are action-oriented statements geared to assist every stakeholder to understand how the strategy can be executed. This approach of Schmidt et al. provides a translation of the balanced scorecard into a language for health. Community health programmes for older people operate within the same constraints as the mental health service described by Schmidt et al. The focus on areas provides a mechanism for telling the story in a language that will communicate the strategy to the stakeholders within the context of health services for older people. This approach resonates with the Habermas Theory of Valid Communication (Habermas 1981) and the Sheffield V-Model (Sheffield 2005) which are core to the development of the implementation pathway, and are discussed later in the chapter.

2.9.3 The performance prism and viable systems model

The results of the implementation of the balanced scorecard would suggest that users have not seen evaluation as a central task they own (Duignan 2002). One reason suggested is that the balanced scorecard was developed for the for-profit business community (Neely, Adams et al. 2001). Businesses have a purpose, e.g. to make
money for the shareholders; they determine their stakeholder group to strategically accomplish this. In the case of integrated community health services for older people, this approach has a flaw; in this case, the key strategies do not belong to the provider organisation; they come from Government and determine that older people will be assisted to age in place. It is, therefore, more productive to start by identifying all the key stakeholders that would need to be satisfied by a community programme for older people. The performance prism approach (Kennerly and Neely 2000) puts the stakeholders first, then identifies the strategies, processes, capabilities, and stakeholder contributions that are needed if the needs and wants of the stakeholders are to be satisfied. This approach sets up some causality in that the success of the services offered, as reflected in the achievement of the needs and wants of the stakeholders, is a function of the other perspectives. Putting all stakeholders first may also provide a means of achieving their buy-in to the performance management approach as they will be able to identify with at least their part of it because they or their representatives will have been engaged in its development.

The Performance Prism also offers the benefit of being easier to understand at first presentation. It starts by asking: “Who are the Stakeholders for this service?” It then asks each stakeholder, “What do you need and want from your involvement with this service?” Other approaches have also called for local stakeholders to be engaged in meaningful ways, and to ask at the outset what the person wants from the service seems to have validity as a way to start doing that (Goodman 2001).

However, it is clear that with a balanced scorecard approach, the integration of strategy formulation and implementation are key weaknesses. There is empirical evidence that current methods such as the balanced scorecard do not deliver the expected results. In a study of the top 200 German companies, a total of 46 percent used the balanced scorecard, but only 31 percent reported that they used the balanced scorecard to improve strategic learning. Only 31 percent reported that their resource allocation was now in line with the strategy; only 10 percent agreed that the balanced scorecard had improved their bottom line; and only 12 percent agreed that their planning and budgeting processes had improved since the introduction of the
balanced scorecard (Krause 2003). A number of shortcomings in the methodological toolkit for implementing the balanced scorecard have been demonstrated. In both a knowledge worker’s environment and in a not-for-profit organisation, superior performance depends largely on the individual’s perception of benefit; maintenance of the performance management system is not well-supported, and there are difficulties with changing management tasks and the resulting change-requests to performance indicators. Strategic concepts tend to be at a fairly high level of abstraction at a strategic management level, while the operational managers perceive that the goals are known and the important thing is to get the relevant data to the users as quickly as possible.

The development of a performance management system is usually based on existing organisational structures. In many cases, the existing organisational structure is an outcome of the way things are done at present, and may in fact be inhibiting change. A model of future business processes would focus on how an organisation should work in order to achieve its goals. Organisational performance is driven by people and resides in its processes. Outcomes need to be linked to critical success factors at the level of organisation-specific processes. There is often a limited transparency of content and structure of performance management systems because metrics remain at a high level of abstraction with formulae, interpretation, and data sources not explicitly defined. Often, new projects develop new solutions which are hardly ever re-used (Krause 2003).

It is possible to achieve change without forcing a change in organisational structures. The Viable Systems Model perspective (Espejo and Gill 1997) provides a unifying view on the 21 distinct funding organisations or DHBs in the New Zealand health system. These 21 different organisations are actually part of one system. In the Viable Systems Model, management is seen as part of a meta-system across operational units. Management is a second-order observer that responds with decisions to the differences between its expectations and information. Differences are symptoms (e.g. high efficiency, but poor quality, or an absenteeism ratio above average in a public office). Management receives conflicting interpretations for the same differently defined problem-situations from various departments and
hierarchies (production, research, sales, and works-council) or from external stakeholders (Schuhmann 2004).

From a DHB perspective, the Viable Systems Model provides a rationale for accepting that all 21 DHB management teams can operate as though they are part of the same system. Within this model, an autonomous unit (or viable system) needs to have five key systems in place if it is to operate effectively in its environment: implementation, coordination, control, intelligence and policy. This is not a mechanistic model, but rather a philosophical one that enables people to think through the complexity of the world they work within. A key concept of the model is recursivity. This is based on the idea that all living systems, including complex organisations, are composed of a series of sub-systems, with each sub-system having its own self-organising and self-regulatory functions (Espejo and Gill 1997). Recursiveness [Definition: a procedure that can repeat itself indefinitely – Merriam-Webster Online Dictionary, accessed 21 June, 2010] is the key aspect of the Viable Systems Model that is useful when considering the implementation of community health services for older people driven by the philosophy of the Health of Older People Strategy. While each DHB system is autonomous, they all try to implement the same policy (directed from the policy sub-system within the Ministry of Health); they all try to control and coordinate what providers deliver; and they all try to gain intelligence about the external environment they work within, both locally and nationally. Within each DHB, home care providers are one sub-system, autonomous from the DHB, but they also seek intelligence about the external environment in an effort to control what their staff deliver. The use of performance management that is driven by a vision offers a mechanism for sharing information accurately across the different subsystems.

2.9.4 Performance measurement
Performance measurement has been defined as a set of interrelated measures that reflect process, outcomes, or both, and enable the facilitation of internal and external comparisons of an organisation over time (Joint Commission on Accreditation of Healthcare Organizations (JAHCO) 1993). Other nuances have been described as instilling and tracking accountability, deriving data for decision making, and
identifying areas of care delivery that need improvement (Jennings and Staggers 1999). Rouse and Putterill (2003) developed a definition that fits well with the concept of benchmarking (introduced in section 2.9.6): “the comparison of results against expectations with the implied objective of learning to do better” (p 795).

The concept of performance measurement has taken a prominent position in health care because the evaluation of performance is regarded as a cohesive way in which to gain the information needed to deal with competing demands (Sahney 1998). In the view of Jennings and Staggers (1999), reports from performance measurement are simply the published summaries of performance measures. They express an appreciation of the fact that health care organisations are taking to heart the need to evaluate and report on performance, but are discouraged that information is being used without an appreciation of the limitations of performance measurement and report cards. These limitations include the potentially pejorative function of report cards, instilling an atmosphere of judgement and punishment instead of an atmosphere of learning and improvement. If the data are not used or are used in a punitive way, various gaming tactics such as underreporting and incomplete reporting may develop (Jennings and Staggers 1999). What is clear is that data collection should only be done when its value to decision making exceeds the cost of gathering it (Brailer 1996). Jennings and Stagger (1999) call for three issues inherent in performance measurement to be considered when developing any performance management system: the concept of quality, the power of the patient, and deliberations about data. These three concepts underpin the development of the implementation pathway in this thesis through adaptations to the balanced scorecard approach and the V-Model.

Underlying performance measurement approaches is a need to ensure that there is a clear logic between the strategic intent and the approaches taken to achieve it so that there is an ‘if /then’ logic to programme activities which then forms the basis of the performance measurement system. In Canada, the Treasury Board requires government departments, agencies, and programmes to use a results-based management accountability framework for quality improvement and reporting purposes. This approach is a multi-stage process that begins with the creation of a
results-based logic model that links resources expended to activities performed, services delivered and outcomes achieved. Originally developed for primary health care services, the same approach has been applied to other services also. Logic models clarify the linkages between inputs, activities, outputs and immediate outcomes, as well as the impact of immediate outcomes on more downstream results. The Results-based Logic Model (RBLM) builds on ‘if / then’ statements, for example, if the people involved in this service engage in activity X, then the result will be output Y which will lead to outcome Z. Inputs, activities and outputs are regarded as areas over which the programme has some degree of control, which outcomes are areas which the programme influences. Efficiency is defined as a function of inputs, activities and outputs, and is a measure of the extent to which the programme is expending the resources available to achieve the desired outcomes. Effectiveness is the extent to which the programme is delivering the planned results (Watson, Broemeling et al. 2004).

2.9.5 Getting communities of practice to work together to enhance practice

Creating an evidence-base is one thing, getting the evidence used in practice is quite another. The evidence-based model can be over-rationalist and play down the social and organisational context within which care actually occurs. Knowledge management in the industrial sector has emphasised practitioners’ tacit knowledge or knowledge in practice. Primary care clinicians work in communities of practice that combine information from a wide range of sources into ‘mindlines’ (internalised, collectively reinforced tacit guidelines), which they use to inform their practice (Gabbay and Le May 2004). Any information from an evaluation needs to be presented in a format that influences opinion leaders within the clinician community and which can be seen to enhance practice.

In health, there are many actors who can negotiate over the goals of a health service; these include owners, board members, managers, workers, the state, and lobby groups. Organisational theory has particularly emphasised negotiations among managers of different organisational sub-units, because they have direct access to the organisation’s decision-making process and resources. However, actors outside the
organisation also influence negotiation about goals: they can provide managerial rhetoric in favour of specific goals and give resources to organisations that pay attention to the goals they favour. Managers acting on behalf of themselves or their organisational sub-units can thus become agents of environmental actors that have transactions with that sub-unit, or can provide justification for it. The theory of the dominant coalition (Cyert and March 1963) states that goals are negotiated with the prior agreement as the anchor, the managers with direct access to the decision-making process as the main actors, and the environment providing problems, rhetoric, and resources that can be used by managers in the negotiation process. As organisations must form goals through collective activities of people, they form dominant coalitions of members and other actors with an interest in the organisation’s operations and an ability to influence it. The dominant coalition does not consist of all interested parties, but only those participants with sufficient authority to enforce the agreement in the short run (Greve 2003).

Greve (2003) hypothesises that organisations search for answers in different ways: slack search, institutionalised search, and problemistic search. Slack search is when workers spend spare work time or their own time exploring new ways of doing things. Institutionalised search is done by departments, such as Research and Development. Problemistic search occurs in answer to an organisational problem. It is the most important form of search because it is governed by performance relative to aspirations. Problemistic search is a goal oriented behaviour and is variable; it is governed by performance feedback and any differences between performance and aspiration level.

A simple model can be built based on the assumption that decision-makers classify outcomes into two categories, success and failure, and that the probability of change is higher in the failure category (Greve 2003). Greve, however, argues that this model is too simplistic, and modifies it by incorporating the possibility for change, even at high levels of performance, to be consistent with an organisation’s on-going slack and institutionalised research activities. He also incorporates the resistance to change and avoidance of risk within an organisation when aspiration levels are being met, and the increase in problemistic search and willingness to take risks when aspiration levels are not being met. He presents a figure (Fig 3 below) for this
performance adjustment of search and decision making. Now, the setting of goals becomes a complex mixture of precedence, politics, payoffs, and proselytizing (Greve 2003).

Figure 3: Framework for performance adjustment of search and decision making (Greve 2001)
The Theory of the Dominant Coalition (Cyert and March 1963) offers a way to understand how the negotiation process works. Individual people have goals; collectivities of people do not. An organisational goal is formed by a coalition of its members and other actors with an interest in the organisation's operations and the ability to influence it. Not all interested parties are necessarily involved, only those with sufficient authority to enforce the agreement to be a coalition in the short run. The dominant coalition may change as new problems occur. This theory takes account of bounded rationality, which is a modification of the rational choice paradigm that underpins much of economic theory. Bounded rationality means that human decision makers have limited information, attention and processing ability; this makes them unable to undertake the maximising activities assumed by normal economic theory, which is comparing all the consequences of all alternatives with respect to their value to him or her, and choosing the alternative with the highest value. Instead, decision makers are likely to 'satisfice', which means they set a goal they try to meet and continue to evaluate alternatives until one that satisfies the goal has been found.

The implementation pathway developed in this thesis needs to provide a means to assist in the establishment of a dominant coalition by getting all the key stakeholders to agree on a set of outcomes or goals which they want the programme they are all involved with to achieve. It then must provide for 'satisfaction' – once a provider has established a means for meeting the goal that is set, and the goal is set, then all stakeholders will be 'satisficed'. If a provider cannot provide satisfaction, there is then an incentive for them to search for ways of operating that will produce better outcomes. The implementation pathway and performance management system developed in this thesis will also assist with that search as it provides for the possibility of benchmarking and the sharing of information about the providers that are meeting goals adequately.

2.9.6 Benchmarking

Benchmarking has been defined as:

_Evaluating and improving an organisation, its units or a network's performance, technology, process, competence,_
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). A further step in this thesis, beyond individual organisational performance management, has been the development of IN-TOUCH, a benchmarking programme among DHBs. The rationale for moving to the sharing of information across DHBs rather than among providers within a single DHB becomes clear in the thesis results. Stakeholders across New Zealand are searching for an efficient and effective way to deliver restorative services. While there are a number of different service providers within 21 DHBs, for the DHBs there is only the one New Zealand health system. From this perspective, it makes sense for all the DHBs to work together as one unit. One of the major problems with conventional performance measurement is the ease with which organisational wholes are carved up, and their interactions with their environments cease to be of interest as management functions or academic disciplines devise measures (and associated targets) for their own territory (Holloway 1999).

2.9.7 Policy and contracting

The implementation pathway developed in this thesis provides an avenue for the 21 different DHB sub-systems within the national New Zealand health system to maintain their autonomous decision-making, but to share ideas about how to control and coordinate the implementation of an imposed national policy. This fits in well with the concepts of the Viable Systems Model described above. This approach also aims to support planners and funders within DHBs in their role as the funders of 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; a major
factor is goal divergence between policy directives and implementation practices as a result of misunderstandings about policy directives and goals, ambiguous definition of performance requirements, and infrequent monitoring. This leads not only to accountability issues for public managers, but also raises efficiency and effectiveness issues. Van Slyke (2005) talks of “a complex managerial environment . . . devoid of competition, administrative capacity, and clearly defined and agreed upon contractual goals and outcomes” (PNP:D3).

One of the purposes of the implementation pathway is to assist planners and funders, as the contractors of publicly funded health services, to develop a high quality approach to managing contracts through developing a balance between agency and stewardship approaches (Van Slyke 2005; Cribb 2006). The aim is to balance trust and accountability through a mix of shared vision and performance measures.

2.9.8 The use of management theories in this research

As issues were raised through the iterative process of interviews and focus groups in Phase 1, theories and approaches were gleaned from the management literature to provide interpretations and formalisations for the results from each interview and focus group. Figure 4 shows how different management concepts were introduced at each stage of Phase 1.
2.10 Approaches to implementation

2.10.1 Wonderful strategies, shame about the result

Implementation of any change in strategy is fraught with the prospect of failure – between 65-75 percent of all public and private sector change initiatives fail (Oakland and Tanner 2006; Kee and Newcomer 2008). While there is a plethora of approaches to change management, this range of available approaches is itself also an issue. Organisations can spend much of their time trialling new tools and then moving on to the next best thing – the typical company has been shown to adopt more than three new tools or techniques annually (Ghoshal and Bartlett 1997).
At the same time, major gaps exist between what is considered to be effective practice because it is supported by theory and science, and what is actually done (i.e. policy and practice (Fixsen, Naoom et al. 2005). Implementation is the management of change as well as the instigation of a change process to put in place new policies, processes, and procedures (Hernandes and Hodges 2003). According to Palmer and Dunford (2008), two competing assumptions about managing change can be identified: management as control versus management as shaping; there are three competing assumptions about change outcomes: outcomes as intended, partially intended, or unintended. Using this framework, six perspectives or images emerge for a manager to consider when choosing how to implement a change process. Three of these have been used as a reference point for the role of a DHB HOP portfolio manager. The ‘navigating’ image, considers that while the manager has some control, there may be a variety of external factors over which they have little control, but which will impact on the outcomes achieved. Management is, therefore, about plotting and re-plotting the course of change as variations are made. The ‘interpreting’ image has managers as interpreters or sense-makers who help people find meaning in change. The ‘nurturing’ image has managers who facilitate organisational qualities that enable self-organising change to occur, and who use communication to foster the conditions for change.

District Health Boards contract services for older people from both in-house ‘provider arm’ providers, and community providers. They operate, in fact, within what is a network (Powell 1990). This means that planners and funders within the Health Boards cannot direct providers to change their service delivery models and simply expect that change will happen successfully. As ‘navigators’, to some extent, they must take control and direct towards intended change outcomes, but they must also accept that there are a variety of factors external to their control. Therefore, they also need to be ‘interpreters’, to shape and provide meaning as they help to make sense of events, and by ‘nurturing’, facilitate organisational qualities that enable positive self-organising to occur (Palmer and Dunford 2008).

This view of the role of DHB HOP portfolio managers is supported by previous management control research. Robert Simons believed that the fundamental
problem facing managers was how to exercise adequate control when there is a demand for flexibility, innovation, and creativity (Simons 1994; Simons 1995). Employees of health services must have a clear and consistent understanding of the core values and beliefs of the service they are providing, and their place within that service. They work within an environment in which specifications cannot be as exact as in a factory that produces widgets, so there is no possible way in which a manager can control every input even at the point of service delivery. A manager must trust the person to do the job specified. However, alongside the statement of core values and beliefs, there must also be a definition of the limits of someone’s expected performance (a boundary system) and an interactive control system that encourages open dialogue to encourage learning [called by Simons ‘Levers of Control’]. In other words, workers need to understand the values and beliefs of the service they are working for, understand what they are not allowed to do, and work within a system that encourages dialogue so that people can test that their work actually does match with their and their organisation’s values. There is an implied belief that they should, therefore, feel encouraged to always learn how to improve performance (Rouse and Putterill 2003). Performance measurement (the diagnostic control system) will give information that can assist them to know the facts about their performance.

2.10.2 Beliefs

In health, there is plenty of research demonstrating how health professional’s belief systems impact on their ability to implement a new service approach (McDonald, Rogers et al. 2008; Papadopolous and Merali 2008), but the experience of people involved in the development of the implementation pathway developed in this thesis is that it is a difficult task for a funder or manager to operate a service framework in which people can openly debate values and beliefs, develop better understanding of what good practice actually means, and then manage performance to achieve that good practice. To develop a shared belief system that will drive appropriate behaviour that supports new approaches is, in fact, not easy. People’s emotions and values are crucial for a full assessment of the validity or truth value of an enterprise, as the ontological and epistemological assumptions of participants are crucial to how people within a system operate (Woodman 2008).
The Theory of Communicative Action (Habermas 1981) offers a way forward. It postulates a process whereby valid communication can occur when technical data is agreed upon by people who then discuss what it means and match that data to their personal and social worlds. The importance of this matching is shown by research into the correlation of belief and emotion, self-representation, and cognitive conflict in the human brain. The ventromedial prefrontal cortex is an important area of the brain for self-representation, emotional associations, and reward and goal-driven behaviour. This same region shows an increase in the blood-oxygen-level-dependent signal when a person is engaging in dealing with a belief. This means that a belief is not just a matter that relates to truth or falsity. One possibility arising from this is that pushing people to undertake reality testing of their beliefs may not, in fact, change their behaviour. People may not struggle to implement evidence-based practice because they are relaxed about their own standards of rationality. They may have relaxed their standards of rationality because certain other ways of thinking fit with their inference machinery in a way that seems credible because they are memorable, emotionally salient, and socially consequential (Harris, Kaplan et al. 2009).

The human brain has evolved to detect patterns in the world. The patterns that are actually detected and laid down are the result of culture and upbringing. Changing those patterns means changing beliefs that are integrated with emotion. The other aspect of the research is that belief in empirically verifiable facts and belief in unempirically verifiable statements all light up the ventromedial prefrontal cortex. What this means, of course, is that facts on their own may not change a belief (Harris, Kaplan et al 2009). People believe in their own truth claims, and may think the truth claims of the other parties are absurd.

2.10.3 A meta-model based on Habermas – a psychological-sociological approach to reaching agreement

Habermas put forward a theory of argumentation as a means for people to come to a common understanding of what is rational by testing the validity of various assertions (Habermas 1981). His main contribution to communication theory was the elaborate theoretical apparatus he described in the two volumes of ‘The Theory
of Communicative Action’, published in 1981. Habermas addressed the following four general themes: a meaningful concept of the rationality of actions; the problem of an appropriate theory of action; a concept of social order; and the diagnosis of contemporary society. This thesis draws on the first two themes only.

Communicative action can be understood as a circular process in which the actor is two things in one: an initiator, who masters situations through actions for which they are accountable, and a product of the transitions surrounding them, of groups whose cohesion is based on solidarity to which they belong, and of processes of socialization with which they are reared (Habermas 1987; Habermas 1995). Central to this social notion of language and human reason is the concept that Habermas terms ‘validity claims’, the idea by which he connects speech acts to the idea of rationality. Habermas adapted Horkheimer’s definition of reason as rationality, and then combined it with the relation-based activities that result when humans agree.

Communicative action is the one type of action that, according to Habermas, uses all human ways of thinking, and language. This combination allows human beings to understand and agree with one another, and to make plans for common action. This coming together and agreeing, communicative action, takes the place of revolution as the mode of change (Outhwaite 1996). Communicative action is action oriented to the attainment and reproduction of mutual understanding. In an essay on universal pragmatics published in 1976 (Outhwaite 1996), Habermas describes the rationality of communication from three perspectives, each of which constitutes a world of knowledge. These perspectives are (i) my world of internal nature, i.e., the personal or subjective world that is the totality of the experiences to which the speaker has privileged access, (ii) our world of society, i.e., the social world that is the totality of all legitimately regulated interpersonal relations, and (iii) the world of external nature, i.e., the technical world of material fact that is the totality of all entities about which objectively true statements are possible. Habermas (1984, 1987) describes the evolution of knowledge in broad terms as a movement from (i) an objective material world devoid of life and, therefore meaning, to (ii) a social world where some living beings achieve a measure of interpersonal understanding and the ability to control aspects of their world, and to (iii) a subjective world where reflection provides
human beings (at least) with the power to re-construct, and learn from, their experiences.

Habermas argues that (i) knowledge claims in the technical world are validated by objective truth, (ii) knowledge claims in the social world are validated by rightness and (iii) knowledge claims in the personal world are validated by personal truthfulness or sincerity. The process of establishing valid knowledge claims in an idealized situation is communicative rationality. The theory of communicative action describes types of action that have different degrees of rationality. For example, Habermas argues that the fair and participative communication claimed for group support systems, or the personal and social goals that accompany the use of group support systems by self-organising groups, is more rational than the deceptive and power-oriented communication associated with strategic (competitive) negotiation (Sheffield 2004).

Based on Habermas’ philosophy, Sheffield’s V-Model provides a process for recursive consultation between all stakeholders involved in implementing any programme that has been developed to deliver outcomes according to a vision (Sheffield 2004). That is, the Sheffield V-Model is a process model, a methodology to assist people involved in a project to ensure they have a common understanding of their intent and action plan, and to implement that action plan by requiring them to test at all stages the validity of their communications and their actions.

The V-Model postulates that systemic knowledge is a holistic understanding of: a) the norms or expectation of people in a system (the personal and social worlds of Habermas); b) the technical system (the technical objective world); and c) the relationship between the two. Eliciting systemic knowledge is likened to a journey of discovery, with the success of the journey being validated by the commitment of the stakeholders to an agreed process for achieving technical excellence. The V-Model (Figure 5) provides a process for discussion between stakeholders about their intentions for any programme and how they will move from intentions to achieving the outcomes they desire.
Figure 5: The Sheffield V-Model

The V-Model (Sheffield 2004; Sheffield 2005) is a universal and pragmatic model. It employs a small number of general systems concepts to develop human understanding of system structure, function, and the linkages among components. The vertical axis of the V measures inclusiveness (hierarchy). The upper two points of the V represent high levels of inclusiveness (e.g., the personal visions and the big picture). The lowest point of the V represents a low level of inclusiveness (e.g., the analysis of technical detail). The horizontal axis measures the links among intentions and outcomes. The left half of the V-Model contains process steps associated with intentions (e.g., developing ideas, objectives and activities). The right half of the V-Model contains process steps associated with developing outcomes (e.g., doing thoughtful activities to achieve results that pay off). Steps one to three successively refine and narrow intentions while steps four through six successively aggregate and expand outcomes.

Sheffield explains that the terminology employed is based on research into organisational (i.e., interpersonal) information requirements, media richness, and
structural design. The two concepts that are utilised in the V-Model (equivocality or conceptual confusion, and uncertainty or lack of empirical data) have been the focus of studies in the social psychology of organising by Sheffield himself (Sheffield 2004) and Weick (Weick 1979). In the V-Model, activities that link levels one and two reduce ‘equivocality’ while activities that link levels two and three reduce uncertainty. Development of intentions and outcomes produce a Wittgenstein language game in which success is measured by cohesion of the chain of evidence (Yin 2003) linking adjacent process steps and the coherence of a web of inferences. Sheffield describes success in terms of objectives and results (level 2) that combine relevance (level 1) with rigor (level 3). The purpose of the V-Model is to develop and test the coherence among intentions and outcomes at three levels of inclusiveness.

This process of developing a shared understanding of intentions and desired outcomes aligns well with what is needed in the implementation of the restorative model across a number of DHBs and service providers. This literature review has led now to the point where the next step is to ask: “Given the need for a restorative approach and the availability of approaches that may be effective in supporting implementation, what are the next steps?” This leads to the research questions for this thesis.

2.10.4 The questions in this research

In this study, the example or focus was on the development of new community services for older people based on recent research evidence that a paradigm shift was needed (Tinetti, Baker et al. 2002; Parsons, Anderson et al. 2006). The research questions were:

1. To what extent is developing a common vision for community services for older people possible?
2. What are the critical success factors that would support the achievement of the common vision?
3. Is it possible to develop an implementation pathway that incorporates a performance management system that is accepted by the sector?
The remaining chapters describe the methodology and methods adopted to answer these questions. After the results are presented, a discussion about the findings and their implications follows.
If social scientists truly wish to understand certain phenomena, they should try to change them. Creating, not predicting, is the most robust test of validity-actionability

Kurt Lewin (Kaplan 1998)

3.1 Introduction

Methodology has been described as a fundamental approach to research that connects research methodologies to particular philosophical frameworks (Tashakkori and Teddlie 2003; Cresswell and Piano Clark 2007). This chapter identifies the theoretical issues that led to the choice of research methodology used to address the research questions raised by this thesis. The particular types of research used to develop the implementation pathway will be outlined: mixed methods research, with its qualitative and quantitative components; and critical theory research. Critical theory provides the ideological framework out of which action research approaches such as participatory action research and innovative action research were developed (Fontana 2004).

The research methodology for a study must consider how the scientific methods to be used will lead to a justified belief that the knowledge gained in answering the research question is valid for the subject matter of that research question (Stanford Encyclopedia of Philosophy; Baltes, Reese et al. 1977). This thesis required the development of knowledge of how two seemingly disparate elements, those of social behaviour and performance indicators, can be combined to support change management within organisations and networks (Powell 1990). This resulted in a research design that combined mixed methods and action research methods. Mixed methods research is itself the combination of quantitative and qualitative research methods. While a quantitative approach leads to the possibility of statistical analysis of the data, a qualitative approach draws wide perspectives together to portray as many aspects as possible. Both these approaches, however, simply record what is already happening (Kaplan 1998). Critical theory research requires that research be concerned about having an impact on the field of practice (Valero and Zevenbergen...
2004). Action research methods provide an avenue for the researcher to be engaged in assisting with the implementation of new approaches rather than just measuring what already exists (Kaplan 1998).

3.2 Research methodology paradigms

Although this thesis focuses on health services, the context for the research can be framed as one of social rather than bio-medical phenomena. District Health Boards (DHBs) and health service providers work with formalised and/or spontaneously occurring social, cultural, and psychological processes (Dash 1993). Social observations are regarded by quantitative research methodology purists as entities that should be treated in much the same way that physical scientists treat physical phenomena. In this positivist view, the observer is regarded as separate from the entities that are subject to observation. The desired result is for the social science inquiry to be objective, and enable development of time- and context-free generalizations about the real causes of social scientific outcomes that have been determined reliably and validly (Johnson and Onwuegbuzie 2004). On the other hand, qualitative research methodology purists contend that multiple-constructed realities abound. From this constructivist, interpretivist or anti-positivist perspective, the knower and the known cannot be separated because the subjective knower is the only source of reality. This means that time- and context-free generalisations are in fact not desirable (constructivists would argue these are actually impossible) because they ignore the issue that research is value-bound, with it being impossible to differentiate fully between causes and effects. The logic flow in qualitative research is from the specific to the general; e.g. explanations are generated inductively from the data (Guba 1990); therefore, from the constructivist viewpoint, a part of the consideration of the validity of any generalisation will be consideration of the time and context.

After some years of intractable opposition to each other’s perspective, both qualitative and quantitative researchers have now moved beyond these purist positions. Johnson and Onwuebuzie (2004) argue that basic agreement has been reached on several major points of earlier philosophical disagreement:
1. The relativity of the perception of reasonableness — it is now accepted that what appears reasonable can vary across persons;

2. The theory-laden perception of facts — accepts that observation is not a perfect and direct window into ‘reality’ because what individuals notice and observe is affected by their background knowledge, theories, and experiences;

3. Under-determination of theory by evidence — it is possible for more than one theory to fit a single set of empirical data;

4. The Duhem-Quine thesis or idea of auxiliary assumptions — accepts that a hypothesis is embedded in a holistic network of beliefs and alternative explanations that continue to exist; therefore, the hypothesis cannot be fully tested in isolation because in order to make the test, various assumptions must be made;

5. The problem of induction — in empirical research, only probabilistic evidence is possible, not final proof; and

6. The social nature of the research enterprise — researchers are clearly affected by their own attitudes, values and beliefs, as well as those of the communities in which they are embedded.

The research paradigms described above each propose a different concept of social reality. Positivism stands for objectivity, measurability, predictability and controllability. It constructs the laws and rules of human behaviour. Non-positivism emphasises the understanding and interpretation of phenomena. It seeks to make meaning rather than laws out of this process. While there has often been a history of fierce opposition between the two paradigms, there are researchers who do not perceive the two concepts as being oppositional when dealing with real life. They believe that, dependent on the situation, there can be value in using both methods. These researchers adopt a pragmatic philosophy that the current meaning truth value of an expression or approach to interacting with the world should be decided by observing the consequences of belief in or use of that expression or approach in the world (Murphy, 1990). This pragmatism has led to the development of mixed methods research.

### 3.3 Mixed methods research

Mixed methods research has been defined as that class of research where the researcher mixes or combines quantitative and qualitative research techniques,
methods, approaches, concepts or language within a single study. According to de Waal (2001), philosophically, it is a ‘third wave’ or third research movement, a movement that extends beyond the positivist / interpretivist paradigm wars by offering a logical and practical alternative. Mixed methods research finds its theoretical base in the pragmatic branch of philosophy. The logic of inquiry inherent in such a paradigm includes the use of induction (or discovery of patterns), deduction (testing of theories and hypotheses), and abduction (uncovering and relying on the best of a set of explanations for understanding one’s results).

Mixed methods research collects and analyses both quantitative and qualitative data in order to provide a comprehensive diversity of evidence that the research issue has been understood, and perhaps solved (Tashakkori and Teddlie 2003; Cresswell and Piano Clark 2007). This provides multiple perspectives on the same issue, and aids the interpretation of results through triangulation, the use of different but complementary data to explore the same phenomenon (Patton 2002). There are four types of triangulation: (i) data triangulation, where as many different data sources as possible are analysed; (ii) investigator triangulation, where different people look at the same area; (iii) theory triangulation, where there are many different perspectives in relation to the same objects; and (iv) methodological triangulation, where different methods are used to address the same issue (Corner 1991). Triangulation encourages more reflective analysis of the data, as well as being a means of testing the validity of any analysis. Respondent validation or stakeholder checks ensure the credibility of the data collected by checking its accuracy with those involved (Farmer, Robinson et al. 2006). This thesis primarily uses data triangulation; it accesses different data sources and seeks responses from different groups within DHBs: planners and funders, home support service providers, needs assessment and service coordination providers, and members of the Disability Services Advisory Committees — and also from different DHBs.

It has been stated that the primary reason for using mixed methods is “to elucidate the divergent aspects of a phenomenon” (Tashakkori & Teddlie, 2003, p 17). When compared with a single research method, which may be constrained by the method itself, the mixed methods design allows for the research to develop as
comprehensively and completely as possible. There are widely held views that because social phenomena are so complex, mixing different types of methods can increase the validity of the results from a study (Tashakkori & Teddlie, 2003). However, while mixed methods studies are combinations of qualitative and quantitative paradigms, methods or techniques, it is the combination of the distinctive execution and representation styles of the different methods that signals the key differences in the inquiry approach (Tashakkori & Teddlie, 2003).

When looking at mixed methods studies to judge if they are convincing, it is essential to investigate how well the needs and expectations of the readers representing the particular mix of interpretative communities have been met (Tashakkori & Teddlie, 2003). Mixed methods approaches on their own may not consider this issue (Hughes and Seymour-Rolls 2000). They can, therefore, be usefully combined with critical theory approaches to research that seek to identify and ensure the interpretative communities have been appropriately considered. The core elements of mixed methods research are usually considered to be qualitative and quantitative research. In this thesis, critical theory research approaches are also considered a necessary component. These elements are explained in the following sections.

3.3.1 Qualitative research

Qualitative research seeks to understand specific behaviours and their subtle variations within a naturally occurring setting. It uses categories to describe and analyse the social phenomena (Pope, Ziebland, & Mays, 1999; Meadows, 2003). A general inductive approach to qualitative research builds categories gradually from the extensive raw text data and condenses it into a summary format (Thomas, 2003). The raw data is derived from responses to open-ended questions which may also provide quotations (Sewell, 2002). A major point of inductive theory is to avoid preconceptions narrowing what is observed and theorised (Ezzy, 2002). Audio tapes and/or notes of face-to-face or telephone interviews are often transcribed verbatim to provide very rich text which can include comments on sighs, laughs, and reports of body language (Pope et al., 1999). This means that the interaction between people can be part of the data collection. Qualitative research can also be a precursor to a
quantitative study by generating research questions. This can particularly be seen in pilot studies. Trustworthiness, which includes consistency and credibility, is a term used to describe the accuracy of qualitative research (Thomas 2006). However, the reliability of qualitative research may be of little relevance if the unique situations cannot be reconstructed. Consistency in measuring the extent to which the account accurately portrays the social phenomena can be assessed by triangulation and by inter-rater reliability of coding; for example, asking another researcher to independently code some of the raw data and then compare the coding (Thomas 2006).

3.3.2 Quantitative research

The second element of mixed methods research, quantitative design, is used for standardised methods of data collection where the information is transformed into numbers to enable statistical analysis (Meadows, 2003). There are two main types of quantitative research: the first involves experiments with random and non-random designs used to test the impact of a treatment; the second involves surveys or questionnaires, including cross-sectional and longitudinal studies that show trends, attitudes, or opinions (Cresswell, 2003). In this thesis, questionnaires were used in Phase 2 to gain information on the performance of different providers against several key performance drivers. Very simple statistical analyses were used so that information could be reported back to DHB planners and funders, and service providers in an easily understood format, using: ‘mean’, defined as the average value, when all responses are added together and divided by the number of responses; ‘standard deviation’, described as providing information regarding the spread of the responses, so that the larger the SD, the greater the variation of the responses, and the less meaningful the mean value is; and ‘median’, defined as the number in the middle of the set of given numbers.

3.3.3 Critical theory research

As stated above, the mixed methods research approach does not solve all the dilemmas researchers have had with investigating social issues. Critical Theory (Valero and Zevenbergen 2004), which was developed after 1960, was critical of the
earlier paradigms as they were not geared towards questioning or transforming the situation they were researching. The new paradigm sought a relationship between researchers and research participants of collaborative inquiry with a focus on transformation; research would thereby become a socially and politically sensitive endeavour (Valero and Zevenbergen 2004).

Critical research theorists suggest the use of two kinds of research methodologies, ideology critique and action research, for undertaking research work (Dash 1993). Critical theory, when related to scientific research, requires a mode of thinking and acting which focuses on deliberation and reflection in order to involve people and inform them about actions that are necessary to promote their emancipation. Ideological critique of a situation, research method or social services implementation regards reality as socially constructed, and promotes patterns of thought and action with the intention of challenging institutionalised power relations. The goal is that science will result in the creation of a more just society. The fact is that while some situations are just, others exhibit injustices and are seen as unacceptable (Fontana 2004).

Contemporary action and participatory action research are grounded in critical theory. Action research is known by many other names such as participatory research, collaborative inquiry, emancipatory research, action learning and contextual action research. All are variations on a theme. Action research is basically learning by doing, where a group of people identify a problem, do something to resolve it, see how successful their efforts were, and if not satisfied, try again. This is different from day-to-day professional practice which places the emphasis on scientific study. The researcher studies the problem systematically and ensures the intervention is informed by theoretical considerations. Methodological tools are refined to suit the context, and data is collected, analyzed, and presented on an ongoing, cyclical basis. The research has a social dimension, takes place in real-world situations, and aims to solve real problems. The researcher makes no attempt to remain objective, but openly acknowledges their bias to the other participants (O’Brien 2001).
Action research, therefore, is collaborative in nature and contextually based. There is an ideal that participants in any research should be empowered during the process of the research through critical reflection and consciousness raising (Kemmis and McTaggart 1988; Altrichter, Kemmis et al. 2002). ‘Contextual Action Research’, sometimes referred to as Action Learning, is an approach that works on relations between organisations. It is contextual in that it entails reconstituting the structural relations among actors in a social environment, domain-based in that it tries to involve all affected parties and stakeholders, and holistic in that it attempts to get each participant to understand the working of the whole. Contextual action research also stresses that participants act as project designers and co-researchers; it supports a liberal philosophy with social transformation occurring by consensus and normative ‘incrementation’ (O’Brien 2001).

However, the scope of change in contextual action research is frequently limited to the individuals involved (Fontana 2004). This limitation was not useful for the research in this thesis, which aimed to develop an implementation approach that is suitable for ongoing use by participants in the delivery of community health services for older people. An approach to research that will assist implementation in real life situations has, however, been developed by management theorist and researcher, Robert Kaplan (Kaplan 1998).

3.3.4 Innovation action research

In the 1990s some management theorists sought to change current approaches to management (Simons 1994; Simons 1995). They believed that current management practices were not desirable or optimal, and wanted to help with changing the status quo. Management research was seen as mostly associated with description, either developing theories to explain how the world is and how it maintains itself, or testing theories. The researcher collected data that tested whether the hypotheses in the theory were consistent with the ways in which individuals and organisations behave. This meant that much of the theoretical basis of such management research was about stability, equilibrium, and optimality (Kaplan 1998; O’Brien 2001). Kaplan developed a variation of contextual action research to support the implementation of change, called Innovation Action Research. In this approach, researchers actively
Chapter 3: Methodology

engage with organisations to implement a new strategy or programme. Through active engagement, researchers learn more about the ideas or concepts that support the strategy or programme that is being implemented, how to improve those concepts or strategies, and the conditions for successful implementation. Kaplan proposed a four-step innovation action research cycle (Figure 6) that is an iterative process of continual learning and improvement (Kaplan 1998). In his model, the starting place is an existing example of innovative practice that is considered to be worth replicating and developing further. Step one requires the observation and documentation of the innovation; step two involves speaking with other people about the innovation - and even teaching others about it; in step three, the innovation is written up and sometimes articles and books are published; in step four, the new approach is implemented in new organisations or situations. This then leads in a spiral pattern back to having a new iteration of the innovation to observe, document, and learn from.

A derivation of this methodology was used in this thesis. The Base Case was interpreted as being information from the HOP Strategy and other research-based documents that identified a new vision for services for older people. Step 1 was interpreted as the use of this information with DHB Planners and Funders to identify new innovations that were needed if the new vision was to become reality. Step 2 was interpreted as bringing other stakeholders into the discussion alongside DHB planners and funders and other stakeholders in order to achieve a shared view of what innovations needed to be made to current practice. Step 3 was interpreted as writing up the comments and views from Step 2 into an agreed approach with specific actions and performance indicators. Step 4 was implementation (Figure 7). Each time around the circle meant involving a new DHB or DHBs, until the final IN-TOUCH programme was developed. The invitations process (between Steps 3 and 4 in the Kaplan model) was DHBs inviting service providers to be part of the implementation of the new service approach. They had already been involved in Steps 2 and 3, but could have decided to withdraw at Step 4.
As can be seen from Figure 7, the implementation pathway innovation action research cycle went through two phases – building on the HOP Strategy, a new approach was developed with DHBs A, B and C; and from there the process was tested with IN-TOUCH. This approach overcomes the limitations of the current idiosyncratic approaches to implementation being used in DHBs by: establishing a knowledge base for innovation development and the implementation process; communicating the knowledge base to others beyond the initial development phase; and implementing and refining the innovation within an organised and structured approach.
3.4 The role of the researcher

One rationale for taking a research approach that engages the researcher in the process of implementing change is that it is actually very difficult to produce change in organisational design and practice (Rycroft-Malone, Kitson et al. 2002), especially when arguments for the change are not fully understood or accepted. While many organisations will espouse that they desire change and improvement, most of them actually practice a theory-in-use that is quite hostile to change (Cullen, Nicholls et al. 2000; Waddell, Cummings et al. 2007). The innovation action research process requires researchers to actively engage with the client organisations. They become part of the attempt to overcome the ability to diffuse the energy and direction from
new initiatives that people in organisations have developed over many years (Kaplan 1998). While the development of the implementation pathway is focused on health programmes, it is primarily social or socio-economic research; that is, it is based on evidence and theories about how to get people to do things and work together, rather than evidence and theories from the biomedical science literature. The hard-line biomedical model approach is based on a positivist philosophy that views totality as a number of separate elements that can all be studied separately and put back together afterwards (Parker 2007). This is too simplistic for the world of everyday health service practice that seeks solutions for implementing community programmes in real life, in real time. Collecting information from outside the process and/or only at discrete points of time means that the information gained to build up solid concepts and guidelines can always be seen as insufficient (Ottosson 2003).

In contrast, action research attempts to address the limitations of the positivistic research model. It requires the development of a relationship between the researcher and the researched, with dialogue being an important tool. Everyone involved in the process is jointly involved in discovering the present reality as well as the creation of a new reality (Van Beinum 1998). This fits with quantum holistic thinking that the observer always influences what is measured. Reality is regarded as fuzzy interfaces that can change drastically within a short time, forming complex situations. It is therefore important to have a focus on open systems and relations in which different fields interact (Ottosson 2003).

The researcher in an action research approach is not solving a problem or finding evidence for others (as in the classical model), but working with others in joint learning. Action research has two basic goals: to solve a problem and to contribute to science. In participatory action research, the researcher combines the roles of researcher and participant in a social research method and process to improve management methods and processes (Greenwood, Whyte et al. 1993). This is evident in Kaplan’s definition of action research as engaging “the researcher in an explicit program to develop new solutions that alter existing practice and then test the feasibility and properties of the innovation” (Kaplan, 1998, p 89). The
innovation aspect involves the researcher being actively engaged in helping organisations to implement a new idea, and working with client organisations to enhance and test an emerging theory that has been proposed to improve organisational performance. The researcher thus acts as an active change agent (Kaplan 1998). This means the researcher has to face and find solutions to one of the key challenges for change agents: how to deal with resistance to change and engage with stakeholders in a way that motivates them to be, at best, positively engaged in support of the change project rather than passively disengaged or actively engaged against it. The challenge to manage both support and resistance to change has been the subject of considerable research (Strebel 1996; Waddell and Sohal 1998; Beaudan 2006).

3.5 Consensus methodology

Engagement with stakeholders can be done in a variety of ways. However, from an ‘interactivist’ social psychology perspective, the co-orientation of individuals in a group towards a statement is a major element in getting consensus. The state of consensus is a dimension and measure of integration (and inversely, of lack of agreement or ‘anomie’ towards tasks and goals (Klapp 1957). Note that consensus means neither the overriding of opposition nor passive acquiescence (Waddell and Sohal 1998); rather, it means active decision-making. The conceptual definition of consensus used in this thesis is of an infinite series of reciprocating understandings between the members of a group (Scheff 1967). In this social-systematic model, there often may be neither complete consensus nor complete lack of consensus, but a partial consensus based upon an asymmetric profile of one-way understanding and realisation. According to a theory of social coordination, understanding of the degree of consensus is important when attempting to implement change because social co-ordination is necessary when trying to achieve a goal (Scheff 1967; Simons 1995). Social coordination is also necessary if people are to communicate sufficiently with each other to reach consensus (Schelling 1963). Social coordination is seen as the fitting together of individual lines of action into a collective act; this is made possible by communication (Scheff 1967).
For communication to occur, people must at least be temporarily joined into a single system; communicating individuals must actually share, at least for a moment, some of each other’s points of view (Dewey 1958). Each person knows what the other is thinking. They are engaged in joint thought about an object (Scheff 1967). Flexible coordination uses consensus in situations such as health service delivery where there are no rigid rules to enforce the fitting together of individuals’ actions into a collective act. Motivation to achieve such coordination needs to be high for the individuals involved, and requires an intrinsic alignment of self-beliefs with the purpose of the activity. If engagement is dependent on coercion, then the consensus will not relate to any motivation by the person to actually engage in the ongoing activity (Scheff 1967).

From the Habermasian perspective (on which the Sheffield V-Model, the methodological framework for developing consensus that this study uses, is based), the coordination and integration of action builds on consensus established communicatively through recognition of the validity of verbal statements. Content is able to be subjected to rational reflection and critique in dialogue. Action becomes based on implicit agreement on social interpretations, action goals, morals, and self-understanding. The consensus is based on linguistic communication which can always, in principle, be contested and made the object of future discursive, argumentative tests (Andersen 2000; Karsten 2006).

From a research perspective, consensus methods provide an alternative means of synthesising information, accessing a wider variety of information than is available through statistical, or even case-study, methods. They also provide a method for harnessing the insights of appropriate experts. In particular, focus groups provide a form of group interview that capitalises on communication among research participants in order to generate data. The idea behind the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one–on-one interview. Group discussions may also generate more critical comments than interviews do (Watts and Ebbutt 1987). Focus groups provide a process through which people can be engaged and data collected, because they allow for the exploration of the degree of consensus among
groups regarding the barriers to implementing approaches. They also provide a means of data collection that is respectful of providers’ opinions and, therefore, might help them to buy into implementation (Kitzinger 1995).

Such a method that facilitates the expression of criticism and the exploration of different types of solutions is invaluable if the aim of the research is to improve services. Focus groups are particularly suited to the study of attitudes and experiences. Interviews may be more appropriate for tapping into individual biographies, but focus groups are more suitable for examining how knowledge, and more importantly ideas, develop and operate within a given cultural context (Kitzinger 1995). The focus group process is aligned to what interactivist social psychologists call a collective process rather than an aggregate of individual processes (Scheff 1967).

In this research study, reaching consensus relied on communication from engaged participants who sought to find agreement on an approach to service development and implementation. The V-Model (Sheffield 2005) and the Theory of Communicative Action (Habermas 1981), which underlies the V-Model, are the core theoretical underpinnings supporting the development of the implementation pathway this thesis research set out to design. The key theoretical concept is the seeking of valid communication between people involved in a common project. The aim is for people to move towards a common understanding of and a rational approach to implementation of their vision. They are, therefore, required to check the validity of their communications and their actions at all stages of a project. This thesis used consensus methods as one approach to gaining collective agreement.

3.6 The use of management concepts in designing the implementation pathway

In each phase of this research, different theoretical management concepts were used to formalise the management knowledge being explored and developed. Management concepts are linguistic expressions of ideas about improving aspects of organisational functioning. More formally, they are ideas that contain elements of a management approach that is grounded in a value basis and equipped with language,
procedure, and tools (Karsten 2006). These concepts make it possible to formalise management knowledge, and thereby rationalise the business practices and techniques being developed (Hatchuck and Weil 1995). One way of conceptualising the purpose of this project was the development of a management system; i.e. a formalisation of management knowledge about a process to lead and manage the development and implementation of new innovative services.

However, as Karsten (2006) states, mere talk about a management concept is not sufficient for the techniques presented to be adopted. As this thesis was intent on developing an implementation pathway that would be adopted in practice, it was important to move beyond what Karsten (2006, p 198) called ‘broadcaster-receiver’ models that lack an analysis of the socially constructed nature of management concepts and the transactional nature of their diffusion. In other words, while there has been a lot of attention paid to the development and diffusion of management concepts by management theorists and gurus, attention also needs to be paid to what enables those concepts to be accepted as ideologies and techniques by the receivers.

Concepts from Habermas (Habermas 1981; Habermas 1985; Arens 1994) were used to guide the process in the development of the implementation pathway, with a focus on identifying and reconstructing universal conditions that might assist the reaching of true or valid agreement between different stakeholders. According to Habermas, rational action oriented towards success requires both instrumental and strategic action, with both being validated by reflections on the efficacy of plans as a means to the desired ends (Mallery, Hurwitz et al. 1987). When undertaking instrumental action, a person evaluates consequences and considers various means to achieve those consequences. Others are viewed as though they are mere objects or organisational resources (rather than other actors), and attempts are made to manipulate their actions. According to Habermas, instrumental action alone cannot form a stable system of social action. Ideally, people must also engage in communicative action, seeking actions based on the recognition of validity claims (Karsten 2006).
This research aims to establish an implementation pathway that can be driven by DHB planning and funding managers within a culture within which actions by those managers will be effective only if other stakeholders buy into the process. It was, therefore, very important to utilise a methodology for the research that is acutely perceptive to the tension between communicative and strategic communications. Strategic action is driven by managers and is socially purposive rational action oriented to the realisation of particular goals under specified conditions. The intention is to achieve a chosen goal using the most effective possible organisation of means (Habermas 1985). One interpretation has been that strategic action is a degenerate form of communicative action in which shared value-oriented communicative action is replaced by the self-interested action of an individual (in this case, a manager) who is relating to other individuals (service providers) in terms of possible manipulation (Arens 1994).

There were several process imperatives that had to be met in the design of the implementation pathway so that it would be useful within a health setting: the implementation pathway needs to combine both communicative and strategic action. While managers might have specific goals, they also have to work in an environment in which gaining a shared vision is important. The workforce has to be trusted to operate according to protocols established to achieve stated goals because the limits of acceptable action cannot be tightly specified (Simons 1995). Managers, therefore, have to truly engage in dialogic communication (based on the validity of the arguments, not on status power claims) with other stakeholders while they pay attention to the listeners and try to find conditions of agreement (Habermas 1985).

A discourse in which all parties acquaint each other with shared meanings is necessary so that everyone can make sense of what they have to do as they strive to find an actionable interpretation of the management concept; in this case, implementation of the HOP Strategy (Watson 1994). Because health service managers do not have the power to use force (empirical coordination), including money, to convince the health professional workforce to accept specific actions, they must use approaches in which claims can be evaluated, validated, and reshaped through open discourse (rational coordination) (Karsten 2006). The resulting
implementation pathway must not only be useful to managers, but also be something they would want to adopt (Guillan 1994). Managers are knowledge workers. As they engage in knowledge work across a wide range of professional enterprise, function, and position, they are involved in a continuous process of making sense of what is happening through interaction with, and the creation of, processes and protocols (Simon 1996). Managers are also engaged in a sense-making process (Weick 1995) with stakeholders, using management tools to assist them to make sense of and use the knowledge available to them. Managers will be more likely to adopt a certain management tool if that tool can meet their needs and help them to perform in the changing environment (Sharig 1998). The organisational context is also important, with support from senior management and buy-in from other key stakeholders being critical (Chan 2004).

Lastly, the gap between the guidelines of the implementation pathway, which is a management concept, and its enactment, also has to be filled (Cook and Brown 1999). Conversations are the way that managers negotiate shared understandings of how something needs to be done (Karsten 2006). During these conversations, the meaning of the concept itself may be changed through the mix of views, thoughts and emotions that are expressed. Once a management concept has been put in place, it then enters into a process of justification in which even those who were not involved in its creation evaluate its practical meaning and identify whether or not they can justify its implementation (Cook and Brown 1999). The research methodology used in this project had to provide not only for the development of the model, but also for the further development of that model through a process of conversation between planners and funders, and service providers that, in effect, served as the justification process. As will be seen in Chapter 4, this involved further development of the Sheffield V-Model.

### 3.7 Conclusion

This chapter has set out the methodology and the philosophical approaches underpinning the research methods used in this study. The topic of this study in the context of its research environment makes purposeful investigation difficult. The research methodology needs to enable a resolution of the philosophical tension
between the managerial imperative to make things happen and stakeholder freedom of choice. Mixed methods approaches within an innovation action research model have been argued to be the most appropriate approach to the research type and setting. The next chapter describes the research methods selected.
Chapter 4: Methods

Things should be made as simple as possible, but no simpler.

Albert Einstein (1879-1955)

4.1 Introduction

This study has been undertaken in two phases. The first phase focused on creating an implementation pathway using management concepts and performance management approaches. The second phase focused on the development of a benchmarking approach using the implementation pathway designed in Phase 1. The V-model (Sheffield 2005) provided the initial process model that was used in this research. This model was adapted during the course of the research, following a performance action research methodology. This chapter outlines the methods chosen, beginning with study population, research design and moves on to analysis procedures.

4.2 Study population

Three District Health Boards (DHBs) were focused on in Phase 1. Planners and funders within DHBs were the key population, but other stakeholders such as representatives of home-based support providers and service users were also involved. At the end of Phase 1, a focus group session was held with planners and funders from 20 of the 21 DHBs in New Zealand. Phase 2 involved five DHBs.

The three DHBs involved in Phase 1 were chosen by purposive sampling; the deliberate selection of units (individuals, groups of individuals, and institutions) that were appropriate for the specific information they could provide in answering the research study’s questions (Patton 2002). In particular, DHBs were sought that were already starting to plan for a shift in the way services were offered, so that they would be keen to assist with the development of an implementation pathway that would be both useable by and useful to them, and thereby hopefully, to all DHB planners and funders (Maxwell 1997; Richards and Morse 2007; Teddie and Yu 2007). The participants were selected, therefore, because on the one hand they provided a typical case to illustrate what is normal or average, and on the other hand, they were already...
opportunistically beginning a process of change. This can be described as stratified purposeful sampling, with the assumption that the chosen DHBs will illustrate the characteristics of any DHBs involved in change, and thereby facilitate comparison (Patton 2002).

The reason to use purposive sampling is that it can lead to a depth of information from a small number of carefully selected cases, whereas probability sampling leads to greater breadth of information from a larger number of units selected to be representative of the population (Patton 2002). For this research study, DHBs involved in the development of community services for older people were the special focus. The DHBs chosen for this part of the study had participants who were working and experienced in the setting being explored, in this case, the development of a new model of community services (Richards and Morse 2007). In this study, the purposive sampling was based on cases which were chosen sequentially based on their relevance to the research questions, not their representativeness as would be the case with randomisation in a randomised control trial (Flick 1998). The selection was made by the researcher using expert judgement (Teddie and Yu 2007). For each case, the criteria were that each DHB expressed interest in being involved, and the researcher assessed (by reviewing their planning documents) that each DHB selected to participate was committed to taking action, and was, therefore, in a position to be usefully involved. However, the DHBs were also selected to increase the representativeness of the sample. The three DHBs in Part 1 of Phase 1 provided a mix of one urban, one large provincial and one small provincial/rural DHB. This meant that the depth of information acquired in each DHB would provide some basis for believing that the information received might be considered representative across other types of population, although this would then need to be verified through acceptance of the results by other DHBs. A data saturation approach was also used, aiming to find the point at which no new information or themes are observed from the data. While saturation is a key concept in the qualitative research literature, there is little in the way of guidelines as to what sample size is necessary to reach saturation, except for one study showing that saturation occurred within the first twelve interviews, with the basic elements for meta-themes occurring within six interviews. Variability within extra data gained beyond the first twelve interviews
followed similar patterns to the first twelve (Guest, Bunce et al. 2006). In this thesis study there were 20 focus groups in phase 1.

To obtain the involvement of each DHB, the researcher approached the Health of Older People (HOP) portfolio manager. In each location, the HOP portfolio manager was seeking assistance to implement community services for older people in order to fulfil their responsibilities to implement the HOP Strategy (Ministry of Health 2002). The HOP portfolio manager within each DHB then identified any other Planning and Funding people the DHB wished to involve. For instance, for DHB A, this meant working with the portfolio manager, the contract manager, the integrated care implementation manager, and the service development manager. These managers then involved other stakeholders as required; in each DHB, this meant working with home-based support provider managers and coordinators, Needs Assessment and Service Coordination Agency staff, and members of the Disability Services Advisory Committees of the DHBs.

At the end of Phase 1, a naturally occurring cluster was accessed. This obviated the need to sample each individual DHB, but instead engaged with a large number of units from the population of interest in a random manner (the gathering was not specifically for this purpose) where the probability of inclusion for every member of the population was determinable (Tashakkori and Teddlie 2003). This cluster was a national gathering of the HOP portfolio managers for all 21 DHBs. The choice of this cluster can be classified as purposive sampling, as the DHB HOP portfolio managers were a major focus of this study with the implementation framework being developed primarily for their use. In Phase 2, five DHBs used the implementation pathway from Phase 1 through the establishment of a benchmarking programme. The five DHBs were those that expressed an interest because they had already been involved with The University of Auckland and the researcher. There was no formal selection process.

4.3 The researcher

In concordance with participatory action research methodology, the researcher took an active role in facilitating and progressing the research. The researcher had
teaching, education, psychology and English qualifications, along with experience as a school teacher (three years) and as a counsellor and family therapist (12 years). He has worked in the area of services for older people since 1995, first as a manager of home care and residential care services, then as a Senior Advisor in the Ministry of Health. He has been active in Age Concern and President of the New Zealand Home Health Association. As a consequence, the researcher brought with him a mix of facilitation skills, experience and knowledge concerning the field of study as well existing relationships with many of the research participants. While in a positivist model this combination would be seen as reducing the objectivity of the researcher, using the participatory research approach meant that the researcher was able to contribute to the development of the implementation pathway and performance measurement system, with the triangulation of the personal, social and technical worlds of all participants providing validity to the process and the end result.

In Phase 2, a research manager, Michelle Gundersen-Reid, was employed to coordinate the data collection and facilitate the report writing for IN-TOUCH. An operations committee, which was chaired by the author of this thesis, was established and included: Associate Professor Matthew Parsons, Dr Diane Jorgensen and John Parsons. All processes were informed by the work undertaken in phase 1 of this thesis and were aimed at moving the results into the implementation of a successful benchmarking programme.

### 4.4 Research design

#### 4.4.1 Phases

The research design is outlined in Figure 8 below, and described in detail in the following section. In the first part of Phase 1 there were eleven focus groups with DHB A: six with the Planning and Funding team only; four that involved service providers, including the needs assessment and service coordination service (NASC) and home support providers with the Planning and Funding team present; and one that only involved the Disability Services Advisory Group (DSAC). For DHB B, there were six focus groups including people from Planning and Funding and home support providers. For DHB C, there were two focus groups with people from
Planning and Funding. At the end of Phase 1, there was a focus group meeting comprising 20 of the 21 DHBs in New Zealand. Following the V-Model process, discussion focussed on developing and achieving a vision for services for older people. Chapter 5 shows how the model was adapted to a triple V to incorporate development, implementation and ‘business as usual’ phases. Phase 2 was the start of the operational stage of formative monitoring / performance management step (Step 4) of the adapted V-Model. The benchmarking project, named IN-TOUCH (Integrated Networks Towards Optimising Understanding of Community Health), used a multi-factor approach in order to provide District Health Boards (DHBs) with information on the quality (both internal and across participating DHBs) of their new community services for older people. Technical data was collected to provide the factual information required for the technical world of the Habermas Theory of Communicative Actions. The focus was on tracking the process of implementation of the new model of community services, that is, how successful all the stakeholders in each DHB had been at undertaking the tasks that had been agreed upon within their particular DHB (Step 4 of the V-Model). Establishing the collection of specified data was a learning process; however, there was an expectation that after a period of time, information would be available that stakeholders would agree accurately represented both the outcomes of the services and whether or not those services had operated according to the agreed guidelines.

With discussion based on this technical information, the various stakeholders explored and furthered the connections between the technical world, their own personal worlds, and the social world, thus increasing the validity of their communication about what was working and what was not (Step 5 of the V-Model). This process also enabled analysis of whether the original assumptions about the key factors for success were correct. Changes to the design of the services could then be made in response to the evidence and the discussion (the link between Step 5 and Step 2 in the adapted V-Model). The benchmarking process used in this project provided a method to determine if the critical processes had been put in place, and how successfully they were operating.
4.4.2 Timeline

Phase 1 began in July 2005. All focus groups were facilitated by the researcher. The focus groups that consisted only of members of DHB A Planning and Funding met
as follows: 5 July 2005, 26 July 2005, 31 August 2005, 8 December 2005, 9 March 2006, and 5 May 2006. The number of people at these focus group meetings was usually four.

The larger focus group meetings that involved both home support providers and the Planning and Funding team were held on 29 September 2005, 11 October 2005, 14 October 2005 and 27 October 2005. While the number of people present varied at each of these meetings, there were always representatives from the Needs Assessment and Service Coordination service (NASC) and the four home support providers operating in DHB A. The consumer-oriented Disability Services Advisory Committee (DSAC) meeting was held on 18 October 2005, and involved nine client and community representatives, including two who were also members of the Board of the DHB, plus two members of the Planning and Funding team.

The focus groups with DHB B Planning and Funding, NASC and service provider staff were held on 20 July, 3 August, 17 August, 24 August, 6 September, and 20 September 2006. Although the number of people present at the meetings varied, the two NASC agencies (one mainstream and one Maori) and the three home support provider agencies were represented at each meeting.

The focus groups with Planning and Funding with DHB C took place on 18 December 2006 and 12 February 2007. There were two people present for each focus group. The focus group meeting with 20 of 21 DHBs took place on 18 September 2007, with 21 people attending. One person was from District Health Board New Zealand. Phase 2 began in August 2007. A Steering Group of five District Health Board Health of Older People portfolio managers and three University of Auckland staff was established to govern the project. The time frame for the project was nine months. Data were collected to establish a baseline as of 1 October 2007, and then again after the implementation of the new service model had begun in a DHB at Month 1 and Month 3 inclusively. This data was used to produce a benchmarking report which was circulated to all participating DHBs. The final focus group meeting on 2 May 2008 involved three of these DHBs. The other two DHBs had planned to attend, but were prevented by internal operational issues.
that arose on the day. The themes for discussion that were relevant to this study concerned firstly the IN-TOUCH benchmarking project, how useful was it and what needed to change as well as the IN-TOUCH benchmarking report itself and specifically what did participants think of it.

### 4.4.3 Business tools

Two business models were initially used to give shape to the discussion and process. The first was the V-Model (Sheffield 2005), described in the Literature Review, which provides an action oriented focus for discussions about moving from an intent to an outcome. The second was the balanced scorecard (Kaplan & Norton 1992, 1993, 1996, 1997, 2001) which provided a performance management framework that enabled the discussion that occurred as part of the V-Model process to combine the ‘technical’ data oriented world (Niven 2003) with the personal and social worlds of the participants.

After the work done with DHB A, the language of the V-Model was changed to conform with the metaphor of a journey. George Lakoff, a linguist, and Mark Johnson, a philosopher, argue that because the mind experiences the world through the body within which it is encased, people have little choice but to conceptualise the world through bodily perceptions. They present evidence that metaphors may actually be people’s primary mode of mental operation. These metaphors through which people conceptualise abstract concepts influence the way they understand them. For example, teaching in the classroom can be conceptualised as a journey, in which ‘knowledge objects’ reside at various locations on the ‘knowledge landscape’. The trip becomes a journey of discovery, rather than just a presentation of the landscape of a discipline. Teaching can be pictured as the teacher and students travelling more or less together, along a somewhat defined route, making frequent stops along the way as students notice something of interest that they wish to explore. Occasionally, there may be interesting side trips to unexpected places. Groups may at times pursue different paths and, after returning to the main road, report about what they have found (Lakoff and Johnson 1980).
Another example of a journey metaphor comes from within the business sector where sustainability has been presented as a journey, and evokes images of organisational adaptation, learning, progress, and a movement away from ‘business as usual’ practices (Markus, Kearins et al. 2006). The use of the metaphor of taking a journey provides a common frame of reference (Mezirow 1997) for all stakeholders. This research shows that it proved highly effective in engaging people in DHBs in discussion about the implementation of the HOP Strategy through community health services.

4.5 Data collection tools

All the interviews and focus groups in both phases were semi-structured, with the discussion agenda developed to further explore themes and approaches already raised, either in the literature, DHB documentation, previous interviews or focus groups. This followed the action research methodology of the innovation action research cycle: read and document material and questions, discuss in interviews and focus groups, write up the findings, write more questions, and then take them to another focus group or interview. All focus groups and interviews were taped and transcribed with the exception of the focus group with the 20 DHBs where permission to tape the discussion was refused. Written notes, that at times included whiteboard notes, were also recorded.

The collection of data in Phase 2 used two processes: one implemented the benchmarking approach; the second gauged the usefulness of the approach taken for planners and funders. The implementation data was collected from questionnaires (Appendix 5), NASC and an analysis of goal setting with clients using the Towards Achieving Realistic Goals in Elders Tool (TARGET). The data collection was organised around four performance areas identified in Phase 1, as described below.

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5 A goal setting tool developed by Associate Professor Matthew Parsons and Senior Lecturer John Parsons with the School of Nursing at The University of Auckland
4.5.1 Effective and efficient services

The results of effective and efficient services were derived from three data sources: (1) NASC package of care information; (2) questionnaires completed by NASC managers and assessors; and (3) questionnaires completed by home care coordinators. The NASC package of care data included information on the complex/non-complex split, allied health referrals, and the size (hours per week and duration) of the package of care. The NASC manager and assessor questionnaires provided data on the NASC manager and assessors’ views of the effectiveness and efficiency of home care providers in their District Health Board. NASC managers, coordinators and assessors were asked to rate statements using a Likert Scale: 1=strongly disagree, 2=disagree, 3=neutral, 4=agree and 5=strongly agree. Home care coordinators provided information on their views of the effectiveness and efficiency of NASC.

4.5.2 Client and family / informal carer driven supports

Completed goal-setting plans developed by NASC assessors using TARGET and reviews by home care providers were entered into Excel spreadsheets, and provided information on client status. Client status was measured through collecting the Nottingham Extended Activities of Daily living (NEADL)\(^6\) and EuroQol 5D\(^7\) scores for complex and non-complex clients. The distal (long term) goal for each TARGET client was entered and scored using the SMART tool (Specific, Measurable, Attainable, Realistic and Time-orientated). The distal goals were also classified according to ICF values (International Classification of Functioning, Disability and Health, more commonly known as ICF). All five DHBs contributed data for the analysis. To ensure that client information became a key driver in ongoing benchmarking, telephone interviews with clients were undertaken in each DHB. The interview asked questions related to the following areas: (i) Did you set a goal? (ii) Were the goals what you really wanted? (iii) Did the support worker assist

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\(^6\) The NEADL measures functional status
\(^7\) EuroQol measure the client’s self-perceived quality of life
you with your goals? (iv) Do you have a good relationship with your support worker? and (v) Do you have enough information?

4.5.3 A skilled, stable workforce

Information was sought on a number of factors that related to the workforce. These factors are described in Table 8.

Table 8: Data sources

<table>
<thead>
<tr>
<th>Data sources</th>
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<tbody>
<tr>
<td>Support worker turnover</td>
</tr>
<tr>
<td>Data were obtained from the home care and NASC manager questionnaires. The managers were asked how many support workers and coordinators had resigned and how many had been recruited in the previous three months</td>
</tr>
<tr>
<td>Coordinator contact time with clients</td>
</tr>
<tr>
<td>In the Coordinator questionnaire, coordinators were asked to estimate the amount of time they spend with clients either face-to-face or on the telephone</td>
</tr>
<tr>
<td>The TARGET forms</td>
</tr>
<tr>
<td>The home care providers were asked to rate statements using a Likert scale regarding training needs in relation to TARGET and their relationship with NASC. NASC assessors were asked to rate (using the Likert Scale) statements regarding their use of TARGET and their relationship with home care providers</td>
</tr>
<tr>
<td>Home care coordinator and support worker interaction</td>
</tr>
<tr>
<td>The questionnaire for home care coordinators asked them to indicate how often they interacted with support workers through team meetings, assessing competency and meeting with them on a one-to-one basis. Coordinators were also asked when they would do a joint visit with a support worker. One coordinator interpreted this as a joint visit with NASC; this data was included in the total percent of responses. They stated they would conduct a joint visit with NASC if the client represented a highly complex case</td>
</tr>
</tbody>
</table>

4.5.4 Funding that is appropriate and applied cost-effectively

Data were collected to ascertain whether DHBs and home care providers were able to manage their budgets and provide appropriate services. Data came from reviews of funding sources, total number of and hours worked by support workers, coordinator caseload, salary ranges, training and comments from Planning and Funding managers.
4.6 Data analysis

General inductive enquiry was used to thematically analyse the material, with themes being organised around the frameworks of the V-Model (Vision, Objectives, Actions, Implementation, Outcomes) (Sheffield 2005) and balanced scorecard perspectives and performance areas (Niven 2003). Using a general inductive approach, the researcher has constructed a code to identify themes from the interview and focus group data (Thomas 2006). In this study, the themes were developed using NVivo. These themes were then fed into each successive stage of development and followed the Innovation Action Research Cycle approach (Kaplan 1998). In Phase 2, both quantitative and qualitative analyses were undertaken. Each DHB and home care provider was coded to protect confidentiality. Secondary data analysis contained information from combined variables such as complexity and Nottingham EADL scores. A further analysis was also made using a three-month review of goals that some of the participating DHBs managed to achieve within the time frame.

4.7 Reliability and validity

A thematic code developed by a researcher is usually verified by getting another researcher to also codify some of the data; cross-matching is then used to check for consistency of interpretation (Thomas 2006). For this study, one form of inter-rater reliability was verification of coding by another researcher from the IN-TOUCH benchmarking project steering group. However, when looking at mixed methods studies to judge if they are convincing, one of the essential elements is to ensure the needs and expectations of the readers who represent the particular mix of interpretative communities have been met (Tashakkori & Teddlie, 2003). In this study, the ‘readers’ have been interpreted as being the representatives of the various communities involved in the research; e.g. the home-based support providers, NASC, and Planning and Funding managers. Trustworthiness, which includes consistency and credibility, is necessary to validate the accuracy of qualitative research (Thomas 2003). The consistency of the extent to which the research portrays the social phenomena accurately can be assessed by inter-rater reliability of coding as mentioned in the paragraph above, and also by triangulation.
Triangulation has been achieved by using respondent validation or stakeholder checks in an ongoing manner during the development of the implementation framework. The stakeholders have operated as inter-rater reliability checkers because the iterative consultation process provided assessment of data accuracy and accuracy of interpretation with those involved on an on-going basis. After each interview or focus group, the developed themes were taken to the next interview or focus group and tested with the participants. If the participants did not agree with the themes developed, or wanted to develop them further, they were changed progressively, meeting by meeting. A major point of inductive theory is to avoid preconceptions narrowing what is observed and theorised (Ezzy 2002). In this study, the validation of the themes was identified through agreement or non-agreement by participants when the identified themes were introduced into ongoing discussion and into the implementation framework. This reduced the possibility of misinterpretation of data and themes by the researcher.

If the writing up of themes from the comments and views of stakeholders was not corroborated when it was taken to the next focus group or interview, then the themes as interpreted by the action researcher were not validated. Validation occurred through agreement to continue. It should be noted at this point that although focus group size and composition varied within DHBs, there was a core set of membership across all groups within each DHB. This mix of consistency and difference in membership, combined with a degree of mistrust between different stakeholder groups, helped to reduce both the risk of group thinking (Baron 2005) and the risk that differences of opinion would not be discussed as part of the process.

Combining insights from the literature, data from study participants, and respondent validation makes the study comprehensive in that it provides reflective analysis of the data, and also tests validation (Pope, Ziebland et al. 1999). There is, however, in the participatory action research approach, a risk that the researcher will be captured by: a) the subject matter, which would reduce validity of both the data collection and analysis, or b) the project participants, which could lead to informal manipulation by the group (or individuals in the group) being studied (Yin 2003).
The innovation action research approach used in this research mitigates this risk by providing multiple perspectives from multiple stakeholders. This approach can be seen as a variation of case study methodology as it includes theory development in the design phase, with experimentation in multiple cases (the three DHBs involved), and implementation in five cases. A previously developed theory (The V-Model combined with the balanced scorecard) is used as a template with which to research and then analyse the empirical results from each case (Yin, 2003). Multiple cases, according to Yin, can be seen as multiple experiments. The argument is that the ability to generalise the results has validity if the theoretical template is supported by two or more cases. In this research, the findings of Phase 1 are validated by three case studies, with support from 20 of 21 DHBs.

4.8 Ethical considerations

The University of Auckland Human Participants Ethics Committee gave ethics approval for this study on 10 November 2004 (Ref 2004/402) as a part of the ASPIRE evaluation. Ethics approval was also received for the IN-TOUCH programme on 13 November 2007 (Ref MED/07/68/EXP).

4.9 Conclusion

Phase 1 had two separate research objectives:

- The development of a process or management control system, namely the implementation pathway that could be adopted by managers who seek to develop and implement new evidence-based services; and

- The development of critical success factors for the performance management of services that operate according to the philosophy and principles laid out in the HOP Strategy.

Phase 2 sought to establish and test the benefits of the benchmarking framework, IN-TOUCH, in assisting the implementation of services by identifying what works well and why. In other words, the IN-TOUCH project was presented to participants as part of a continuous quality improvement programme or performance management process.
Chapter 4: Methods

The aims of the project have driven the choice of the research methods. The implementation literature (Fixsen, Naoom et al. 2005) acknowledges the importance of good communication in achieving success. It also acknowledges how difficult it is to get the various stakeholders in any endeavour to communicate well. The Theory of Valid Communication (Habermas 1981; Sheffield 2005) provides a mechanism for moving through the dependencies and interdependencies in a sector as complicated as the health system (Powell 1990; Papadopolous and Merali 2008). The technical data obtained through this research had to provide useful information that assisted all stakeholders to challenge their personal and social world views and allowed DHB Planners and Funders to manage the movement from intention to outcome as effectively as possible. Chapter 5 presents the results.
Chapter 5: Results

Vision without action is a dream, Action without vision is simply passing the time, Action with vision is making a positive difference.

Joel Barker

5.1 Introduction

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). This thesis has provided a mechanism that can assist planners and funders to manage this tension so that they will be successful in developing and implementing new services. This has been done by developing an implementation pathway that incorporates a meaningful performance management system that is supported by the sector. The principal concept underlying the development and implementation pathway is the provision of a mechanism for valid communication that matches technical data with the personal and social worlds of stakeholders in home care services (Habermas 1987).

This Results chapter has two sections; the first describes the work with each District Health Board (DHB) developing the implementation pathway, and explores visioning (Research question 1), identifies critical success factors that provide the technical data for the implementation pathway and performance management system (Research question 2), and describes the usefulness of the implementation pathway and performance management system to DHB planning and funding managers (Research question 3). The second section outlines the findings for Phase 2 where the focus is on the functionality of the critical success factor approach as part of a benchmarking process when used to monitor the progress of the implementation of home care services for older people (Research question 2), as well as its usefulness to DHB planning and funding managers (Research question 3).
Section 1: Phase one

Although multiple groups were involved in the focus groups, the themes generated were remarkably consistent. The findings are, therefore, grouped around these themes. A saturation approach, as discussed in Chapter 4 Methods, was employed in the focus groups, with transcripts analysed upon completion of each group. Themes derived from the focus groups were, therefore, developed iteratively as part of the developmental process for the implementation pathway.

This process of development through Phase 1 is shown in Figure 9. The prism on the left hand side shows the progression from a narrow focus on the Health of Older People (HOP) Strategy and the DHB planning documents into a widening exploration using focus groups to study the meaning of these documents for home care services and the issues that impact on the development and implementation of new services. The focus then narrowed again to examine the management scorecard with critical success factors that was developed in this phase of the research. The themes of vision (Research question 1), critical success factors (Research question 2) and implementation and performance management (Research question 3) that arose from the focus groups are presented for each DHB.
Chapter 5:Results

Figure 9: Phase I

The Health of Older People Strategy, DHB documents – Five-Year Strategic Plan, Annual Plan, RFP for Home Support Services

Phase 1 – Development

Creation of 1st Pathway with DHB A
Beginning July 2005

Further development with DHB B and DHB C
From March 2006

Consultation on 13 Critical Success Factors
June 2007

Focus Group with 20 DHBs

DHB A
6 focus groups with Planning & Funding
4 focus groups with service providers
1 focus group with DSAC

DHB B
2 focus groups with Planning & Funding
4 focus groups with service providers

DHB C
2 focus groups with Planning & Funding
5.2 District Health Board ‘A’

The research process began by focusing on the vision offered in the HOP Strategy, and exploring what that meant in terms of the critical factors to be found in a home care service that was operating in concordance with that strategy. The initial vision presented by the researcher was framed as: ‘The wellbeing, health, and function of older people is maximised.’ This is an adaptation of the official long-term outcome, “The wellbeing, health, and function of people are maximised so they can be as independent as possible and participate in society to their fullest ability,” as expressed in both the HOP Strategy and DHB A planning documents. While the statement presented was regarded as the desired outcome of the HOP Strategy and the DHB documents, it was also identified within DHB A as being the same as the community perspective required by Leggat and Leatt (1997). The Disability Services Advisory Committee (DSAC) committee members argued that, from a community perspective, one long-term performance measure was that the community gradually became healthier. The argument was that if the older population is being assisted to be independent and their participation in society is maximised, then the community perspective for older people is being met. There was also acceptance of the need to explore a number of indicators of achievement; e.g. residential care entry rates, and emergency care entry rates; although no decision was made about which outcome indicators were critical.

Agreement on the desired outcome statement was reached quickly; it was accepted that a simple refinement of the words used in the HOP Strategy was needed. Basically, the vision was given by the government strategy. There was no dissension about the vision. There was, however, recognition that this new approach was actually a huge challenge to home care providers’ ways of thinking and operating. One home care provider acknowledged the challenge:

The world we live in now, in terms of home support, is very surface, there’s not a lot of depth; it’s mostly to do with volumes and that’s pretty much it. So we’re changing the approach quite significantly, for all of us.

Dialogue, therefore, moved quickly on to what the vision meant in terms of community services for older people, in particular, home care services. The discussion focused on two
areas: (i) performance perspectives including factors that were critical elements of any successful home care service; and (ii) factors that would impact on the success of implementation of a new approach to home care service delivery. The results are organised under these two categories.

5.2.1 Performance perspectives on factors leading to success in restorative home care

Table 9 outlines the themes emerging from DHB A, and presented herein, on performance perspectives leading to success in restorative home care service provision.

Table 9: Themes for performance perspectives for restorative home care services arising from DHB A

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Client-driven / strengths-driven services</td>
</tr>
<tr>
<td>2.</td>
<td>Restorative approach / philosophy / culture</td>
</tr>
<tr>
<td>3.</td>
<td>Options / flexibility / responsiveness</td>
</tr>
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<td>4.</td>
<td>Sustainability – workforce, financial, and provider</td>
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Client-driven / strengths-driven services

There were strongly expressed opinions that a key issue in facilitating better outcomes for clients concerned the fact that health professionals were perceived not to be listening to what clients wanted when setting care or treatment plans in place, and that home care providers were task driven and not responsive to client input. This was stated by the DHB contract manager as:

Assessment is something health professionals do to people; agreement is mutual.

However, the term ‘client-centred’, quite common in discussions within the health system at the time (Registered Nurses Association of Ontario 2006), was not regarded highly:

They all say they are client-centred, even the hospital. Doesn’t mean they listen to the client. (Allied health professional attending DSAC)

When examining the concept of client satisfaction, all DHB planning and funding
staff stated that they had complaints about service providers not respecting ethnicity, age, or disability. The HOP portfolio manager expressed this as:

We get this material through about cultural safety, and people always think it means ethnicity. And we do get complaints about services not being sensitive to Maori, Indian, etc. But there is also respecting age – not thinking people are stupid because they are 85 – and competence despite being disabled. Sometimes, when you hear the complaints, we despair. There is certainly not a strengths-based approach often.

There was also discussion about whether having a focus on clients maintaining independence sufficiently covered the concept that services had to be appropriate to different ethnic backgrounds. DSAC would have liked ethnically appropriate services added to the list of factors needed for a positive outcome; however, this factor did not survive discussion in later focus groups as stakeholders wanted to reduce the number of factors to only the most significant, and it was thought that, in principle, this factor would be covered by adherence to the chosen factors. In the first focus group, this theme began as a discussion about being ‘client-focused care’, but the phrase ‘Client mana /dignity is preserved’ was preferred. While this may to some extent appear to mean the same thing, from the perspective of focus group members it was agreed that ‘client-focused’ as a term was jargon and also very difficult to monitor. One planner and funder commented:

Well, everyone says that. And then they do what they think the client should have. It rolls off the tongue nicely, but we, from our perspective working with providers and the hospital, don’t see it happening.

As a consequence of the comments surrounding the terminology, in focus group four, ‘client focused’ was changed to ‘Client-driven – strengths-driven services’, because it was believed this would be more meaningful to health professionals. Using the term ‘client driven’ rather than ‘focused’ was seen to overcome the objection raised in focus group one.

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8 A strengths based approach comes from social work, and proposes that people are active participants in the helping process (empowerment), all people have strengths, often untapped or unrecognised, that strengths foster motivation for growth, and that strengths are internal and environmental Saleebey, D. (1992). The Strengths Perspective in Social Work Practice. White Plains, NY, Longman.
They focus on us all the time. What we want them to do is listen to us, to do within reason what we want, well at least be driven slightly by our lives.  (Client representative on DSAC)

**Restorative approach / philosophy / culture**

The discussion pertaining to a restorative approach mainly concerned what it meant, what other DHBs were doing and how it could be mainstreamed:

*What we need is to restore older people to previous levels of independence, not rob them of it.*  (DSAC committee member)

*If only we could do with people, rather than for.*  (Home care coordinator).

*We've heard a lot about restorative home support; how can we implement and perhaps more importantly sustain it here? But we are still trying to work out what it is.*  (Planning and funding manager)

There was also unease about the term ‘restorative’:

*What about the people who are not going to recover, the ones who are nearing the end? We can't restore them. We would be lucky to even stabilise them and maintain them at a lowish level of activity after a fall or something like that.*  (Physiotherapist now part of planning and funding team)

*What about our service? Where do we fit in? Are you saying we shouldn't work with older people? That's ridiculous!*  (Hospice representative on DSAC)

Participants were prepared to tolerate the term when people understood its history⁹, and that the idea of client-driven services and maximising independence and participation included assisting people to manage and maintain their health as much as possible. However, the term remained an issue that needed to be explained in each DHB and in each focus group that had new people in attendance.

By focus group four, two other themes - integrated co-ordinated services and enhancement of social support - were subsumed into this one, because all three were regarded as having

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⁹ The Minister of Health in the period 2002 - 2008 had a preference for the term restorative over other alternatives and refused to accept any other terms despite being told of confusion over its meaning.
common elements. Having an integrated continuum of care is a major emphasis of the HOP Strategy. For DHB A stakeholders, the meaning of this revolved around several items, including duplication of services:

*Five people in one day – the District Nurse, the home care worker and the home care service coordinator, the physio, and the Needs Assessment and Service Coordination nurse. And then there will be no one going in three days.* (Age Concern DSAC member)

gaps in services:

*She needed a hand rail fitted, that's all. Not hundreds of visits by helpers. Then she could have kept looking after herself* (DSAC member talking about her mother)

as well as social support. The concept of enhancing social support was seen to encompass both the client and any social network they might have, such as family carers. There was discussion about home care workers providing social support for older people:

*We have this strange situation where we have poorly trained support workers with English as a second language being the only person some clients see all week. They are the social network. I don't think it's appropriate.* (Planning and funding manager)

There was a strong view that services were needed to support the client to connect or remain connected; however, people were uncertain whether home care services should be part of this, or whether it should be the responsibility of primary care or volunteer networks alongside families:

*We can't expect doctors to do it. And our workers, well in the current approach they don't have the training or the time. They have things to get done, not to sit around talking.* (Home care provider)

There was acknowledgement that informal carers included other than family, such as community networks. There was also discussion about the rights of the client to agree to the involvement of any carer, and the limits on any right to require family members to provide care:

*This issue of how much support to put in when there are family members around is tricky. How much personal care should a son do for a mother? Should we expect men to cook if they never have in their life? What if the person has never got on with that family member?* (DHB contract manager)
Chapter 5: Results

This raised issues of carer welfare, with discussion about what level of assessment of the carer was necessary if it was thought the carer needed assistance. There was agreement that it needed to be the goals and needs of the carer as they relate to their role with the client, with guidelines being necessary.

*Family carers ideally would be partners in care, but this is not necessarily critical. Mind you, if we are going to manage the budget, we do need to look at how families can be encouraged to do as much as possible.* (DHB planning and funding manager)

**Options / flexibility / responsiveness**

All participants commented on the need to deliver appropriate services in a timely manner, as illustrated by a planning and funding manager:

*If only we could bring high quality services to the client’s door when they need it rather than waiting for them to turn up sick in an emergency department.*

This was further supported by a home care provider manager:

*It’s time to stop being the ambulance at the bottom of the cliff.*

A member of the DSAC committee gave this theme further emphasis:

*If I got a dollar for every time I heard someone complain that they asked for help in returning to independence, but all they got was an hour a week of someone to mop their floors…come on!*  

The sharing of information was also raised as part of this theme. Home care providers raised information as an issue affecting responsiveness, because from their perspective, the new approach would not work if the existing information sharing approach continued:

*We get sent this referral and they don’t put on it what the person’s condition is. Just three hours a week of personal care and 2 hours a week of household management. We have to go out and do our own assessment to find out what the risks are. Why can’t they just tell us what they know.* (Home care provider)

**Sustainability**

Under the theme of sustainability, there was discussion about three areas of concern: workforce, financial, and provider. Workforce sustainability was considered by providers as one of the biggest issues to impact on their ability to operate, strongly emphasised by the 30 to 45 percent annual turnover of support worker staff. They also faced the risk of their
nursing coordinator workforce leaving, as nurses who worked in hospitals had received a large pay increase. Much of their time was spent seeking new staff or trying to find cover at short notice for staff who were absent. From their perspective, this was a significant threat to any attempt to develop a new type of service. As one home care provider put it:

*We are like decapitated chooks some days. I don't see how we can do this goal-setting, more intensive stuff at the moment. Our coordinators spend so much of their time seeking staff rather than dealing with clients.*

Providers felt that a separate category of ‘Provider Capacity’ was important, as providers are a major component of DHB service requirements. That is, if there are no providers, there is no organisation for workers to function within, and, therefore, there is no organised service delivery system. At the same time, providers did not want too much DHB involvement in their day-to-day activities. Comments from providers suggested that they regarded this as an important issue, although it had not been mentioned by DHB planners and funders. This topic was raised after the discussion about workforce. As one provider stated:

*I know the workforce is important, of course they are key. But there is no mention of the providers. If we are not there to organise everything, nothing will happen.*

Later on in phase one, provider capacity was subsumed under workforce. This was mainly a pragmatic decision as workforce availability was, at the time, the key factor in whether or not providers would be able to meet demand.

**Financial sustainability**

One of the home care providers, with support from the others, limited the whole discussion about approach and outcomes to the issue of being paid adequately:

*This goes back to the getting what you pay for issue. We can't offer services that are Rolls Royce on peanuts. We can't pay people to get the capacity. You have to look after us [indicating the providers] to get a service.*

For the DHB, the issue was more complex. They needed to ensure that services were sufficiently funded to be sustainable, but at the same time, they needed to ensure that the
services were of a quality that was acceptable, and that they were not paying too much for the service. They also had little idea what a ‘fair’ price would be.

*We’ve got historical pricing really, based on a designated tasks per hour. We have no idea how to fund a service to be flexible and respond to changing needs.* (DHB contract manager)

Funding, both amount and method of payment, was seen as fundamental to success. The fee-for-service model used to pay for home support services was seen as a major problem. Providers were paid to deliver a set number of tasks within a certain time period designated by the funder. The model did not encourage flexibility or responsiveness to changing client needs. Although funders thought the best approach would probably be a case-mix bulk funding model, other approaches to funding were seen as temporary but necessary because there was insufficient information to develop a case-mix model. A bulk funding model was also seen as extremely difficult to monitor and hold providers accountable to. The contract manager was very concerned about how to contract and then monitor the services if a bulk funding model was introduced, although she acknowledged the current funding model was an obstacle to change, saying:

*The problem is we pay on a per hour of service model. It is very difficult to figure out how to pay for a flexible model. At the moment, the provider gets paid to go in to a home for an hour or two at a time. How do we get them to go in for 10 minutes a day one week, then for four hours each day the following week because the older person has a cold or flu or something, and then reduce it again the following week? How do we pay for that, and monitor that, and make sure they are delivering enough service, and not just reducing service to earn themselves more money? How do we pay appropriately and manage the risk?*

The funding amount was the major factor for home care providers, who held the notion that once the amount of funding was known, then they would work out the inputs. While the identification of critical success factors was an important aspect of this research, so also were issues re the implementation and management of change. The themes that arose about implementation and performance management are presented next.
5.2.2 Implementation and performance management

Table 10 outlines the themes under this category.

Table 10: Themes about implementation and performance management

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<td>Fear by service providers of being blamed by clients and their families for changes to services</td>
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<td>5.</td>
<td>Home care provider desire for clarity of expectation with operational distance from the DHB</td>
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<td>6.</td>
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Lack of leadership from the Ministry of Health

While the HOP Strategy was regarded highly, there was a feeling that the Ministry of Health (MoH) should take more of a role in facilitating the development of approaches to implementation. It was generally believed that staff at the MoH had the time within their workload to work with DHBs to facilitate the development of approaches across DHBs. Instead, DHB planners and funders regarded the MoH as refusing to take on this leadership role, and having more interest in telling DHBs they were going to be accountable for achieving the implementation by 2010. The frustration felt was voiced by one member of the team as:

*The Ministry can run national workshop days once a year, and tell us that we have to report what we are doing, but that is not enough in terms of leading the change. They should be facilitating more*
This resulted in frustration at the duplication of work with other DHBs. Each DHB was struggling to work out what implementation of the HOP Strategy meant in practice. There was a sense that things would be much easier if an organised way of working nationally was developed. As the MoH was not providing sufficient assistance, DHB A planners and funders believed DHB HOP managers were trying to organise the sharing of information amongst themselves. The overall sense was that every DHB was beginning from a zero baseline. The DHB A HOP portfolio manager described the situation as a scramble:

We have monthly meetings or telephone discussions with other Health of Older People portfolio managers. We are all scrambling around trying to do the same thing. It seems like so much duplication of effort. Everyone is trying to do the same thing from scratch.

Lack of health professional understanding of the HOP Strategy

The planning and funding team understood that they had to get other people involved in the health system to shift their paradigm of care if their implementation was to be successful. This meant there was a need to get buy-in from health professionals, meaning that the approach had to be grounded in evidence and provide training (Mezirow 1997). There were two main health professional groupings that were of concern. One was general practitioners:

The GPs keep referring for rest home care. They don’t refer for assessment. They have no idea what services are available to help someone stay at home, and they want to keep the daughter quiet. So they just want the older person to go into a rest home so they don’t have to bother any more. (NASC manager)

An additional concern related to the hospital being seen as being internally focused, with little regard for what happened for patients once they left the hospital,

Part of the problem is that the hospital wants to just empty the beds, so sends older people to rest homes without going through the proper assessment process to see if the person could be supported at home. They just subvert the process, as they are driven more by freeing up beds than achieving good outcomes for the old person. (DHB planning and funding manager)
This highlighted the sense that there was not a shared community or health professional vision.

**Language confusion**

Having valid communication necessarily involves people understanding the words each party is using. A key rationale for the V-Model process is to obtain common meaning and understanding. This research highlighted that sometimes different meanings were given to the same word, or that the meaning of a word was not actually certain to everyone. There was agreement that it was important to find a language that was meaningful to all parties. An example of confusion over meaning occurred in the first focus group in DHB A involving service providers, when one provider suggested that the first outcome term to be explored be the term ‘restorative’. After 25 minutes of discussion and confusion, the researcher suggested that the discussion move to a more straightforward term. The provider who initially suggested discussing the term ‘restorative’ said:

*I thought that restoration is pretty simple really*, to which another provider replied: “Obviously it’s not, it depends…..

This language confusion became highlighted as an important issue in the last focus group meeting at DHB A, when it became clear that one of the providers hadn’t actually realised that they would have to change the way they delivered services. In their view, they were already delivering a restorative service. The provider’s understanding of the existing service specification was that it described a restorative service, which is what they were delivering. The confusion arose because in the late twentieth century, what had actually been delivered had become very restricted in scope and task focused, not restorative focused. The service provider interpreted the word through the historical filter, the funders through the new vision lens. The following dialogue shows the confusion:

*But we have our workers go in now and do that. I am not sure what the issue is. Our main issue is managing the rosters so we can get the staff there.* (Provider)

*But...you can’t just go on in the same way. Your staff are doing things for people, not working alongside them. They will need more training.* (DHB Funder)

*Of course, more training is good, if we can afford it. But they provide space now for people to recover, I mean, restore. That’s what we do,*
do things for people so they can recover, or at least get by if they are beyond recovering. (Provider)

A further example of the difficulty of reaching a common understanding of a term like ‘restorative’ was exploring what was meant by the term ‘rehab potential with no rehab gains’ (a category raised in the interRAI assessment tool, a tool of assessment that is gradually being introduced into all DHBs in New Zealand). It became clear that the term ‘rehabilitation’ has a specific meaning to health professionals such as physiotherapists and that this does not necessarily correlate well with the term ‘restorative’ with its subtexts of independence and client control. This led to discussion about what if any difference there was between the term ‘maintenance’ and the term ‘restorative’.

This confusion resulted in an attempt to find an easier first word or concept. The phrase ‘Active decision making’ was agreed on. Discussion focused on the idea that the client should feel in control, and there was agreement there would need to be a goal-setting process. There was agreement that the required outputs would be that goals are agreed to by the client, and services meet client expectations. Inputs would be training for staff and a goal assessment tool.

 Fear by home care providers of being blamed by clients and their families for changes to services

Home care providers were clear that they were not prepared to be seen by older people, their families and other health professionals in the community as the people responsible for the change. They all said they agreed with the new model, but thought there would be some public opposition, particularly if people had their total package of service reduced. One provider was vehement about this:

*We can’t do this on our own. You can’t expect us to change the way GPs [general practitioners or primary health care physicians] behave. If they and the older person’s daughters and sons want to refer the older person to residential care, they won’t listen to us about how we can keep their parent safe at home and help them improve. Who are you kidding? The DHB has to lead this!*
Home care providers’ desire for clarity of expectation with operational distance from the DHB

The home care providers were very clear from the beginning that they wanted the funder to tell them what the expected outcomes would be, and then they would go away and determine the activities and outputs they would need to achieve those outcomes. They did not want to be told what inputs would be needed. They wanted to be able to work out the inputs after they were told the amount of resource they would be given by the funder; i.e. their inputs would be determined in part by the amount of money they were to be paid by the funder. One provider was clear that he was far too busy for this fiddling about:

*It’s just class work. Without meaning to be rude, I’m sure we can manage in our own way, there are slightly different structures in the way organisations work and they will require different operational implementations. To sit here and go through nothing more than generalisations as to how activities and outputs link up inputs and outcomes is a little bit academic in this setting.*

Another provider was focused on the operational detail that dominated providers’ lives every day:

*As a provider, you live and breathe operational management. When you get given a task you’re going down a road of saying yes we’ll do this, that, that, that, and you don’t often have the time to take a step back and say why and what’s the expectation. You tend to operate from what you’ve got.*

and yet another was absolutely clear that he could not organise a service until he knew how much money was available:

*We agreed we would work together to make it viable. There’s a key measure for that. Given that volumes are xx, the key measure is what is the funding rate for the various services, because I’ve got a spreadsheet ready to go on various sorts of models, that if I get paid for that sort of service, then I need this sort of volume of staff to provide this level of service to clients because the funding rate will dictate the amount of staff it will take.*

This view was later corroborated by a provider who phrased the issue very well by defining it as the difference between a highest quality service and an average service:

*What these guys are saying is that we’re still working out for a service implementation by the lead-in time, something that is currently based on the old service basis, when in actual fact we’re really talking more creatively about it. I mean this is a really good service (that is being*
planned). In some ways it’s the Rolls Royce compared to what we’ve currently got and is there going to be some match in terms of how do we get the Rolls Royce up and running, or actually are we looking at a Corolla at the moment?

Mistrust between the funder and the providers

There was a sense of mistrust between the funder and providers. The funder expected that the providers would want to continue with business as usual, happily taking any development money but trying to change as little as possible. The planning and funding contract manager thought the providers would see them as trying to get more service for less money:

One of the providers is OK, probably has some understanding of what we are wanting to do, but the others just want to do the job. Partly, they are too busy just coping day-to-day; partly, they just want to make money, just do the job without having to think too much.

The planners and funders expressed concern about entering into the next phase of this research, which brought the other stakeholders, in particular home care providers and the consumer representatives, into the discussion. In particular, it was thought that the discussion about objectives and performance measures might bewilder or concern people because they would not be able to understand the approach being taken. As the DHB contract manager put it:

There is already a fair degree of suspicion. They believe they are not paid enough now, and will be highly suspicious that we want to ask them to do more for the same resource. Two of these providers are also quite small owner-operated businesses, so we need to be sure we use concepts and language they can follow. Plus the consumer reps will be watching to make sure that we are not just planning to cut services. Remember there is a lot of history.

There was a negative response by the home care service providers against the DHB for the request of performance management measures, particularly when it involved discussion about measuring such things as the ratio of coordinators to the number of home support workers for each provider. One provider was outraged at being asked to be involved in the development of something modelled on a balanced scorecard, which he interpreted as being undue interference by the DHB in his business:

This is none of your business. We run our operation as best we can. How many coordinators to home support workers we have, how
efficient we are, how much overhead we have, that is our business. You want a service; measure whether or not you get the service, not how we are managing our own business.

Need for simplicity
A key issue in developing a vision and approach was that the process needed to be clear and simple. The feedback from DHB A about the initially proposed implementation approach was that it was not easy to understand or implement. With a history of systems not working and management not understanding the day-to-day pressures and limitations of service providers, there was a real fear of having a system that was too complex. This was described by one DHB planner and funder as follows:

I think we have to be careful that we don’t have too complex a system – one that’s not able to be easily understood – so it won’t happen; and that takes up enormous amounts of resources, time away from provision of the service.

This view was supported by a health professional at DSAC:

My plea today is not only for some significant change from what you have presented, but to simplify what is happening; this is far too complex for anyone to be able to gain from it, in my humble opinion, my professional opinion actually.

Another health professional at DSAC agreed:

I do not think we should proceed with this sort of evaluation. It is far too complex, too detailed, too involved, will not give us the desired outcomes, and in my opinion, will never be able to be readily or easily implemented.

Home care providers took a pragmatic approach and, therefore, did not want to have much discussion about measures and indicators. They all felt they were too busy and did not have time for homework. As one provider put it:

I think it would be great if you came back to us and said, ‘I think we need to measure our service in this way, what do you think about that?’ It would be a lot easier for me; at the moment, I feel like I don’t need any more homework.

The feeling amongst the home care providers was that the funder knew what they wanted, so the simplest thing would be if they just stated that so the providers could get on with it. One provider stated it this way:
...as the funder, you’re going to measure outcomes; and in terms of measuring those outcomes, you will have indicative activities that you would expect to see being performed that produces those outcomes; can’t we just know what it is you expect?

DSAC agreed with the idea that a systematic approach to service development and implementation was needed. They also agreed that the implementation pathway format could be a useful systematic approach, so long as service providers were fully engaged, and the performance measurement system was kept simple. This need for simplicity was very apparent when discussing possible performance measures. An Excel spreadsheet approach was used to attempt to identify the tasks and roles that would deliver the ‘effective, efficient, sustainable services.’ This approach did not work well. The empty boxes disturbed people, but did not create the desired result, a “disorienting dilemma that moves individuals from pre-contemplation to contemplation of change” (McWilliam, 2007, p74). The boxes actually seemed to result in people feeling angry and helpless.

**Suspicion of the development process and the person involved**

Suspicion of the development process and the researcher was voiced by the community sector:

*I was kind of thinking this guy comes from a management position and this seems really rational and it doesn’t feel real *(A consumer representative on DSAC)

The researcher was seen as yet another outside person, coming in with answers and perhaps no understanding of the community sector. This concern was also echoed by the home care providers who feared they would be presented with a system into which they’d had little input. The feeling was that this would limit their creativity and not support them in finding their own solution to day-to-day problems. One of the health professional representatives stated:

*If the intention is to focus on client outcomes, one of the historical traps there appears to have been with providers is that when the outputs are set, perhaps the inputs are set as well. There appears to be a danger of that here. I wonder if there is a possibility in there of the outcome focus being maintained. There needs to be room for the providers to define what their particular outputs might be, rather than it being set in the contracting process. It would seem to me, then you’ve got the ability for providers to work in their way with their clients to define what those outputs might be so they may vary from*
contract to contract; but the focus is on the outcomes and the evaluation, so it could be different outputs and inputs for different people.

**Raising expectations**

There was fear that in talking to home care providers and other stakeholders, particularly clients, about the new programme, expectations would be built up that could not be met. There was a bit of discussion about previous experiences where new services were promised and then either started and failed to match what had been originally discussed, or did not start at all. This was well presented by one consumer representative:

*The thing about this is it’s all got to be negotiated in the end because the provider still has to provide and feel comfortable that it’s going to be delivered . . . what often happens in setting up something like this, actually what you are doing is you are giving a golden wand to consumers and families; this is what we’ve been wanting to hear for ages; but then suddenly – the expectations are huge, they are reasonable but still huge – they still have to be negotiated.*

**Communication**

There was a real understanding that good communication between all parties was at the core of what was needed to make any new approach work. One of the consumer representatives at DSAC voiced this awareness of the difficulties of getting people in a very convoluted health system to work together:

*I got a sense that a lot of it was about people not communicating effectively, so I thought of it as this – a method about aligning... otherwise they’re going off at different tangents, and don’t even know that they are.*

**Fear of performance measurement**

Discussion on performance measurement, particularly when there was some suggestion of linking the achievement of outcomes to payment for services, raised anxiety in the providers. One home care provider manager verbalized the impossible position he thought he was being put in:

*I don’t see how we can give you any commitments in relation to a lot of these things, we can’t give you a robust commitment; at least until we understand the funding, because you are asking us to commit to a series of measures and outcomes that we have, at this point, no*
understanding of how we’re going to be funded for. I just don’t understand how you expect us to do this.

Another presented his discomfort in terms of financial ability to deliver to meet measurement targets:

\textit{the point is, we can’t commit to a robust discussion of inputs and measures unless we know what the fabric is . . . you’re asking us to come up with all these things against a fabric which is unmeasured – and the measurement is money. We do need to understand the measurement against which we’re making these statements. If, on the one hand, the statement is the way we are presently funded, we may have to couch or term it this way. If it’s another measure, if the way we’re funded is different and in a different context, we’ll have to couch our terms in that way. We have to be able to measure the level of commitment we’re giving to these inputs and outputs relative to our ability, whether we can, in fact, deliver.}

There was also recognition that performance measurement can drive behaviour, and that this can be both good and bad. One health professional, who had worked for Non-Government Organisation providers for a number of years, commented on the sometimes perverse results arising from putting in a performance measurement system, saying:

\textit{I have one comment I want to make – and this is from working at the grass roots of care over a long number of years – . . . the comment you made right at the beginning about the measure changes behaviour: it absolutely does. Because care becomes secondary to the objectives of the contract, whether they be funding or whatever, they [the measures] change the whole process and the way people behave.}

Home care providers were also worried that a performance measurement system would hold them responsible for outcomes or outputs that were not, in fact, related to the vision, or could not be measured accurately enough to provide valid data. One provider was very clear:

\textit{We’ve got to decide what is the measurement tool for this project and how we’re going to measure with it because we will run two risks: either setting objectives that are inconsistent with accurate measurement or, three risks actually, determining measurements that fit with the objective and produce rubbish; or thirdly, producing data that’s inconsistent with the original vision simply because we’ve got nothing else to work with and apply it in a skewed fashion. So it’s really a critical point understanding what we’re measuring and how we’re measuring it.}
This meant that they did not want to have measures imposed on them, clearly stated by one provider as:

*If performance as service providers is going to be measured, then we have to have some input as to the validity.*

and by another as:

*...I'm not trying to be argumentative here, but it concerns me that we could find ourselves measured by criteria over which we have no control.*

Essentially, the idea that the performance of each provider might be measured and compared made them all suspicious at first. This meant that it took a while for them to free up in the focus groups and talk. When they did begin to speak freely, the fears expressed about comparison related mostly to the risk that they might come out unfairly as poor providers when compared to other providers. This was regarded as a business risk, as it would impact on their financial viability if clients then chose not to use their service. The risk of unacceptable comparisons being made related to the differences in client complexity:

*And what about the differences in clients? We might be regarded as worse than them* [pointing at the representative of a different service provider] *at getting clients to recover but in fact, most of our clients are sicker or more disabled than theirs to start with.* (Home care provider manager)

### 5.2.3 Alignment to the V-Model process

The V-Model provided a framework for iterative discussion between stakeholders who were exploring topics such as the intention behind wanting to deliver a new model of community health services in people’s homes, how the idea could be described in terms of objectives to be achieved, what would need to be done in an action plan, and what successful implementation of services that delivered according to the intention would mean in terms of measurable outcomes. At this stage, therefore, the focus was on Steps 1 and 2 of the V-Model, and on what the evidence for Step 4 would be, as shown in Figure 10.

Following the V-Model process helped to show that different stakeholders had varied understandings of the concepts and terms being used. This meant the DHB planners and
funders in charge of the change management process were able to identify stakeholders they needed to bring on board if their action plan was to work (Dolan and García 2000; Fixsen, Naoom et al. 2005; Friedman 2005). The V-Model approach thus helped the change management team avoid getting locked into an approach they liked, but one that might not work because some key stakeholders were resistant to the proposed change (Birch 2002; Jacobs and Heracleous 2006).

The tension between the vision of the HOP Strategy, DHB planners and funders desire to see it implemented, and the pragmatism of the home care providers became clear. From a V-Model perspective, the DHB had been given the vision and objectives (Step 1 of the V-Model) by the MoH, and then left to get on with sub-objectives and action planning (Steps 2 and 3) by themselves. The home care providers were less interested in the vision, and more interested in the funding available and the actions they would be measured on: Steps 3 and 4. However, while the home care providers raised concerns and issues, they also understood that the DHB had been given a directive from Government, and they indicated support for the intentions of the DHB (Step 1), even if a little begrudgingly. As one not-for-profit home care provider stated:

*From our point of view, we’re really interested in this stuff, because it is finally getting to an interesting point with community services. You guys, by the sound of it, have also got a point to prove. You are certainly taking a leap nationally compared to the DHBs I work with in terms of having a go, and you want to get a win. You want to be able to say we tried this, it works, we stuffed it here, we fixed it here but on the whole, it is a provable process.*
A further home care provider clearly identified that because the government was promoting the HOP Strategy, the approach being taken in DHB A was eventually going to have a national impact:

_We want to support that completely; success goes both ways; we want to be able to say we have done it in DHB A as well, because we’ve had the same kind of carry on in other areas as well._

At first glance, this fits with the V-Model concept that ‘the idea’ needs to be shared across both social world and personal world views for all relevant stakeholders. However, the desire of home care providers for clarity of expectation along with operational distance from the DHBs demonstrates the usefulness of following the process outlined in the left hand side of the V-Model; moving from a vision to an action plan. To an extent, the home care providers could be paraphrased as saying:

_The vision is all very well, but we want to work the other way around. Tell us what the action plan is (what are the resources that will be available and the tasks that are required) and we will tell you what vision can then be delivered._
From a V-Model perspective, the vision of the home care providers was not the HOP Strategy at all. Although they understood and perhaps agreed with the HOP Strategy, the vision that drove them was undertaking to meet the requirements of the DHB in order to receive funding to provide the services, in both this DHB and nationally. Identifying this difference in vision supports seeking a common language, one that is understood by all, since the theoretical basis of the V-Model process is a concern for valid communication. It also demonstrates that this model for finding a path forward was useful at this stage. It helped planners and funders understand that they needed to find a language that was meaningful to all parties that had to agree on the vision of the HOP Strategy, the objectives and sub-objectives, and what these meant in practice. It helped them to understand that terms had different meaning to different stakeholders. They also became aware that sometimes the language they used did not fit with service providers, and raised concern that the language used might be too academic for a general audience. The researcher agreed to write a common language manual that could be used once other stakeholders were also involved. The DHB A planning and funding group was presented with the draft common language manual (Appendix 2) that described the process they had been going through. The manual included a section that asked stakeholders for their opinions about performance measures for each outcome described.

At this stage, the programme was called “The real time implementation and evaluation system,” a name based on literature that showed that one of the issues for people involved in funding services was that evaluation often produced information too late to be of assistance in the process of contracting decisions (Duignan 2002). The V-Model was modified in the Real Time Implementation and Evaluation System (Figure 11). The name of Step 1 was changed to be ‘The Vision’, in response to comments from focus group 2 concerning the need for a common language. The term ‘The idea’ had no meaning to people without explanation. The other aspects added to the V-Model were based on management literature.

An assumption was made by DHB A planners and funders as well as the researcher that developing the Objectives and Sub-Objectives Step 2 of the V-Model and turning them into an Action Plan in Step 3 would be a very difficult process. It required stakeholders to
move from grand visionary statements to describing the actual activities that would be undertaken by a provider. It required stakeholders to validate their understandings of the vision against the reality of the steps that would be taken to achieve it. To assist stakeholders to follow the discussion process, the V-Model was supplemented with ideas from the Balanced Scorecard model (Kaplan and Norton 1992), the Performance Prism model (Neely, Adams et al. 2001), and the Results-Based Logic Model (RBLM) (Watson, Broemeling et al. 2004). The aim was to provide a discussion template that ensured all relevant perspectives were taken into account in a manner that was understandable to practitioners.

The discussion template, designed on an Excel table model, required all parties involved in the home care service to be involved in the discussion, with the first step being to work through the outcomes they would all expect from the vision. They also needed to discuss the inputs, activities, and outputs they would expect to see in place in order to achieve these outcomes. Before moving on to Step 3, developing an action plan, it was necessary to identify possible performance indicators, decide which ones were most important, and agree on performance measures. The rationale for these changes was that the terms ‘objectives’ and ‘sub-objectives’ were found to be confusing in that they did not clearly indicate what people had to do next. For some people, the vision was the objective. The exact process of the RBLM was followed in the initial stage as outlined in the common language manual, in that terms such as inputs, activities, outputs, etc. were used in the same way. Also, the ‘if / then’ approach was used to identify links between what people were trying to achieve and the actions they took to achieve those goals. On the right hand side of the V Step 4 was changed to be ‘Implementation’. The term ‘Issues’ was placed between Steps 4 and 5, with arrows leading to it from both steps, and with an arrow leading from it to the term ‘Consultation’, which was placed under ‘What’ in the middle of the V. Arrows then went both ways between the term ‘Consultation’ and Step 2 and the term ‘Issues’. The purpose was to make it clear there would be issues arising from both implementation and the results. In Step 4, the action plan might not be implemented fully. In Step 5, the results might not support the assumptions made in Step 2. A process needed to be established for ongoing consultation between the stakeholders so that changes could be
made to the programme as problems with either implementation or the results became apparent.

There was a decision in focus group six to proceed with the common language manual, and to have further discussion on the performance measures. However, the name ‘The Real Time Implementation and Evaluation System’ was considered too difficult to understand because of the combination of implementation and evaluation. The group decided that what was happening was the development of a pathway they could follow when implementing a new service, so it was suggested that the approach be called an ‘implementation pathway’. However, the planning and funding team were concerned that the V-Model pathway suggested a smooth linear process from discussion of the vision through to implementation of an agreed plan, and on to a wonderful outcome. Everyone knew from experience, and the literature (Neely and Bourne 2000; Rycroft-Malone, Kitson et al. 2002; Rouse and Putterill 2003; Fixsen, Naom et al. 2005; Pye 2005) supported them, that a smooth, easy implementation journey seldom happens. As one person described it:

You’re making it look too easy – Step 1, 2, 3, 4, 5, and yeh, you’re there at 6. We go round and round, back and forth. You have to get real here. We don’t know enough about what is needed out there to be absolutely correct with what we put together first up.

and the contract manager noted:

It’s not like we will just hand it over at Step 4, you know. We can’t just make the plan and let them get on with it. This will go on for ages. We need to work alongside them once the service starts till we know that it is working. We’re not just planners you know. I have to make sure it works.
There was also a feeling that some people got lost on the way. As one home care provider said:

_We’re just trying to do a good job day-to-day. When you are involved in operational stuff, we just try to survive often – just trying to find workers to cover everyone is enough. All this planning is fine, but it is so hard to get people to focus on stuff like ‘goals’, etc. Our staff haven’t got the time, or often the education, to read those big documents._

Or as put by another home care provider:

_All these words! Just give us something simple._

There was agreement in DHB A that continuing with a systematic approach to service development and implementation would be useful; however, key understandings at this stage were that the implementation pathway and performance management system had not been presented in a manner that communicated well. This was voiced by the stakeholders as a need for simplicity and common language. These findings meant that the wording for
the V-Model had to be revised, and a one-page representation of the HOP Strategy developed, before moving on to work with DHB B.

5.3 District Health Board ‘B’

The data collection in DHB B was separated into three distinct phases. The first involved two focus groups with funders and planners and home care providers and related in the main to the iterative development of key performance areas. The second involved a further two focus groups and concentrated more on the development of the critical success factors that would be required to be successful in the performance areas. The third stage, involving two more focus groups directly addressed implementation issues.

5.3.1 The development of the key performance areas

As with DHB A, the research in DHB B commenced with a discussion of the vision and objectives of the HOP strategy and the DHB’s strategic and annual plans. Building on the HOP Strategy and DHB A and B strategic and annual plans, the researcher developed a one-page representation of the HOP Strategy (Figure 12) as it relates to community services for older people. The wording has some differences from the MoH HOP Strategy, because the strategy was translated into wording that was appropriate for the strategic and annual plans of DHB B, and for the community sector the DHB planning and funding managers work with. The one-page representation is read from the top; the long-term objective reflects the desired outcome at the end-point of this journey. The remainder describes how the journey would be undertaken.
LONG-TERM OUTCOME SOUGHT

Good outcomes for people in DHB B

THROUGH THE PROVISION OF

A responsive restorative / recovery focused integrated continuum of care and support that provides people of all ages and their family/whanau with the right health and support services in the right place at the right time.

ACHIEVED BY ENSURING THE FOLLOWING SERVICE CONCEPTS ARE FOLLOWED. THERE WILL BE:

<table>
<thead>
<tr>
<th>A focus on promoting and supporting active recovery /wellness &amp; rehabilitation</th>
<th>An easily accessible single entry point to an integrated assessment process that produces a plan of care based on the goals and needs of the person and their family/whanau</th>
<th>Responsive -ness &amp; flexibility</th>
<th>Smooth transitions between episodes of care and different providers</th>
<th>Information sharing between the client, family/whanau and health and support providers</th>
<th>A focus on preventing unnecessary loss of independence</th>
<th>Care co-ordination or management</th>
</tr>
</thead>
</table>

DELIVERED THROUGH EFFECTIVE, EFFICIENT, SUSTAINABLE SERVICES, BASED IN PRIMARY CARE, FOR BOTH URBAN AND RURAL POPULATIONS

Figure 12: One-page representation of the Health of Older People Strategy for DHB B

In a further attempt to simplify language and processes, the HOP one-page representation was turned into a target diagram (Figure 13), pictorially like a dart board. This was created as an alternative to the Excel sheet approach that had been so unsuccessful in DHB A. It was titled ‘Long-term outcome: Good outcomes for the people in DHB B’. ‘Integrated continuum of care’ was placed at the centre of the dart board, because the DHB strategic and annual plans named this as the major factor in achieving the desired outcome. The next ring outside of the centre ring contained the core factors that would have to be in place to produce success. A further ring named some of the service components that would be in place if each factor was operating well. There were eight segments to the circle, with the seven service concepts being combined with the delivery of effective, efficient and sustainable services. People at the focus groups were then asked to say what capabilities would need to be in place in the short- and medium-term for the named service components to function, and what indicators of performance they would regard as useful.
The theme of simplicity and avoiding language confusion was also applied to the V-Model. The language was adapted to fit the analogy of a journey, and redesigned to be more reader-friendly to a non-academic audience (Lakoff and Johnson 1980; Mezirow 1997; Markus, Kearins et al. 2006). This is shown in Figure 14. Essentially, the language was changed to conform with the metaphor of a journey.
Discussion tended to reinforce the themes raised in DHB A and although the four themes echoed those already developed, there was significant discussion concerning the perspectives and interestingly much related to the relative hierarchical value of each. Table 11 highlights the themes which are discussed herein.

**Table 11:** Themes for performance perspectives for restorative home care arising from DHB B

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Placement of factors</td>
</tr>
<tr>
<td>2.</td>
<td>Client and family driven services</td>
</tr>
<tr>
<td>3.</td>
<td>Effective and efficient services</td>
</tr>
<tr>
<td>4.</td>
<td>A skilled stable workforce</td>
</tr>
<tr>
<td>5.</td>
<td>Funding that is appropriate and cost-effective</td>
</tr>
</tbody>
</table>
Placement of factors

Building from the information gained working with DHB A, the researcher proposed that each member of the DHB B planning and funding group rank the items being discussed in order of importance for achieving the overall vision. One respondent commented:

*Why would we do that? Being asked to rank items is not feasible. I have tried it myself when thinking about this and it is too hard. The purpose of integrated care is to have a range of items available, not to prioritise them. Ranking in order of importance does not make sense.*

However, the other participants agreed that although ranking was an inappropriate terminology, they confirmed that the items were hierarchical in a balanced scorecard sense, in that if all the factors identified had a causal relationship with the vision, then achieving the vision required completion of the critical success factors before it was realised. One person very involved with managing home care contracts stated:

*Ranking is, I think, the wrong phrase. I would see it more as a progressive completion of factors. I suppose you could call it a sort of ranking. I mean, we can’t have any service without funding, so I suppose that does come first. We can’t have a workforce unless we pay them! And unless we have a workforce it doesn’t matter what the client wants or needs, so I guess we do need the workforce next. Client driven – well, I would put it before efficient and effective actually, because it won’t be effective if the client isn’t properly involved.*

Client and family driven services

Participants across the focus groups in DHB B confirmed the value of client driven and strengths based services, although also stressing the significance of the family in contributing to the wellbeing of the older person:

*Naturally, the older person remains central to this, though without the family member, ageing in place would not be possible. It’s the families that complain.* (DHB planner and funder)

and:

*I suppose I would see it more as client and family rather than older person alone. We have to deal with the families all the time.* (Home care manager)

This congruence across the participants led to a change in the name of the perspective
from client-driven / strengths based approach to client and family driven services.

**Effective and efficient services**

There was considerable discussion pertaining to the theme ‘restorative approach / philosophy / culture’ that had arisen from DHB A. Again much discussion focussed on the meaning of restorative:

> *What is restorative, do we really know, and more importantly does the client and their family know. If we were looking at a home care implementation model, surely we would want to make it more generic.*

(DHBP planner and funder)

Other participants confirmed this view, raising the notion of efficiency and effectiveness:

> *Isn’t it efficiency and effectiveness that we are after, across the whole system. If the process isn’t restorative focussed, the system would not be efficient or effective.*

(Home care manager)

However, there were some concerns around these terms, confirmed by one funder:

> *I am not actually sure what ‘effective and efficient’ means. We need to make sure we don’t get bogged down in thinking about cost. All our COO (Chief Operating Officer) will focus on is as cheap as possible.*

(DHBP planner and funder)

Their concerns were allayed somewhat by further discussion that explored the notion in more depth:

> *I agree, at the end of the day we need to be efficient and effective. But we are now, we think. We provide good service at minimal cost. What do you mean by the terms; it just needs clarity, if we could name the elephant and describe what we are after, that would help.*

(Home care manager)

Overall, at the end of the discussion, participants agreed that factors could be appropriately organised around the term effective and efficient services.

**A skilled stable workforce**

Analysis of focus groups within DHB A pointed to the strong relationship between sustainability within the workforce and funding. Analysis of the focus groups within DHB B points to a separation of workforce from funding. To illustrate, one planner and funder commented:
We deal with the providers all the time over funding, but the complaints we get from the public are usually over the standard of the workforce. We need to make sure we don’t get hooked up in the funding to the detriment of everything else. We need the funding to get the good workforce.

All participants across both planner and funding and home care stressed that workforce is essential, needing to be developed alongside funding but as a separate category or perspective so that a focus on workforce was maintained.

No funding is separate, without workforce we are nothing, and given that employing and retaining staff is only going to become more difficult, it must be developed as a separate item. (DHB planner and funder)

With this in mind, ‘A skilled stable workforce’ was developed as a separate category, distinct from ‘Sustainability – workforce, financial and provider’ which arose from analysis of focus groups within DHB A.

**Funding that is appropriate and cost-effective**

There was some discussion about provider sustainability, but agreement with the DHB A perception that this was in the main covered by facilitating the operational management of finances and workforce. Discussion on finances covered the difficulties of costing services that were required to be flexible and responsive, of finding effective payment approaches for flexible services, and of ensuring that funding was used appropriately. The term ‘appropriate and cost-effective’ was suggested by a DHB B planner and funder as being sufficient for their purpose, which was to fund so that the service could be provided and to report to their management that they had used public funding well:

*The providers want us to pay them well; the DHB wants us to pay as little as possible. In the end, we have to justify to both what we pay. The current Ministry of Health jargon is cost-effective. Let’s go with that.*

**5.3.2 The development of critical success factors**

The focus groups and subsequent analysis undertaken to this point revealed key themes relating to the four key performance areas of: (i) client and family driven services; (ii) effective and efficient services; (iii) a skilled and stable workforce; and (iv) funding that is
appropriate and cost effective. However, although these concepts arose from an extensive and iterative process, they remain somewhat nebulous. From a Habermasian perspective, there might be personal and social world agreement on these concepts, but there was no technical world aspect to triangulate with them to ensure valid communication. To provide this greater level of meaning and understanding, the key performance areas needed to be translated into critical success factors that would enable performance measurement and thereby provide technical data with which to test the validity of any personal and social world consensus. The focus groups drew attention to this by forcing participants to consider how they would measure success in each of the four performance areas.

To facilitate this process, participants were provided in advance with an illustration of what restorative home support intended to accomplish (Table 12). This schema summarises the key features of restorative home support. The perspectives of the balanced scorecard are on the left hand side of the table with the consumer perspective being split into client and informal carer, and with the community perspective, or outcome, being at the bottom. The elements along the top represent the four themes that arose in discussion about critical success factors with the effective and efficient services theme separated into restorative focus and a responsive and flexible focus. This split was the wish of the focus group at this point, as they considered the differentiation would assist them to be particular about issues and avoid too many generalisations. This meant the components that had been the practices that would be expected to be operational in a home care service would be viewed through the lens of each balanced scorecard perspective. For example, from the client perspective, if restorative/recovery-focused care was being supplied, the service would be built around the client’s life goals and motivation, and encourage client self-activation and a social role for the client in their community; there would be a care plan in place derived from client life goals; and the client’s mana/dignity would be preserved. If responsive and flexible care was being provided, from the client perspective there would be assessment from first contact; the client would receive a solution-oriented service tailored to their goals and needs; the services offered would be in a flexible package that included both formal (paid-for) and informal (community and volunteer) supports; and, communication would be perceived by the client as respectful. As another example, from the finance perspective,
if responsive restorative/recovery-focused care was being delivered, services would form part of a flexible package; the packages would be reviewed regularly against the client goals and the services would be sustainable.
Table 12: Table of necessary performance factors that need to be in place if the vision is to be achieved

<table>
<thead>
<tr>
<th>CLIENT DRIVEN</th>
<th>RESTORATIVE</th>
<th>RESPONSIVE &amp; FLEXIBLE</th>
<th>FUNDING</th>
<th>WORKFORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client’s life goals assessed and included in care plan</td>
<td>Built around client life goals &amp; motivation: self-activation / social role</td>
<td>From First Contact – If in doubt, assess</td>
<td>Workforce paid appropriately</td>
<td>Competent, appropriate workforce available</td>
</tr>
<tr>
<td>Individualised responsive package</td>
<td>Care plan derived from client life goals</td>
<td>Solution oriented, with solution tailored to the client’s goals and needs</td>
<td>Workforce can be flexible and still get paid</td>
<td>An adequate supply of workers available</td>
</tr>
<tr>
<td>Workforce supports client establishing &amp; achieving own goals</td>
<td>The client’s mana/dignity is preserved</td>
<td>Flexible packages of care, including both informal and formal supports</td>
<td></td>
<td>Workers receive training</td>
</tr>
<tr>
<td>Workforce competent &amp; appropriate</td>
<td></td>
<td>Communication is respectful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARER</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer’s goals assessed</td>
<td>The life goals of the client are maximised</td>
<td>Same as above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate support provided</td>
<td>The carer is part of the caring team</td>
<td>Reassurance re risk-management approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has information - about care plan</td>
<td>The carer’s goals &amp; needs are recognised</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- about how to get help if there is an issue</td>
<td>The carer receives assistance to understand the dignity of risk/duty of care paradigm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsive</td>
<td></td>
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</table>
Table 12 (cont.): Table of the necessary performance factors that need to be in place if the vision is to be achieved

<table>
<thead>
<tr>
<th>CLIENT DRIVEN</th>
<th>RESTORATIVE</th>
<th>RESPONSIVE &amp; FLEXIBLE</th>
<th>FUNDING</th>
<th>WORKFORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERNAL BUSINESS</td>
<td>A client life goals setting and achievement approach is in place</td>
<td>Solution oriented culture</td>
<td>Workforce paid appropriately</td>
<td>Recruitment and retention of appropriate workforce</td>
</tr>
<tr>
<td></td>
<td>The provider walks alongside the client</td>
<td>Open access to assessment</td>
<td>Monitoring care manager variance</td>
<td>Philosophy Attitudes</td>
</tr>
<tr>
<td></td>
<td>There is a culture that restoration is possible</td>
<td>Clear model for bringing in expertise as needed; e.g. social workers</td>
<td>Monitoring care provider variance</td>
<td>Remuneration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce competency</td>
<td>Budget monitoring in place that supports flexibility</td>
<td>Meaning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Payment system pays correctly in a timely fashion</td>
<td>Training</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>There is monitoring of client outcomes versus resource use</td>
<td>Supervision</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Detailed accurate information is collected and reported on</td>
<td>Career pathway</td>
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<td></td>
<td></td>
<td></td>
<td>Team</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Relationships</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- Client</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Co-workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Organisation</td>
</tr>
<tr>
<td>Process and format in place for assessing client’s goals</td>
<td>Staff trained to do goal assessment are doing the assessment</td>
<td>Care plan is being developed from client goals</td>
<td>Care Plan is being implemented</td>
<td>Continuity of staff</td>
</tr>
</tbody>
</table>
Table 12 (cont): Table of the necessary performance factors that need to be in place if the vision is to be achieved

<table>
<thead>
<tr>
<th>CLIENT DRIVEN</th>
<th>RESTORATIVE</th>
<th>RESPONSIVE &amp; FLEXIBLE</th>
<th>FUNDING</th>
<th>WORKFORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEARNING AND GROWTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client involvement in governance &amp; service development</td>
<td>Training in the culture and the practice of a restorative approach</td>
<td>Training</td>
<td>Continuous Quality Improvement</td>
<td>Training Supervision</td>
</tr>
<tr>
<td>Client goals in the care plan as item in the training programme</td>
<td></td>
<td>Continuous Quality Improvement: there is a formal structure in place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FINANCE</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Packages of care</td>
<td>Flexible packages of care</td>
<td>There is a whole systems approach to funding issues; e.g. PH, DSS, MH</td>
<td>Workforce development costs recognised</td>
<td></td>
</tr>
<tr>
<td>Flexible funding approach supported</td>
<td>Packages reviewed regularly against the goals</td>
<td>Supports packages of care</td>
<td>Service approach costs recognised</td>
<td></td>
</tr>
<tr>
<td>Funding approach supports low staff turnover</td>
<td>Sustainable</td>
<td>Recognises costs of training /competency</td>
<td>Consistency re: resource decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has drivers for flexibility</td>
<td>Operate within budget</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Contestability</td>
<td>Good provision is rewarded</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Value for money</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Consistent approach from the funder</td>
<td></td>
</tr>
</tbody>
</table>
### Table 12 (cont.): Table of the necessary performance factors that need to be in place if the vision is to be achieved

<table>
<thead>
<tr>
<th>CLIENT DRIVEN</th>
<th>RESTORATIVE</th>
<th>RESPONSIVE &amp; FLEXIBLE</th>
<th>FUNDING</th>
<th>WORKFORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY</td>
<td>Clients participate in the community (Social contract)</td>
<td>Monitoring of achievement/benchmarking</td>
<td>Responsible/equitable/accountable decisions</td>
<td>Community Care workforce valued</td>
</tr>
</tbody>
</table>
Discussion was broadly focussed around the four key performance areas in addition to the vision. For the purposes of clarity, the themes have been organised around these areas.

Vision
The vision or community perspective was renamed to be ‘People’s independence and participation in society is maximised’. This was essentially because participants wanted alignment with the HOP Strategy. The four balanced scorecard perspectives were renamed as Key Performance Areas (KPA), which was a more meaningful term in this context for stakeholders.

Client and family driven services
The consumer KPA was relabelled to better recognise the perspective of both the identified client and their carer network. Both the client and the carer were acknowledged by all stakeholders to be, to some degree, clients, although the carer may be better recognised as a partner in care.

We’re just dealing with a case where the home care provider has asked if we can approve more funding, because if they don’t provide more service, both the client and her husband will end up in care. She’s 81 and he’s 86, with him looking after her. (NASC coordinator)

It’s hard as a funder. We get criticised for big packages, because it looks like it’s for one client. But if they go into residential care, we have to pay for both of them anyway. (DHB planner and funder)

If the carer is not supported sufficiently and becomes sick or disabled themselves, the result is two people receiving care services (Department of Health 1996; Department of Health 1999). It is also clear that carers have a major role in determining the ability of older people to remain at home and avoid residential care entry (Jorgensen, Parsons et al. 2004). Two critical success factors (CSF) were developed for this KPA. The first was titled, ‘Informal carers are involved and supported’. The involvement of informal (unpaid carers) is a major factor in the support of older people, with research suggesting that the ability of any carer to function in their role has a major impact on the ability of an older person to remain living in the community (National Health Committee 1998; Shelton, Schrader et al.
2001; Goodhead and McDonald 2007; Rural and Regional Health and Aged Care Services Division 2008). It was recognised that sometimes the informal carer was not a family member, and that community networks could also be involved. The second CSF was developed as ‘Client needs are assessed and influence the services and support plan’. This is a basic first step in that if the client is not assessed, then everything must logically be driven by the system not the client. If the restorative approach concerns optimising function and comfort (Tinetti, Baker et al. 2002), then a client goal driven approach is always necessary. The client must be involved in decisions regarding how to optimise their functional ability. The relationship between the term ‘restorative’ and the term ‘maintenance’ was intensely discussed in many of the focus groups. The use of goals was seen as a way through the dilemma of deciding on a course of action when maintenance was thought to be all the optimising possible. The main issue seemed to relate to which individual, health professional, client or family carer would decide what approach was necessary. Using goal facilitation was seen to create shared decision making situations, as reflected in the following piece of dialogue between two providers:

So where does the client goal fit in? Are we determining all the goals, or is the client determining all the goals? And that’s another debate, I suppose, so that’s another level of complexity to who’s driving the goals and the outcomes that are being measured.

Well, I’d have thought that we were driving the goals with the clients and the care co-ordination centre; that’s our role, as part of the outcome from the assessments themselves

Netten et al (2002) found that when older people say they want to retain their independence, what they mean is that they want to retain a sense of control. This was supported by funders and planners from DHB A who proposed that it would be demonstrated in practice if clients were treated by services in a respectful manner, and if the care or service plan was derived from the client’s goals. This led to agreement across the three DHBs that, ideally, any service would be organised so that the client took part in a goal assessment, signed off the goal assessment and signed off the care plan. Home care providers and NASC would have a client goal assessment tool in place, undertake a goal assessment, start from the client’s goals when planning care or service, and provide training for workers in goal assessment and working to client goals. Additional agreements were reached: the workers’
performance appraisal system would include an assessment of client-driven philosophy; workers would attend training in goal assessment; and the funder would assure that all contracts specified a client-goal-driven approach.

**Effective and efficient services**

The internal business perspective of the original balanced scorecard refers to the question, ‘At what must we excel?’ These are mechanisms through which organisational performance expectations are achieved (Kaplan and Norton 1996). The term internal business had no common meaning to the participants in this research and required much explanation. The best fit to cover the same concept appeared to be that of working efficiently and effectively; this is encapsulated by the following five CSFs.

CSF three emerged as ‘Client support is co-ordinated and/or care managed’ and is a major dimension of efficient and effective care. There is considerable literature relating to the effectiveness of care management for people with complex conditions (Challis 1992; Landi, Gambassi et al. 1999; Kodner and Kyriacou 2000; Challis 2003; Downes, Hefford et al. 2004; Hutt, Rosen et al. 2004; Parsons, Anderson et al. 2006). In contrast, the National Health Committee reported that lack of coordination was a major factor in the disappointing quality of health care for older people (National Health Committee 2000). The ASPIRE trial proved that coordination of services had a statistically significant effect on improving outcomes for older people (Parsons, Anderson et al. 2006). However, care management and/or co-ordination is difficult, especially when it is across secondary care/primary care/community provider boundaries. As stated by one DHB manager:

> Discharge planning! We’ve had so much feedback from the community and reference groups about the problems with older people’s lack of a discharge plan and how they end up with a readmit. When you run a report on a readmit, somebody’s been readmitted into a DHB within 40 hours from a discharge, they can pick it up as the last admission, so you miss the readmit. The only way we found that out is that I fought through some barriers and we did an audit. We actually selected a case where this man, here I can tell you he is going to get readmitted in three days, he’d had eight admissions in six months, and the discharge planning every time was hopeless, even though he was discharged as a planned discharge. It was a failed
discharge, because he re-presented within 48 hours. Our discharge planning is shocking but trying to raise the awareness, nobody’s interested, because we don’t decide, the provider arm decides about that.

The fourth CSF was ‘Public information supports the approach’ and reflects concern by service providers that they were being asked to shift service provision from one paradigm, a ‘do for’ model, to another, a ‘do with’, but without their client base or the referrers of those clients being told of the change. There was recognition by DHB staff that this was an important issue. It was very common for primary health care workers, particularly General Practitioners (GP) to refer clients to NASC for household management, but not for assessment. Many existing clients were habituated into having someone come into their house to do their cleaning. The new service model aims to support people to regain and maintain independence for as long as possible. It is not therefore an entitlement model, in which people can expect to receive services, for example, two hours per week of household management (house cleaning) per week, for the rest of their lives. The home support providers raised this need for public information as a very serious issue. It is difficult for them to provide a service that supervises and supports the client or carer to do the required task if that person and their support network, including health professionals, expected that work to be done for them.

Home care providers did not want to have the responsibility of telling GPs that their client might receive assistance to get better at doing their tasks themselves, and that assistance would be reduced over time and possibly removed altogether. There was also concern about how existing clients and their families would react. From a home care provider perspective, it was important that the DHB inform the health professionals, clients and families about the new paradigm and why it was being implemented. As one home care provider commented:

While I agree with what you want, and for us it will be better to not be just domestic servants, I don’t want to take the blame. We are in competition with these other guys [the other providers present at the focus group]. It has to be seen as all of us changing our approach to meet DHB demands, or we will be caned for it.

The fifth CSF became ‘Services and treatment are responsive and flexible’. This is important because if no service is delivered when one is planned, there are clear
issues around system viability and inflexibility and lack of responsiveness with the result that in the main people can only receive tightly specified services that might not be what they actually need when they need them. The health status of older people with complex needs can fluctuate from day to day, meaning that their functional ability can also fluctuate from day to day. This means that a provider may need to provide intensive care one week, and very little the week after. The provider, therefore, needs to be both responsive to the changing needs of the older person and flexible so that the service delivered can change to meet changing need (Minister for Senior Citizens 2001; Ministry of Health 2002).

The sixth factor is that ‘All parties receive all information needed for support plans to be developed and implemented’ and arose from a common problem that emerged from discussions with the three DHBs: the lack of information sharing among providers looking after the same person. Home support providers complained that the Needs Assessment and Service Coordination Service would not send them information about the client they were being asked to support; this prevented them from tailoring their service to meet the client’s goals and needs. This theme is supported by the findings of previous work; for example, consultation during the development of the Health of Older People Strategy (Ministry of Health 2002).

Sometimes the reluctance to share information has been on the basis of concerns about privacy, but this has been identified as a misunderstanding of the New Zealand Privacy Act (The Parliament of New Zealand 1993). Protocols were required to ensure that providers receive the information they need in order to provide the support they are contracted to provide.

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10 The rules are in fact clear: Health information must not be collected by any health agency unless (a) the information is collected for a lawful purpose connected with a function or activity of the health agency; and (b) the collection of the information is necessary for that purpose. It is a function of a health agency, including home support services, to provide care and treatment for a person, and the sharing of information is legal for that purpose. Rule 1 provides the only restriction on the purposes for which an agency may collect health information in the code. It effectively obliges health agencies to be clear about how and why they intend to use the information they collect, before the point of collection, if possible. Privacy Commissioner (2008). Health Information Privacy Code 1994: incorporating amendments and including revised commentary. Auckland, Office of the Privacy Commissioner..

11 The need for sharing of client information is placed in this section rather than the Learning and Growth section, because it is not about information systems, e.g. information technology, as such.
The seventh CSF emerged as ‘Client goals are assessed and aimed for in a service plan.’ This requires that the treatment and support plan is driven by client goals and is managed within client needs and abilities in order to maximise function. The key driver of effective and efficient services has been identified in the literature as services that engage the client so that they are partners with health professionals in their treatment and support package (Anderson, Ory et al. 2000). If they are not partners, the client may ignore the prescribed package which would result in low adherence (meaning that the time spent by health professionals in putting the package together has been wasted), or the client may adhere to the package but give up being motivated to manage their own care, and thus become dependent (Anderson, Ory et al. 2000; Bray 2003; New Zealand Guidelines Group 2003). Assessment of client goals is basically an assessment of client motivation – what do they want to achieve in their life and how will health services help them (Peri and Kerse 2004); this will determine the service provision. Alongside this factor of client goal assessment, however, is the need for the goals, needs, and care plans to be taken seriously.

A skilled stable workforce
Three primary areas identified as important by Kaplan and Norton (1996) in the Learning and Growth perspective of the balanced scorecard were people, information systems and organisational processes. People in the workforce were focused on as the key CSF for this management scorecard, because of recent research identifying that workforce issues were the major restraint on the development and maintenance of a high quality home support system (Parsons, Dixon et al. 2004). Home care providers were concerned that their viability as service providers had not been considered, but agreed their sustainability would be assisted if the workforce could be made stable and skilled. From the discussion with the participants from the three DHBs, the key themes that emerged related to the workforce area included a focus on worker retention and worker skill levels. While remuneration has been a highly researched area and has identified that many home support workers salary has been inadequate (Top Drawer Consultants 2006), it has also been identified that money is not the only issue. Retention also depends on workers feeling that what they are doing is valued, and that, therefore, they belong to
the organisation (Parsons, Dixon et al. 2004). Three CSFs were identified for this KPA.

The eighth CSF was that ‘Workers must feel valued’. Operating according to a restorative home care model has been shown to reduce staff turnover from more than 42 percent, to 17 percent (King, Parsons et al. 2010). This aligns with other research on people in care-assistant type roles which shows that staff turnover fell when assistants were able to work more closely with a client, with the hypothesis being that the sense of being able to do a good job is important to staff satisfaction (Anderson, Corazzini et al. 2004).

The ninth CSF was that ‘Workers are trained and assisted to become skilled.’ Research undertaken by The University of Auckland (Parsons, Dixon et al. 2004) identified this and the next success factor as important, and this was affirmed by the stakeholders engaged in this thesis. The logic for this CSF is clear: a restorative model of support in the home requires the workforce to assist older people rather than do things for them. They are required to be able to assist the older person to follow the instructions of a physiotherapist while they complete repetitive exercises such as sit-to-stands (Parsons 2002). This requires a level of training beyond doing normal housework duties.

The tenth CSF emerged as ‘Workers are adequately remunerated.’ There has been evidence that the take-home pay of home support workers has at times been less than the minimum wage after they have paid for their own travel expenses (Burns, Dwyer et al. 1999; Parsons 2004a). There were several references by home care providers that they were offering staff the same pay as supermarkets, yet demanding more skills. Everyone in this study agreed that, for equity reasons alone, take-home pay had to be at least better than the minimum wage. While it was not certain this was adequate, as no research shows what impact this would have on retention, it was accepted that anything less was inadequate. Although adequate was never officially defined, in the context of the focus groups it appeared to mean sufficient to attract people to stay in the job.
Funding that is appropriate and cost-effective

Three financial themes emerged from the focus groups in DHB B but were a key feature in all three DHBs involved in the study. The first was that DHB funders are accountable to the public (i.e. the Government) for the effective funding of services, meaning that services delivered are effective at a reasonable cost. The second common theme was that available funding was hard to access for any new, more flexible service paradigm because of existing rigid payment mechanisms. The providers could not be flexible in their service delivery if the funder could not then pay them because the services provided did not match the very tight service descriptions required by the payment mechanisms. The third theme was that this new system required a highly trained workforce which could be difficult to achieve within the current funding amount. The following quote from one DHB planning and funding manager shows the frustration with the issues, and an understanding that methods of funding can make a difference:

*I took them back at that day to 1990s, remember the standards that came out, the Ministry of Health standards, now they very clearly said what we are all trying to do now, so why didn't it happen in 1994. That was because, I think, of the way we contracted and funded for it. It limited our ability to do that and in fact we didn't really have any robust measures and things in place to tell us when we were going off track; and there's still a risk, so we know we need to develop those measures in our mind. The next thing that we have to do is some measures so that we've got a comparison, so we know we need to develop our outcome measures, we know we need to do that and we haven't done it. We know that there isn't a funding method throughout New Zealand that's been determined, so we're no worse than any other DHB, we're doing exactly what we've always done and that's why we're all going down this same path of trying to find a way around the system that's in place.*

The eleventh CSF was that ‘Services are cost-effective’, which stemmed from strategy documents and DHB strategic plans. Discussion showed that it is very difficult to specify exactly what it means or how cost-effectiveness can be measured in real life. For instance, one suggestion discussed in each DHB concerned the comparison of the cost of someone being cared for in the rest home or continuing care hospital to that of keeping someone in a similar condition at home. DHB funders would have loved to have been able to do this comparison, as shown in the next quote:
We have to show the Board that we are spending money well. But the data is so poor in terms of the total health spend. I guess we can show that the part of the disability budget spent on a person is less than if they were in residential care, but what about pharmaceuticals, primary care, district nurses, ED visits, etc. What is the cost of the total package? We wouldn’t know. So we report that we are saving the DHB money, and someone on the Board asks about the other costs, what do we do? All we can say is we are reducing the disability budget? The usual silos problem.

The twelfth CSF was that ‘Funding supports flexible packages of care’. One of the big issues for DHB funders and planners was the national fee-for-service payment system. This meant that services could only be paid for on a per hour basis as per a contract, and this contract had to specify in advance how many hours of service per week were being funded. Funding in advance or bulk was very difficult:

If I tell the provider to aggregate their funding and be flexible, so that instead of delivering four hours service per week, they deliver as required – say six hours one week, four the next, three the next, five the next, and so on – the payment system cannot cope with this unless the provider lies in their invoicing and reports that they delivered four hours per week. So we are funding some of these new approaches through a different system, but this does not give detailed data, so we cannot compare what we are doing with other DHBs. Who knows what the data coming through means? What is there depends on the creativeness of the funder in finding a way around the system.

At the core of the issue was finding a way to fund providers that allowed providers to be flexible so they could respond to the needs of their clients, needs that could change day to day.

The thirteenth CSF was that ‘Funding supports training and supervision for workers’, which links directly to the previous key performance area and CSF in that workers should be trained and supported to be skilled. While the national home support contract states that the price included the costs of training for the staff, the reality is fuzzy as has been shown in previous quotes from providers about the issues of determining the amount of money available before determining the service that will be offered. Clearly, if the funding for training is not sufficient, the training may well be inadequate.
The management scorecard

The development of the 13 CSFs organised around the four key performance areas led to the development of a management scorecard (Figure 15) that had the community perspective at the top as the overall outcome to be achieved.

![Management scorecard for community services for older people](image)

The outcome desired is at the top, because its achievement determines the whole purpose of the services being put in place. Although the elements of this management scorecard have a top down appearance, the logical flow is from the bottom up, that is, there has to be funding to have a service with a paid trained workforce for what is a service delivery industry; the service has to be effective and efficient if it is to be sustainable; and the service has to be driven by client and family outcomes or it will not achieve the desired outcomes.
5.3.3 Implementation and performance management

The final stage of the research with DHB B involved a specific focus on implementation of community health services. The key themes corroborate the findings from DHB A, but add further depth and context. In addition, a further two new themes were identified, that of the need to be direct and that the journey is not straightforward. Table 13 highlights the themes which are discussed herein.

Table 13: Themes for implementation arising from DHB B

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Simplicity</td>
</tr>
<tr>
<td>2.</td>
<td>Being direct</td>
</tr>
<tr>
<td>3.</td>
<td>The journey is not straightforward - revising the V-Model</td>
</tr>
<tr>
<td>4.</td>
<td>Need for a national approach</td>
</tr>
</tbody>
</table>

Simplicity

The one page representation of the HOP Strategy worked well as a visual focus for discussion about purpose. Participants found it simpler to follow than the target diagram, which was OK but regarded as messy. The conclusion was that the target diagram did not contribute enough to make it worthwhile. The net result of the work with DHB B was that the steering group coalesced around a joint vision, and agreed on a general direction and steps, but at the end it was still not exactly clear what had to be done by whom, and how people would know if the required actions had been taken. The format was too complicated and needed further revision. This was exacerbated by having a planning and funding team that were working within an environment in which the politics between the CEO and the Board were difficult, making it very complicated to get necessary approval at a senior management level. However, the process and templates used with DHB B were much more successful than the initial process and templates had been with DHB A. The move to common language and simplicity did seem like a move that assisted engagement by stakeholders. The Community Consultation Group willingly participated, and produced a set of necessary activities and indicators of success for the DHB to act on.
Chapter 5: Results

Being direct
There was a noticeable reluctance to actually fill in gaps in the template seeking to relate the vision to objectives to actions to measures. It seemed that level of attention to detail was too much for people to cope with. People struggled with the ideas of ‘Competency required’ and ‘Contribution required from each stakeholder’. The best response was obtained by being direct: What has to be done? Who has to do it? How will you know if it is being done? Is anything or anyone missing?

The journey is not straightforward: revising the V-Model
DHB B planners and funders were suspicious of the implementation pathway displayed by the V-Model, because it suggested that the steps from 1 to 6 were straightforward. They thought the process needed to acknowledge that there are different phases in the partnership between funders and service providers during the development and implementation of services. What became recognised as the most important change needed was the introduction of a three-phase concept: a specification phase, an implementation phase and a business as usual phase. Using the journey analogy, as with the construction of any moving vehicle, this meant there had to be a development phase. Some of this would be before the journey actually began, but there would be ongoing testing in the first part of the journey. Once people were reassured that the means of transport was sound, then the only testing would be maintenance and quality refinements. This was described in DHB terms as a ‘business as usual’ phase. This change acknowledged that the means of transport could not be bought off a dealer’s show room floor. It needed to be constructed in the DHB. The result was the evolution of the Sheffield V-Model into the Triple V Implementation Pathway (Figure 16).

The rationale for developing this three-phased approach was to deal with the issue raised by DHB planners and funders that time frames within health are often far too short for the reality of the messy system they work within. Also added to the V-Model is an arrow going from Step 5 to Step 3. This represents the reality described by DHB B, which made clear that new information that comes through as the new service is being implemented may mean that the new service will be redesigned during implementation. The assumptions or evidence that led to certain approaches
being adopted in Step 2 could be challenged by the evidence coming through in Step 5. The V-model was adapted to show this iterative process.

Once the Triple V Implementation Pathway diagram was in place, DHB B was asked to consider whether or not the journey, as presented, was a true representation of their understanding of the process they were undertaking, with the vision depicted in the one-page representation of the HOP Strategy as the direction, and the performance management and measurement system as the check points to confirm they were heading in the right direction. There was broad agreement that the journey metaphor, as presented, did represent their understanding of the process they were embarking on, and was helpful to them in preparing for what had to happen.

Figure 16: The beginning of the Triple V Implementation Pathway

The need for a national approach
The need for a national approach to change management was supported in DHB B, along with a desire for agreed measurable outcomes. There was an underlying theme of anxiety about whether the development and implementation of the new service
model was going to be successful; this produced a sense of vulnerability and isolation at all levels. The planners and funders had to report to the DHB Board who required the new model of service delivery to be successful, yet the planners and funders weren’t sure about what they needed to do. Home care providers and NASC also felt vulnerable; however, there was a feeling that if more than one DHB was doing the same sort of work, there was some safety in numbers. This was stated by a planner and funder:

*The way we want to do it, because what we are doing, is very complicated and unknown for all of us; we want to do it in a very structured way so that we can refer back to what we’ve done; this bit worked and this bit didn’t. And we want to be able to compare and learn from other DHBs.*

5.4 District Health Board ‘C’

As with the two previous study sites, DHB C focus groups were audio recorded and transcribed verbatim to allow for analysis on completion of each focus group to determine when thematic saturation occurred. There were two focus groups in DHB C; both had DHB planners and funders only, because the research process shifted to the implementation of phase two soon after the second focus group. A simple one-page representation of the HOP Strategy for New Zealand was taken to participants of DHB C, without the target diagram, and with the management scorecard (discussed under the performance management section).

The HOP Portfolio managers from the three participating DHBs knew each other and were in contact regularly. This meant information was shared during this research among the HOP Portfolio managers in DHB A, B and C about what data they required in order to report to their DHBs about the new service models. This sharing ensured that each iteration of the process with the new DHB was not starting from the same baseline. DHB B and DHB C knew what had happened in the preceding DHB(s), and there had been some discussion between them about what had worked and what needed improving. By the time DHB C was involved, the HOP Portfolio manager had clear ideas about what was needed. There was information in five themes that added to the information from the other two DHBs (Table 14). This is explained below.
Table 14: Information on themes for implementation arising from DHB C

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Support for systematic implementation process</td>
</tr>
<tr>
<td>2</td>
<td>Language confusion</td>
</tr>
<tr>
<td>3</td>
<td>Setting timeframes</td>
</tr>
<tr>
<td>4</td>
<td>Professional presentation</td>
</tr>
<tr>
<td>5</td>
<td>What happens next</td>
</tr>
</tbody>
</table>

Support for systematic implementation process

As well as issues, there was also support for a systematic implementation process, in this case the V-Model approach. The first quote below shows that this person has recognised that the V-Model approach would be useful in developing an approach to contracting in which the competencies, inputs, and outputs agreed on are reached through a logical and respectful process, one that might fit more with a stewardship (Cribb 2006) and trusting approach than was obvious in the tensions between funders and providers in this research:

> The other thing I like about this model is, when you talk about logic, it is logical, but from different approach, a productive rather than a deductive approach; the other thing I like about that is that once you’ve used this process to nut everything down to find out what your outcomes are and what you need to get there, that actually helps you build your contract as well, because your capability and particularly your competencies and your providers’ specific terms and conditions are going to fall out of all of that.

> I think that for me maybe there’s too much self doubt, but there was always a feeling like we’d missed something; it was an elephant and we couldn’t get our heads around it; we were eating it bite by bite, but every now and then we’d choke on it. Whereas, if we’d had a process to know that yeah we should have covered that off, yes we have covered that off. Some guidance at the beginning would have been useful for us because I think we’re both riddled by self doubt at times, Jane and I, so for someone to have even given us – challenge us like this – we were probably more than equal to the task, but we didn’t exactly know what the task was.
The second quote shows an understanding that without an organised implementation process, a vision remains a dream, and the planners and funders get frustrated in a disorganised process:

*I think the vision actually got signed off reasonably early, but I think that what happened was that I don’t think that we described the vision well enough; so even though they’d signed off on it, then questions popped up over that in the next few months, and I think that was why it looked like we had 18 months, but in fact, when you go back over, because remember I had that stack of papers, when they’d signed off on the original document it was in that first six months, and then we spent the rest of the time explaining it all to them, so they’d signed off on it and then we had to keep on going back and revisiting it, It was like what things were we going to do to operationalise that vision, that was the next little bit*

**Language confusion**

The need to work out if people do, in fact, give the same meanings to the words they use, and the usefulness of a process like the V-Model which brings up the issue of valid communication at the beginning of the development process, is supported by this quote from the DHB HOP portfolio manager:

*And I think there’s so much happening, I think we’ve all become aware that we have conversations like that one with the palliative care people the other day, when we sat in that room and everything starts off a bit tense and then in the end it was discovered that, in fact, we were all saying the same things; we were all wanting the same things in terms of outcomes, but we were using different language in terms of how we were going to get there. So at the end of the day, everybody breathed a sigh of relief; it took us a while to get there, so we talked in some ways that would help us do that without going through the angst, because sometimes that tension is a bit of a negative.*

There was in DHB C agreement with the results achieved with DHB A and DHB B. This was particularly clear when considering the changes to the V-Model.

**Setting timeframes**

One DHB C planner and funder voiced well the confusion about how to determine time frames:

*We set the milestones and the target at the beginning, and then we tweak them as we go along. Originally, I think our boss said six to twelve months for this project and we said no, we won’t get this done. It’s a big project. I think we should put two years
on it and then that got… it was 18 months. We put the contracts in for 18 months. We agreed that we would need at least 18 months and then probably a 6 month implementation phase beyond that. However, that got stretched as we got a bit wiser; but I think in terms of the review stuff taking 18 months, that’s basically what it took us. We haven’t had a robust method for determining timeframes really.

Professional presentation

Although the DHB C planning and funding team liked the journey metaphor that was used in the revised V-Model, they felt uncomfortable with using it within the DHB. This meant they had no issues with using it with the communities they worked with, but thought that it did not present a professional image if they were to use it when presenting planning documents or reports to the internal DHB committees:

I want to use this in my reporting to DSAC and the Board, but the COO [Chief Operating Officer] is an accountant – he won’t cope with this journey stuff.

You know we have to talk to medics and CEOs about this. It needs to be a bit more serious in the language it uses. Simple, but not able to be seen as flighty.

The V-Model diagram was therefore further revised (Figure 17), keeping the journey metaphor in the title but utilising a story-telling metaphor in the language for each step.
Chapter 5: Results

Figure 17: The V-Model revised for DHB professional use

What happens next?

The one-page representation of the HOP Strategy developed in DHB B (Figure 5-4) still left people wondering what to do next.

*We’ve been thinking about this since the (HOP) Strategy came out. We’ve had so many meetings. We try things, and I hoped meeting with you would help, but I look at the diagrams and I still don’t know what to do.* (DHB HOP Portfolio manager)

*I’ve got to get the providers on track. And we talk about the HOP Strategy, look at all the documents, and still aren’t clear. Those boxes of yours are good, but you have to really concentrate to get it. What about the providers?* (DHB contract manager)

While in DHB C there were no changes suggested to the critical success factors, there was real interest in the idea of having four key performance areas as a way of simplifying discussion with all stakeholders about what was being developed and why. At one stage while looking at both the one page representation of the HOP Strategy and the management scorecard with its 13 critical success factors, the contact manager suggested that it would be good if the two diagrams were more clearly linked. She also made the observation that the four key performance areas
sort of related’ to the bottom section of the one-page representation that related to services, “...delivered through effective, efficient, sustainable services based in primary care, for both urban and rural populations.”

The ‘effective, efficient, sustainable’ bit is what interests us. That's what we want to figure out. The other bit we know about – it's like a mission statement. But what does the service have to look like?

Four ‘Supported by’ factors were added to the bottom of the one-page HOP representation, as performance areas that implementation should focus on. This fits with if-then thinking from the RBLM, because if these ‘Supported by’ factors are key performance areas, then critical success factors for those areas should be put into a performance management system, measured, and monitored.

As a result, what was presented to the national focus group of DHB HOP Portfolio managers had four factors at the bottom that supported the implementation (Figure 18). These do not exactly relate to the Key Performance areas in the management scorecard (Figure 15), because with their home care providers DHB C wanted to highlight their concern about their sustainability. However, all four balanced scorecard perspectives of the management scorecard are incorporated in these four factors. The difference between the two illustrates the way in which sense-making (Sharig 1998) means that the way in which things are presented has to change for the audience. One DHB C planner and funder was clear:

I would like to have less providers. Two of them are too small to manage this new approach. But due process and all that. We can't be seen to be trying to get rid of anyone.

From her perspective, the HOP Strategy one-page representation had to provide a sense of both purpose and security for home care providers. The management scorecard should take inspection of what the four ‘supported by’ factors meant all the way down to an operational level, with a focus on what was possible and most relevant in the context of place and time. It was from this discussion in DHB C that it was decided to take a more general approach to describing the four ‘Support by’ factors in the one-page representation, and to stay with the management scorecard key performance areas.
Focus Group with DHB Health of Older People

Portfolio Managers

On 18 September 2007, 20 DHB HOP portfolio managers met in Wellington. At the request of the researcher (supported by the service development manager for District Health Board New Zealand [DHBNZ], a national support agency of DHBs), one of the items on the agenda was a focus group discussion to seek a national approach for implementation of the HOP Strategy. A detailed written record was kept of the session as not all participants agreed to audio recording. The researcher presented the one-page representation of the HOP Strategy as well as the 13 CSFs in the management scorecard. This was an opportunity to test the generalisability of the outcome from the three involved DHBs to other DHBs. The presentation to the focus group focused on both the validity of the one-page representation of the HOP Strategy; and the management scorecard comprising four key performance areas and

<table>
<thead>
<tr>
<th>LONG-TERM OUTCOME SOUGHT FOR OLDER PEOPLE</th>
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<tbody>
<tr>
<td>The well being, health and function of people are maximised so they can be as independent as possible and participate in society to their fullest ability</td>
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<tr>
<th>THROUGH THE PROVISION OF</th>
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<tr>
<td>A responsive restorative / recovery focused integrated continuum of care across all health and support services that provides people and their family and whanau with the right support in the right place at the right time, while ensuring equity of access and outcomes</td>
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<tr>
<th>ACHIEVED BY ENSURING THE FOLLOWING CAPABILITIES ARE IN PLACE:</th>
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<tbody>
<tr>
<td>Clients’ goals and needs are assessed, and both drive the support that is put in place</td>
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<tr>
<td>There is a focus on assisting client independence &amp; participation through maximising health &amp; function</td>
</tr>
<tr>
<td>Informal carer and social supports for the client are supported and if possible enhanced</td>
</tr>
<tr>
<td>Support is solution focused, responsive and flexible</td>
</tr>
<tr>
<td>Support is integrated and co-ordinated</td>
</tr>
</tbody>
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Supported by
- Support is driven by the goals and needs of clients and their families
- A workforce that is capable, stable and sufficient
- Providers that have management, financial, and workforce capacity
- Services that are cost-effective

Figure 18: The one page representation of the HOP Strategy at the end of work with DHB C
13 CSFs that had been developed from work with the three DHBs. The written records were later analysed to identify key themes using a general inductive method of enquiry as described in Chapter IV. Three key themes emerged: agreement with the one-page representation of the HOP Strategy, issues with developing a national approach, and agreement that the management scorecard using critical success factors might work as a method for national discussion.

The HOP Strategy
The one-page representation of the HOP Strategy was endorsed as a useful tool for identifying what the strategy meant. This endorsement was shown by agreement that it be used in a document to go forward to DHB General Managers seeking agreement for a national process for implementation of the Strategy.

A national approach
At the same time that there was agreement with proposing a national approach, people were doubtful it would be approved. Although people were clear they wanted to meet to share ideas and support, no one could identify a systematic approach to developing a national work programme that would satisfy DHB General Managers of the need for such national collaboration. Certainly people thought they would not get funding for regular national meetings:

\[I \text{ talk to other HOP portfolio managers on the phone a lot. We have a regional phone meeting every month. But a national meeting – this will be the last I think.}\]

\[The \text{ budgets are a bit dire. I won’t be able to travel up here again, I don’t think}\]

While the HOP Portfolio managers expressed a wish to have a regular dialogue with each other about who was doing what, how they were doing, what was working, what wasn’t, etc., there was no agreement on how to develop national approaches to work that would suit everyone.

The management scorecard with critical success factors
The management scorecard and the one-page representation of the HOP Strategy, were accepted as being useful tools to explain what needed to be operationalised to other stakeholders, such as General Managers. It was also agreed that they presented
a possible framework for sharing ideas and identifying common issues. It was accepted that exploring their DHB’s progress on each of the thirteen critical success factors would provide a common focus for the sharing of information and discussion. This was seen as a necessary condition for national processes, but it was thought that such processes would have to develop in an ad hoc rather than an organised fashion.

Despite this uncertainty, the group agreed that the management scorecard be used in a proposal to DHB General Managers attempting to get agreement to the funding of a national process for sharing information and developing national approaches. A proposal was put to the DHB General Managers through DHBNZ, but unfortunately it was not accepted. No nationally consistent process for implementation of the HOP Strategy, or for DHB planners and funders to share information and avoid duplication of effort has been put in place.

Throughout the work with all three DHBs and the national HOP meeting, a recurring key theme concerned the need for a national approach both in the sharing of appropriate data but also in the implementation of a consistent model of community services for older people. The development of the 13 CSFs aligned to the four performance areas within the management scorecard lent itself to the emergence of a benchmarking process. The final stage in the development and testing of the implementation framework was the delivery of the benchmarking tool, the Informing Networks Towards Optimising Utilisation of Community Health (IN-TOUCH) programme which occurred across five DHBs. IN-TOUCH concerned the collection of information on multiple factors in order to provide DHBs with information on the quality of their new home care services for older people. This is reported next in the final section of the results chapter.
Section 2: Phase 2 Informing Networks Towards Optimising Utilisation of Community Health (IN-TOUCH)

5.6 Introduction

The IN-TOUCH benchmarking programme was the final stage of the development of the implementation pathway. The planning and implementation process is taken beyond the left hand intent side of the V-Model and institutes ongoing assessment of how well the new service model is being implemented and what outcomes are being achieved, the right hand side. It provides corroboration for planning and funding managers and home care providers of the extent to which services are delivering what is required in order to achieve the vision or purpose those services are for. The IN-TOUCH benchmarking programme identified and collected technical data that could be used within DHBs to triangulate with the personal and social worlds of stakeholders as they discussed the success of implementation and quality improvements that were needed. This section explores the development of performance measures for IN-TOUCH, issues with data collection and how the data from IN-TOUCH was reported to DHBs. Finally, the section reports on the focus group held with the planning and funding managers involved in the IN-TOUCH programme, which explored the relative perceived usefulness of the IN-TOUCH programme. As described in Chapter III, data were collected every three months and a report generated at six months to provide information concerning the performance within each DHB in terms of the CSFs. The four balanced scorecard perspectives were termed key performance areas for IN-TOUCH as this language made sense for stakeholders in the context of performance management and measurement.

Well, I have my own perspective on things. They’re not really perspectives are they? They’re more aspects you want us to perform well in. (Home care provider)
5.7 Collecting data about the critical success factors

The data collection for IN-TOUCH was organised around the CSFs, in that each factor was broadly represented by some level of data. The performance measurement framework was structured on the basis that the four key performance areas and associated CSFs would lead to achievement of the vision, ‘Older people’s independence and participation in society is maximised.’ This section outlines the process for identification of the appropriate data collects, not the actual results; significantly, this thesis concerns more the process of the development of IN-TOUCH rather than the report per se. Appendix 3 presents the full description of the data collects for each of the CSFs and for purposes of completeness, the IN-TOUCH report can be viewed in Appendix 6.

5.7.1 Key Performance Area: Client and family driven services

Informal carers are involved and supported
Research repeatedly points to the significance of the carer in supporting older people with disabilities in the community, which has been supported throughout this thesis. Wherever a carer was involved in the care of a client, they had their own specific needs assessed. For some carers, it was considered clinically important for them to undergo regular reviews using the Caregiver Reaction Assessment and this was undertaken by the home care coordinators. However, it was based on clinical judgement and was not routine. Given the standardised approach to this, it was considered not possible to routinely collect this information as part of the IN-TOUCH programme. Formalising an additional assessment of carers using the Caregiver Reaction Assessment for all clients of the restorative home care model was regarded as non-acceptable by NASC and home care providers:

\[\text{Look, it's the thing I think we should do much better and if we did it would make a major difference, but (exclamation), we don't have a (exclamation) show. Let's start with the possible. (DHB planner and funder)}\]

Clients’ needs are assessed and influence service and support plans
The measures chosen to indicate achievement of this CSF were the size of the package of care and the input of allied health into that package; in other words, the
number of hours of input a client would receive per week from the home care provider in terms of support worker hours, coordinator hours and allied health. In addition to the baseline assessment, three monthly client reviews were expected to be conducted involving goal facilitation, assessment of needs and quality checks. In the IN-TOUCH report (Appendix 6), these areas are reported on in Figures 2 to 8 and Table 1.

5.7.2 Key Performance Area: Effective and efficient services

Client support is coordinated / care managed
Pragmatically determining whether this aspect was achieved or not is always difficult. However, given that there was an expectation that clients would be actively care managed on an ongoing basis by the home care coordinator, IN-TOUCH involved the collection of data both around the available time coordinators had to spend with clients (In the IN-TOUCH report, Appendix 6, Figure 17) and probably more definitively, the ratio of coordinators to clients (Appendix 6, Figures 18 and 19).

Public information supports the approach
Funders and planners were interviewed as part of the IN-TOUCH process and questions relating to media use were included. In addition, the direct client interviews involved gathering information around aspects of their knowledge regarding media and public information (Appendix 6, page 21).

Services are responsive and flexible
Responsiveness and flexibility concerns pragmatically both the delays in receiving services but more significantly providing appropriate responses to changing client needs. Delays in allied health referral were monitored as too were any delays in accessing home care services following NASC assessment (Appendix 5, Table 1). More significantly, given that an absence of client review would make responding to client need changes almost impossible, actual home care reviews were assessed against the standard three monthly review requirements (Figures 10 to 13)
All parties receive all information needed for a support plan to be developed and implemented

Previous policy prior to the trailing of the IN-TOUCH programme was for limited flow through of assessment details from NASC to the home care provider. This was due in part to the lack of trust between the NASC service and provider. Interestingly, discussion repeatedly focussed on this, as evident below:

X doesn’t get on with the NASC manager. He will just withhold info, or say he will send it. But it won’t happen. (DHB planner and funder)

They don’t want the other providers to know how they are doing. They might deal with Y [the NASC manager], they trust her but it will be hard. (DHB planner and funder)

The NASC just won’t give us all the referral information. They seem to see us as either competition or not as good as them. I think the latter; they see themselves as professional and us as support workers. (Home care provider manager).

Consequently, both the flow through of information to providers was captured in IN-TOUCH as too the relationship between the NASC worker and home care coordinator (Appendix 6, Figures 20 to 32).

Client’s goals are assessed, set, and aimed for in a service plan

The measures for this CSF attempted to ascertain specificity by assessing the goals against the International Classification of Functioning (ICF) criteria as well as measuring whether the distal and proximal goals were SMART (specific, measurable, attainable or achievable, realistic, and timely). Questions were also asked of clients concerning whether they believed that their wishes and desires had been adequately explored and valued through a goal orientated manner. The IN-TOUCH results are reported in Appendix 6, Tables 2 to 4 and Figures 9 to 13.

12 The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. These domains are classified from body, individual, and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individual’s functioning and disability occurs in a context, the ICF also includes a list of environmental factors.
5.7.3 Key Performance Area: A skilled, stable workforce

Workers feel valued

The measure chosen as an indicator of whether workers felt valued was the stability of the workforce. The turnover of the home care workforce in New Zealand had been previously reported as high, ranging from 39 percent (Parsons, Dixon et al. 2004) to 49 percent (King, Parsons et al. in press). Reducing this turnover rate was identified as a key indicator of progress in helping home care workers regard the work as worth staying with. Workforce stability is reported on for IN-TOUCH in Appendix 6, Table 8 and Figures 47 and 48.

Workers are trained and assisted to become skilled

The frequency of assessment of support worker competence (Appendix 6, Figure 53) was measured on the assumption that assessment indicated some check of quality and some commitment by the provider to assist support workers to gain and maintain a standard. For DHB planners and funders, this was regarded as a more sound measure than simply asking about training because it was difficult to measure how many support workers actually attended training sessions. On the same basis, coordinators were asked to indicate how often they met on a one-to-one basis with support workers (Appendix 6, Figure 54). This measure does not indicate the quality of the meeting, but the fact that meetings occur was measured as an indicator due to concerns that many support workers operated in isolation from any support system (Parsons, Dixon et al. 2004). Home care coordinators were asked to report on the main reasons a joint visit would take place (Appendix 6, Figure 51) as a measure of whether or not support workers were being supervised. This was regarded as being an essential part of a training programme, alongside attending a training programme based on restorative principles that had been developed for support workers by the Industry Training Organisation, CareerForce. Home care managers were asked to report how many of their support workers were trained to Foundation Level II and what percent this was of their total workforce (Appendix 6, Table 7).
Workers are adequately remunerated

The measures for remuneration were hourly rates and the extent to which guaranteed hours\(^{13}\) were being implemented for support workers (Appendix 6, Figure 50). Hourly rates could be compared to the minimum wage and health professional rates of pay as a proxy for whether this workforce was being treated as an untrained workforce (support workers) or as of less professional status than hospital health professionals (Co-ordinators) (Appendix 6, Figures 55 and 56).

5.7.4 Key Performance Area: Funding that is appropriate and applied cost-effectively

Funding is cost-effective

Coordinator caseload and complexity was chosen as a performance measure because there was a real uncertainty relating to what an efficient case load was:

*That provider has about 700 clients per coordinator following the old task-driven model. The one that has been working following a restorative model for a while seems to have about 1 coordinator to 150 clients. That’s a hell of a difference. Can we afford that?* (DHB planner and funder)

*We’re putting money into this you know, on top of what we’re being paid. I don’t know how long we can do that for, but at the moment we seem to have to to make it work. I think if we could get to 250 clients per coordinator, it might fit the funding, but will the model work then?* (The home care provider (a not-for-profit) that was working on a 1 to 150 ratio)

The number of complex and non complex clients per home care coordinator varied significantly across home care providers (Appendix 6, Figures 18 and 19). This variation makes it difficult to show a true indication of coordinator caseload and complexity. DHB planners and funders wanted some certainty in identifying good practice in terms of caseload, which meant that they wanted investigation and discussion, exactly what the IN-TOUCH benchmarking process was designed for. Case Mix refers to the percentage of complex versus non-complex clients. The

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\(^{13}\) Guaranteed hours for support workers could be either full time or part time and involve ‘salarying’ a support worker for a fixed number of hours per week irrespective of whether they actually see a client or not. It is a basic working condition that is invariably missing in the home care industry.
findings raise questions for DHB planners and funders about why their case mix might be different from other DHBs (for example, different age structure, more or less effective referral system, better functioning services so that clients improve and, therefore, no longer need as much service).

**Funding support for flexible packages of care**

In terms of managing budgets, planning and funding managers complained in particular about the fee-for-service model they had to use when approving payments to home care providers through the MoH funding service called HealthPAC:

*The system is a bloody nightmare. We have to say that we are approving two hours a week for a period, and then the provider can charge for two hours per week. They can’t do five hours a week for two weeks, reduce to four, go down to 1, and then when needed increase again. There is nothing flexible about it.*

*We juggle with the system. Actually, we try and avoid the fee-for-service by paying through the internal DHB system. But that is quite difficult to manage, and it means there is no national data being collected.*

NASC managers found the rigid payment system very difficult, as they had responsibility to manage the home care budget on behalf of the DHBs.

*We struggle enough to manage day-to-day operations, and then they want us to be flexible and not overspend. But sometimes we don’t get a budget report for three months. It is actually very hard to figure out what we are spending*

For services to be flexible, support workers needed to be able to sometimes travel to a client more than once a day. If travel costs were not covered, this reduced the ability to provide flexible, responsive care. As one home care provider noted:

*Support workers cannot afford the petrol… the DHB does not have sufficient budget to pay for all travel.*

**Funding supports training and supervision for workers**

A training programme was made available to staff from NASC and home care and the level at which this was taken up was monitored through IN-TOUCH. In addition, as previously stated, support worker engagement with CareerForce training programmes was measured.
In summary, for each CSF attempts were made to find performance measures that would indicate whether or not each critical success factor was being achieved. The measures selected were the best available at the time, given the issues involved in ensuring data collection was not too onerous given the already intense daily operational pressure on home care providers. The measures described above are, therefore, best regarded as works in progress. In the future, as IN-TOUCH continues, these performance measures need to be continually refined so that at all times the data being collected is meaningful to the stakeholders and adds to their understanding of the operation of the restorative home care model.

5.8 Discussion about IN-TOUCH

The development of critical success factors and performance measures presented above was intended to gain technical data that would enable triangulation with the personal and social worlds of stakeholders in home care services for older people. For this research, the issue was then to identify whether this information, and the process of getting the information and discussing it, was of use to the DHBs. A focus group was held with the DHB HOP portfolio managers of the DHBs involved in the IN-TOUCH programme. The topics discussed concerned the usefulness of the IN-TOUCH programme, both content and process as well as the IN-TOUCH report; any issues the managers had and what they wanted; and dissemination of the report information to other DHBs and to service providers. A series of themes emerged as outlined in Table 15.

Table 15: IN-TOUCH themes

<table>
<thead>
<tr>
<th>Number</th>
<th>Theme</th>
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<tbody>
<tr>
<td>1</td>
<td>Usefulness</td>
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<tr>
<td>2</td>
<td>Engagement with service providers</td>
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<tr>
<td>3</td>
<td>Presentation of data</td>
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<tr>
<td>4</td>
<td>Content</td>
</tr>
<tr>
<td>5</td>
<td>Peer review sessions</td>
</tr>
<tr>
<td>6</td>
<td>Benchmarking</td>
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5.8.1 Usefulness

Four out of five of the DHB planning and funding personnel found the IN-TOUCH benchmarking approach useful. These DHBs had difficult issues with relationships between home care providers, NASC and hospital health professionals. For them, they did not trust that the providers and other stakeholders shared the same vision or were totally honest in reporting difficulties. From their perspective, the ability to compare providers on some agreed performance measurement criteria was useful, not just to benchmark providers against each other and provide a mechanism for meaningful dialogue, but also to facilitate their reporting about these services to the DHB. The DHB planning and funding manager who did not find value in IN-TOUCH thought the information was too complicated, and he had little desire to compare the results of his DHB with others. His view was that it was easier to work alone. Interestingly, this DHB was the smallest of those involved, so perhaps had less complex issues to deal with, or stronger interpersonal relationships that enabled internal DHB resolution of issues. As the person from this DHB said:

*I can tell they [the NASC] are not performing well because of the complaints. I have told the NASC manager and her manager, we will sort it. I talk to the home care provider and we work around it.*

Three of the five stated that they would like IN-TOUCH to continue for their DHB. One said that they would like to continue with it again, but not at the moment. Their contracts with home care providers were nearing their end date and they were thinking of putting out a request-for-proposal for restorative-based home care to see if there were any new providers available or if they could remove one they were having trouble with. Some comments from those wishing to continue were:

*We’ve got two good providers, we think, one OK, and one we have strong doubts about. It’s so difficult to know for sure. This might help us sort out the issues, and either help the weaker ones to change, or help us move elsewhere.*

*There are so many factions, people not sure about this home care approach, treating it as though it must be a cost-cutting thing. Any information that helps show that it is good for older people – well, give it to me!* 

*We have these regional meetings and such, but it is very hard to compare actually. I mean, you try and get a sense of what they mean, and we assume we mean the same often, but*
sometimes I think their providers must be so much better than ours. And yet two of them are national providers. Surely there can’t be that much difference? It’s great to actually be able to compare

The DHB planning and funder who didn’t want to continue at all did say that he thought the process would be good for other DHBs starting out:

We’ve been doing this for a while now. And we’ve been able to restructure, and shuffle staff that were not good. Other DHBs I know will find it harder. It’s another way of sharing information, so I suppose that’s good.

Other DHBs have also seen the value in the IN-TOUCH benchmarking process, with two further DHBs becoming involved up to 2010.

5.8.2 Engagement with service providers

All three DHBs noted that engaging home care providers in the IN-TOUCH process in an ongoing way was difficult. While in every DHB home care providers had agreed to participate, there were always difficulties getting accurate data in on time. The operational difficulties home care providers face daily obviously makes regular data collection onerous. There were missing providers in the initial report due to a lack of returns from some providers. The report was, therefore, unable to provide a comprehensive snapshot for some DHBs. Ways of making the data collection process easier need to be found. One DHB was concerned that providers would not stick with the IN-TOUCH data collection process long-term, as it required effort at both a management and administrative level, with further development of the reporting process necessary to make the process meaningful to them:

These guys struggle with managing their day-to-day activities now, given the issues over finding staff, allocating staff to new clients, etc. Any extra reporting requirement is a big ask.

One suggested possible answer to this was aligning data collection points for IN-TOUCH with normal DHB reporting mechanisms. The idea was that IN-TOUCH reporting should match as much as possible reporting the providers had to do anyway as part of their contractual obligation. This could also start to build a national reporting system framework. In some DHBs, providers had some financial/contractual incentive to participate in the IN-TOUCH project as
involvement was written into their contract. In these DHBs, reporting for IN-TOUCH would meet the providers’ reporting requirements. In other DHBs, the providers participated simply by good will.

5.8.3 Presentation of data

The tables in the report drew positive feedback. There was, however, considerable confusion about what the information in them meant. It took considerable explanation from the researcher to explain each table to the DHBs. The DHBs were clear that they could not send the report as delivered out to service providers because it would not be understood or would be misunderstood. Even with a joint meeting to discuss the report, they felt that the information would not be sufficiently clear.

*Look, I can see that it is useful information after you’ve explained it to me. But on its own? I don’t know if I will still follow most of it when I look at it again.*

*There’s no way I’m giving this to providers. We’ve just had experience of them all misinterpreting the last report to the Board, and getting all snitch. They won’t follow this, well, probably X will, but not the others.*

The report needed to be changed into a format that was a more clear and transparent way of reporting for both the DHBs and the service providers. This has happened in later reports for IN-TOUCH, in which spider graphs have successfully been used to convey comparative information more clearly and concisely.

5.8.4 Content

The DHBs liked the information provided in the report. One DHB commented that the initial report was more comprehensive than they thought it would be. Some of the initial report provided general comments that were seen as insufficiently focused. There were suggestions that the issues with understanding what was reported to them would be assisted by the report being strictly focused around the 13 critical processes. All data being collected needed to be reviewed to ensure that it aligned with the 13 critical processes, and then the whole process and rationale needed to be talked through again with providers to get their engagement.
5.8.5 Peer review sessions

The general response was that peer review sessions of the IN-TOUCH data would be valuable. All DHBs were absolutely clear that there needed to be both presentation and explanation of data as well as delivering the report to providers. It was suggested that a Power Point presentation of the results be added to the report with people from The University of Auckland conducting face-to-face peer review sessions at each DHB with providers and NASC.

5.8.6 Benchmarking

In terms of dissemination of information, all five DHBs currently involved had requested each others’ DHB codes. Each DHB agreed that the initial report was not suitable for wider dissemination beyond the DHBs currently involved, as the project is still very much at a developmental stage with potential for misinterpretation of the results. The idea of more DHBs eventually being involved was regarded as worthwhile, but a framework for discussion of protocols between already involved DHBs and new DHBs needed to be developed.

5.9 Summary

The V-model, with its theoretical basis in Habermas’ Theory of Communicative Action, acted as the process map for this research. This meant that there had to be ‘the idea’, or what became termed during this project, ‘the vision’. This led to the development of the one-page representation of the Health of Older People Strategy, and also to the development of the performance management system. The V-Model process was something people in this project experienced through their discussions about the services they wanted to be involved with delivering or shaping. The themes and issues that arose during the focus groups confirmed that the implementation pathway, modelled on the V-Model approach and incorporating performance management and measurement, helped people make sense of the world they were in and identify what needed to happen to implement the new community health service model. The performance measurement system outcomes, key performance areas and 13 critical success factors form the basis of the IN-TOUCH benchmarking study. While IN-TOUCH confirmed the validity of the performance
measurement framework, it was only partially successful due to the limited availability of data for measures, variability in completeness of the data provided, and therefore difficulty in completing the report. Nonetheless, IN-TOUCH has continued and is still operating at the time of completion of this thesis, involving a further two DHBs. The implications from the results are discussed next in Chapter VI.
Chapter 6: Discussion

6.1 Introduction

Developing evidence-based services to meet a strategic need, and then successfully implementing those services, is difficult and resource intensive with no guarantee of success (Kennerly and Neely 2000; Krause 2003; Van Slyke 2005). There has been a great deal of thought and research into ways to assist those responsible for funding the development and implementation of new services to manage the process; no standard model has emerged that has been accepted across health services in New Zealand (Greve 2003; Kyro 2003; Niven 2003; Gabbay and Le May 2004; Cribb 2006; Schmidt, Bateman et al. 2006). This thesis developed an implementation pathway to guide and facilitate the process of developing health services designed to deliver specific outcomes. The pathway was developed using community home care services for older people as an example of a new service model that requires a paradigm shift from existing service models (Tinetti, Baker et al. 2002; Parsons, Anderson et al. 2006). A two-phase process was used to address the research questions:

1. To what extent is it possible to develop a common vision for community home care services for older people?
2. What are the critical success factors that would support the achievement of the common vision?
3. Was the implementation pathway and performance management system developed in this research project accepted by the sector?

This discussion chapter interprets the results presented in Chapter 5 in light of the existing literature. The chapter is organised into three sections. The first addresses the research questions directly. The second highlights specific areas of interest that arise from exploring the themes raised in the results. The third section presents the limitations of the study, avenues for further research, policy implications and conclusions.
Section 1: The research questions

6.2 To what extent is it possible to develop a common vision for community home care services for older people?

The HOP Strategy (Ministry of Health 2002) provided a vision for services for older people in New Zealand. This vision included the development of services in the community to support the concept of ageing-in-place (Ministry for Social Development 2001). In the sense that the V-Model calls for a common vision, there is a policy imperative in New Zealand that is a government-prescribed ‘common’ vision. Following the concepts proposed in the levers of control (Simons 1994; Simons 1995), the issue is whether this common vision is shared by the people who are involved in developing and implementing home care services. Differences in beliefs between different groups of stakeholders are important, because both clients and workforce have to believe in the common vision at an operational level for the vision to be effectively achieved. Belief at a management and/or conceptual level, but not at an operational level, is insufficient. This thesis developed a process in which service development was driven by a vision that all stakeholders shared. By involving participants in a communication process to develop a common vision, valid communication occurred through the sharing of the personal world, the social world, and the technical world, as shown by the results in Chapter 5. These show that developing a common vision that is understood and agreed to by all the stakeholders in service development is possible, although difficult.

Vision statements tend to be broad and general. Obtaining agreement from stakeholders at a conceptual level is, therefore, about gaining acceptance to the principles and general tenets of the vision. Moving beyond acceptance of principles and concepts means moving to more detail, and starting to identify actions that are needed to achieve the vision. The DHB HOP planning and funding managers present at the final focus group in Phase 1 accepted the one-page representation of the HOP Strategy as an accurate depiction of what the HOP Strategy aimed to achieve: the wellbeing and independence of older people. They also agreed that it
presented the major service elements that would need to be functioning well if the main intended outcome of the HOP Strategy was to be realised. These service elements became the key performance areas in the management scorecard.

This agreement was reached through consensus, which does not give information about whether all people involved in the consensus decision actually believed in and agreed with that decision (Jones and Hunter 1995). Consensus models do not suppose that every person involved in the consensus has a passionate belief in what has been agreed to. Some people could have decided they had little energy to oppose the proposition being discussed, either because they perceived sufficient people were against them to make argument futile, or because they just did not care. However, in this research, the DHB HOP planning and funding managers agreed with the detail of the HOP Strategy in the one-page representation plus the management scorecard with the list of critical success factors (CSFs). The CSFs represented operational aspects that could be measured; the consensus agreement on the four key performance areas and the 13 CSFs is evidence of belief by each DHB HOP planning and funding manager that acceptable performance in each of the 13 CSFs would lead to achievement of the goal of the HOP Strategy. This agreement was also not passive, because there was a possibility that the CSFs might be applied to their DHB if the proposed national approach to HOP Strategy implementation (mentioned in Chapter IV) proceeded.

In real life though, the implementation of a strategy does not depend solely on people at a management level. In home care services, the actual operational activities are performed by workers who have direct contact with clients, and often work in the clients’ homes without direct supervision. To get workers to operate according to a vision, managers have to act as leaders who engage the workforce in the vision (Fixsen, Naoom et al. 2005; Pye 2005). One of the key issues found in this research is the difficulty, and importance, of getting the direct contact workforce to understand the purpose of their work. Simons (1994) postulated that in situations where workers cannot be supervised or monitored at all times, a useful quality control mechanism would be to get those workers to believe in the goals and approach of the service. The hypothesis is that if the workforce believes in operating
the way management wants them to, then they will do so of their own accord. This research shows that the key issue in implementing a successful restorative home care service is that the different stakeholder groups all focus on an agreed outcome.

The degree of contact with consumers determines the actual beliefs that are necessary within each stakeholder group. For HOP planning and funding managers who have little direct contact with consumers, agreement with the management scorecard and its CSFs did not necessarily mean they believed in the goals of the HOP Strategy; it did mean they believed that the goals would be achieved if the CSFs were in place. Implementation is what each manager’s performance is measured by, so agreeing to the CSFs is a proxy for belief that implementing the HOP Strategy is important to them; this belief is sufficient to act as a lever of control. The managers do not need to believe in the HOP Strategy itself, but they must believe that implementing the HOP Strategy is what is required by their management and Board. When the HOP planning and funding managers agreed to the CSFs, it also showed belief in the logic of the development method, and that by following this approach and striving for success against these measures the desired outcome should be achieved.

Other stakeholder groups who have a more intensive level of day-to-day contact with clients, as well as accountability requirements to DHBs, are more likely to interpret the meaning of the HOP Strategy in terms of day-to-day operations. There is a risk that for home care providers, at both management and direct client contact levels, agreement with the HOP Strategy was a case of agreeing with people in positions of power to avoid conflict. The common belief or understanding required for successful implementation has different nuances between DHB HOP Planning and funding managers, home care providers, and Needs Assessment and Service Coordination (NASC) services dependent on their roles and power relationships (Cribb 2006).

This research showed that HOP planning and funding managers felt uncertain about what to do; this made it difficult for them to take a leadership role (Pye 2005). They were pressured by the MoH to deliver according to the HOP Strategy, but did not
feel supported by them. They were keen to share information with other DHBs about what might work, and the Informing Networks Towards Optimising Understanding of Community Health (IN-TOUCH) process provided a mechanism whereby involved managers could work from a common understanding when meeting either formally or informally. Furthermore reaching agreement on meaning may not prove to be too difficult a process in a situation where people have similar jobs and responsibilities within a public service. They are used to reading Government and DHB documents and then working out what they might mean in terms of requirements for service delivery. This is not the case for other stakeholders who actually deliver home care services to older people: home care managers, co-ordinators or care workers.

The relationship between the MoH, DHB HOP planning and funding managers, and then home care managers and care workers is a good example of the recursive systems presented in the Viable Systems Model (Espejo and Gill 1997). At each level, there is a mix of policy and operations, with each level needing to be linked to the next in order for strategy to become successfully implemented operationally. Each level needs to understand policy in its own terms, which means it needs to interpret the policy handed down to it from other levels of the network (e.g. the DHBs interpreting MoH policy, the home care providers interpreting DHB contracts). This may be a partial explanation for why it is so difficult to actually achieve successful implementation even when there is what appears to be a shared belief. Home care managers were clear that their key driver was to shape their service delivery to meet the funding available. While they were amenable to the goals of the HOP Strategy, and some of them may have really believed in it, their main driver was actually financial. While HOP planning and funding managers also have a financial driver to ensure cost-effective service delivery, another driver for them is the ideology of the Government and the DHB, in this case represented by the HOP Strategy and supported within DHBs by the Disability Services Advisory Committees. The HOP Strategy vision is, therefore, a key accountability driver for DHB planners and funders; it may not be for NASC and home care workers.
These different levels that each stakeholder has within the home care service network (MoH policy, DHB policy and funding, home care provider policy, and operations) also demonstrate that one obstacle in gaining a common understanding of what a vision means in operational terms may be a combination of context and education. HOP planning and funding managers operate within a national and DHB policy framework, and are expected to be well educated about government policy and processes. Home care and Needs Assessment Service Coordination (NASC) personnel work in a day-to-day operational service delivery context, and may have clinical and operational training, but little education in policy and government. The field of vision or lens through which the world is viewed is different for each stakeholder group.

However, home care and NASC are also driven by the need to maintain a good relationship with the DHB from whom they receive the funding for the services they deliver. If the DHB does not approve of what the NASC or home care personnel communicate about their beliefs and intentions for the services they offer, they may renegotiate or not renew contracts. It is, therefore, harder to establish what the NASC and home care workforce actually believe, because there is a risk they will say whatever the HOP planning and funding manager wants to hear.

In fact, the results strongly suggest there is indeed a gap between what HOP planning and funding managers are told when negotiating and monitoring service contracts, and the belief system operating within NASC or home care. An example is the belief expressed in the HOP Strategy that older people need to remain in control, and that health services can best support this by listening to older people about what they want to achieve over the rest of their lives, and shape the offered services around those goals. For the home care and NASC workforce, a belief in the goal of assisting older people to remain in control of their own lives is important because it has a direct influence on how they work day to day with the ones who are their clients. However, the results from IN-TOUCH reveal that goal-setting practice is highly variable, with only 38 percent of clients saying they had set goals, and with the SMART average score being only 56 percent. This suggests that some NASC and home care coordinators pay lip service to the idea of older people being in
charge, but actually believe they already know what older people want, to remain at home, and therefore they work through the goal-setting process quickly to organise the delivery of standardised rather than individualised services.

As mentioned above, the extent of involvement in day-to-day service delivery may impact on what belief in the HOP Strategy vision means. There were no interviews or meetings with the home care workforce in this research, so it is difficult to be certain what beliefs home care workers had about how they should react with older people. However, the results from the IN-TOUCH programme show that only 32 percent of home care coordinators had team meetings with home care workers every two weeks, and only twenty-one percent of home care workers had a six-monthly competency assessment. Coordinators met with only thirty-five percent of home care workers one-to-one every week, and often on an informal basis. Very few home care workers had received CareerForce Level 2 training. Since these are indicators of CSFs 8 and 9 under the Key Performance Area: A skilled stable workforce, these results cast serious doubt about the ability of home care providers to deliver the required outcomes. Given the research (Jorgensen, Parsons et al. 2009), it is probable that if one asked home care coordinators, they would say they would prefer to meet with all home care workers individually and in teams regularly, and to have every worker’s competency assessed. However, the Parsons et al. (2004) workforce report clearly shows that operational pressures (i.e. trying to replace sick workers) overtake good intentions. The majority of home care workers in this research were poorly trained and poorly supervised. Even if the home care coordinators believed in the restorative model, the realities of daily operations means this belief may not have been translated to a change in support worker practice; i.e. workers no longer do everything for the client, but instead help the client to do things for themselves, all the while being driven by the client’s goals.

In summary, all levels of management from DHBs to home care providers accepted the one-page representation of the HOP Strategy as a true representation of that strategy. This showed that there was a common belief that the HOP Strategy was the ‘intent’, Step 1 of the V-Model. The extent to which this belief moved beyond agreement at the level of the principles and concepts in the HOP Strategy to
agreement on what implementation meant at an operational level, however, was not clear. Instead, there was support for the concept presented in Habermas’ Theory of Communicative Action: having a shared vision and a shared understanding may be different things. In terms of the research question, the answer is yes; achieving a common vision is possible at both conceptual and operational levels. However, at operational levels, it is harder to judge if there is actual agreement because implementation of change is so difficult. It is problematic to assess whether workers who communicate agreement and then do not deliver actions that match that agreement have been agreeing simply to ensure there is no conflict with people at different levels of the network, or if it is a case of the usual difficulties in actually changing behaviour to fit a new paradigm (Lucey 2008). This shows that there is a need for an implementation pathway linked with a performance measurement system so that those responsible for developing and implementing new services can track issues key stakeholders may have with the service, and intervene when necessary to reaffirm and regain commitment to the vision and the steps to achieve that vision.

6.3 What are the critical success factors that would support the achievement of the common vision?

A major outcome of this research was achieving agreement on four key performance areas as perspectives of a balanced scorecard, plus the 13 CSFs agreed on by the end of Phase 1 as being important in determining whether a home care service for older people was operating according to the principles and intent of the HOP Strategy. Having too many success factors and measures has been shown to be detrimental to the implementation of performance management and measurement (Aday, Begley et al. 1998; Green, Kagolovsky et al. 2000; Coleman, Smith et al. 2002; Pineno 2002). Having a smaller number of CSFs, in this case 13, increases the likelihood that they are truly part of the story or sense-making process (Weick 1995).

The V-model process was effective in engaging people in a discussion where technical data were triangulated with personal and social worlds. This was confirmed by acceptance of four key performance areas that were renamed to fit the perceptions of stakeholders regarding the purpose of each balanced scorecard perspective, and the reduction to 13 CSFs from the more than 40 discussed in DHB
Chapter 6: Discussion

A and B. The gradual change in the number of factors in the research, and the renaming of the perspectives, showed that people engaged with the discussion, and disagreed when they believed something had little value or was misleading. The V-Model implementation approach that linked the vision with CFSs worked as a method to encourage people to discuss what the vision actually meant in terms of the actions needed to achieve it.

6.4 Was the implementation pathway to incorporate a performance management system developed in this research project accepted by the sector?

The results from Chapter 5 and subsequent continuation of the IN-TOUCH benchmarking programme provide evidence that the implementation pathway and performance system was accepted. From a Habermasian perspective, the engagement of DHBs in the IN-TOUCH benchmarking process is data from the technical world. In the social world, DHB HOP planning and funding managers may have engaged in dialogue in which they agreed with a view that involvement was a good thing. If they had then chosen not to involve their DHB, it would provide data that, perhaps, their social world view was not congruent with their personal world view. There also may be other factors that would prevent involvement, such as their DHB refused funding or was not ready to develop a new approach to home carer service. However, lack of involvement enables dialogue about the cause of non-involvement, while involvement suggests that the DHB HOP planning and funding managers had a personal world agreement with the approach that matched what they presented in the social world.

Interestingly, on completion of this research a further three DHBs contracted for ongoing involvement with IN-TOUCH. This suggests that DHB HOP planning and funding managers in the involved DHBs considered IN-TOUCH to be sufficiently useful to them that they put forward business cases to their DHBs and obtained a commitment for the necessary time and resources for involvement. While research of this type can never establish causality, ongoing involvement by people who need to manage time and resources carefully would tend to confirm they perceive the value.
Underlying the comments from DHB planners and funders concerning usefulness is a suggestion that what may have been most helpful was the systematic approach to management of a development process. The planners and funders’ task was to deliver the HOP Strategy, part of which depended on the development of new approaches to home care. They needed to be able to report on progress to their managers and Board; that is, they had accountability requirements. With the implementation pathway and IN-TOUCH benchmarking approach, planners and funders felt they could show that they were doing what was required in a systematic manner through following the Triple V Implementation Pathway.

However, doing something systematically in the short-term is different from its ongoing consistent application. Research shows that implementing change is a long and often extremely difficult process (Fixsen, Naoom et al. 2005). Achieving agreement at a national focus group meeting is clearly different to accomplishing operational change at a provider level through the three phases of the Triple V Implementation Pathway. This means there are two aspects to the usefulness question. The first has been answered: planners and funders found the process developed was useful as they set up new community services for older people. The second aspect of the question is whether the process is useful over time so that it continues to be used even when in the third, business as usual, stage of the Triple V Implementation Pathway.

There are at least two factors that are necessary to enable a process to be useful over time. The first is that it must provide something that the people who use it want. The second is that it must be constructed sufficiently well that, operationally, it can withstand all the demands made on it. In the Methodology chapter, a number of issues were raised that successful implementation, performance management and measurement, and evaluation systems had to satisfactorily respond to if they were to be successful. These issues revealed that implementation, performance management, and evaluation are a Pandora’s Box. How the implementation pathway and performance management and measurement system developed in this research responded to those issues is reported next.
6.5 Implementation, performance management, measurement and evaluation

The Law of Unintended Consequences states that any intervention in a complex system, such as the one home care services for older people operate in, may or may not have the intended result, but will inevitably create unanticipated and possibly undesirable outcomes (Norton 2008). An analysis of the possible causes of unintended consequences is postulated as i) error, ii) ignorance, iii) immediacy of interest, iv) basic values, and v) self-defeating prediction (Merton 1976). A methodical approach to health service development and implementation such as the Triple V Implementation Pathway and the IN-TOUCH benchmarking programme addresses each of Merton’s causes of unintended consequences as follows:

1. Using an implementation pathway that includes performance management enables errors to be identified early;

2. Using a communication process that engages people in discussion about what the vision is, and what it means in operational terms, increases the validity of their communication; done well, this would hopefully lead to a reduction in ignorance;

3. By establishing a discussion framework and ongoing benchmarking approach, immediacy of interest (defined by Merton as instances in which someone wants the intended consequence of an action so much that he or she purposefully chooses to ignore any unintended effects) can be controlled to some extent, because the person has to be accountable for what is happening with other people;

4. When it comes to looking at basic values, Merton postulated that when a system of basic values leads to a belief that certain specific actions are required, people can become concerned not with the impact of those actions, but only in having the satisfaction of knowing they have performed their roles well (Zingerle 1998). However, if the idea of basic values is combined with an ongoing focus on intent and how intent relates to the action taken, as in the Triple V Implementation Pathway and IN-TOUCH benchmarking programme, a consistent mechanism for an ongoing reality check is in place. Step 5 of the Triple V Implementation Pathway requires people to explore whether the results they are achieving match with what they expected; they cannot just get by with getting one hundred percent application of the action plan (Step 4); and

5. The last aspect of Merton’s causes, self-defeating prediction, refers to instances in which public prediction of a social development proves false precisely because the prediction changes the course of history; for instance, when predictions of world starvation at the beginning of the twentieth century led to the development of new methods of food production. The Triple V Implementation Pathway and
IN-TOUCH benchmarking programme probably have no impact here. An example of where this concept might be correct is if the prediction of a major dementia crisis from an ageing population leads to a vaccine or cure.

The key issues with unintended consequences are that they can be either positive or negative, and they do occur. This means that any manager or stakeholder needs to be aware of the bigger picture beyond the day-to-day operational detail. The Triple V Implementation Pathway helps ensure that in developing the vision of a service and its action plan, a total stakeholder and research based view is considered. The IN-TOUCH benchmarking programme helps ensure that the information considered to be important is measured, and that there is then discussion on what the data means. While this cannot ensure that ‘group think’ does not occur, or that unintended consequences are not ignored, at least a systematic process for discussion and valid communication is put in place.

Ideally, an implementation pathway and performance management system would be useful over time, because it assists people to observe and make sense of observations. The design should have considered the management of all processes and outcomes, wanted or unwanted, foreseen or a surprise. The management of unintended consequences then depends largely on the observational competencies and intelligence of those involved. In the literature review some key factors were found that needed to be successfully addressed in order for an implementation pathway to be useful – and used. The way in which this research addressed these key factors in the design of the implementation pathway and management scorecard is now presented.

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14 Groupthink occurs when a group makes faulty decisions because group pressures lead to a deterioration of “mental efficiency, reality testing, and moral judgment” (p. 9). Groups affected by groupthink ignore alternatives and tend to take irrational actions that dehumanise other groups. A group is especially vulnerable to groupthink when its members are similar in background, when the group is insulated from outside opinions, and when there are no clear rules for decision making. (Janis, I. L. 1972).
6.5.1 Propositional knowledge

Both client and clinical perspectives are heard in this methodology (Rycroft-Malone, Kitson et al. 2002). The combination of a Theory of Communicative Action approach aligned with a balanced scorecard model provides a process in which every voice can have an impact through engagement in the process of linking their personal worlds with the social world (the world of social norms) and the technical world (the world of data and facts). The population of interest in this thesis was older people. The decision makers were the planners and funders, who needed to develop services within a new paradigm that would have an impact on both older people and clinicians. One of the advantages of using a balanced scorecard approach is that by including a client perspective the other stakeholders are forced to consider the population they are serving. Linking the balanced scorecard to the implementation pathway places the older person and their family into the frame of reference, and then seeks information not just about what was done to them, but about what the older people wanted to achieve (their vision). The reporting and discussion process then encourages all stakeholders to be involved in identifying the meaning of the information they are getting. While the older person may not actually be involved in these discussions at a planning and funding level, or when planners and funders are meeting service providers, the inclusion of the clients’ perspective in the data collection ensures that they cannot be ignored. The service providers, including clinicians, are then engaged in an ongoing process in which the data and its meaning can be discussed. This allows research data to be combined with clinical experience to become propositional knowledge, whereby clinical or craft knowledge is verified consensually through critical reflection, critique, and debate (Rycroft-Malone, Kitson et al. 2002).

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15 The traditional or standard analysis of propositional knowledge according to the traditional definition is belief of a special kind, belief that satisfies two necessary conditions: (1) the truth of what is believed and (2) the justification of what is believed (http://www.bookrags.com/research, accessed 20 October 2010). Professional craft knowledge can be transformed to propositional knowledge and verified consensually through critical reflection, critique, and debate of clinical experience (Rycroft-Malone and Kitson 2002). In this thesis, clients are also considered as having the equivalent of professional craft knowledge, their personal experience of their condition and life knowledge. Combining their voices with those of the health professionals strengthens the propositional knowledge gained.
6.5.2 Effectiveness and efficiency

At a micro level, the IN-TOUCH benchmarking programme provides information about the clinical effectiveness of a service through ongoing information collected in reviews of care plans. It provides some information about production efficiency through examination of the quality and usage of the workforce. Over time, it could assist with identifying procedural inequities when used in a benchmarking process. By sharing information between DHBs and across providers, it becomes possible to identify disparities in the way clients are assessed (for example, identifying that in some DHBs people with low functional disability are being assessed as needing high packages of care).

At a macro level, assessment of population effectiveness is assisted because the outcomes and service packages across clients with similar levels of dysfunction can be compared over time and between DHBs. Determining a fair price for restorative home care services has been difficult, with the existing funding model based on the allocation of household management or personal care. If cost refers to the amount paid to produce a good or service, representing the sum of the value of the inputs in production, then understanding the necessary components of a restorative home care service must be an important element in determining a fair price for that service. The IN-TOUCH benchmarking programme will assist in determining the necessary service components. The information collected through the implementation pathway will show, over time, whether the assumptions behind this model are, in fact, correct. Data from IN-TOUCH will enable the development of a case mix approach to funding these services. Following that, cost will be able to be clearly compared to outcomes, and allocations can be shifted to more closely target effective intervention. However, in terms of substantive equity, at the moment, the IN-TOUCH benchmarking programme has no process to use to identify disparities between ethnic groups; however, it can identify disparities between DHBs for clients with similar levels of dysfunction.
6.5.3 Goodmans' five principles

To address both the formative and summative aspects involved in evaluating the complexities of community programmes, five principles were developed by Goodman (2001). The Triple V Implementation Pathway requires both formative evaluations (at Step 4 and 5, and summative evaluations at Step 6). The IN-TOUCH benchmarking programme can be viewed as a formative evaluation process; it uses performance management to identify what is or is not working, and this information can then enable quality improvement. Therefore, the five principles espoused by Goodman must be met for IN-TOUCH to be effective.

The first principle is that evaluation should include an assessment of programme theory; that is, there should be a theory of causation or action, or a logic model. The elements of the theory or model form a template that can be used to compare the consistency of the programme that is implemented with the programme that was planned for. The implementation pathway meets this principle through the combination of the Triple V Implementation Pathway and a balanced scorecard. The scorecard provides a logic model built on evidence and stakeholder consensus. The outcome desired is at the top of the scorecard (and is the vision from Step 1 of the Triple V Implementation Pathway). If all the key performance areas, equivalent to perspectives in the original balanced scorecard, are working well, then the outcomes should be achieved. Within each key performance area, key success factors have been identified. The logic in place is that if measurement shows that all the key success factors within a performance area are working well, then that particular performance area is functioning well.

Combining the balanced scorecard approach to performance management with the Triple V Implementation Pathway also provides a framework to enable evidence-based discussion between stakeholders about what the performance measurement data means. Are providers undertaking the tasks as they said they would? What is the meaning of differences from expected outcomes, even when the programme is being implemented as required? The first question is about consistency between the objectives and the action plan (developed in Step 2 and Step 3 of the V-Model) with what actually happened during implementation (Step 4). The second question is
about consistency between the results expected (Step 5) and the assumptions behind the objectives (Step 2). In other words, the implementation pathway provides an approach for testing consistency at two levels, implementation against action plan and results against assumptions.

The second principle is that evaluation instruments must be contoured to each individual community to reduce culturally induced bias by taking into account the language skills, age appropriateness, cultural relevance and attention span of local audiences. The results from working with DHB A revealed that the initial implementation pathway was not well contoured for the local community. The providers struggled with the language and the ‘pickiness’ of it. The language at this stage attempted to detail what all the steps meant in terms of actions required from all stakeholders. The reaction was that this pictorial format was too complicated – it was not contoured well for the community.

The V-Model was, therefore, further modified for DHB B and DHB C to incorporate the journey metaphor from Lakoff (1980). The results show this was successful in engaging the stakeholders and leading them to an understanding of the process. All stakeholders were receptive to the analogy of going on a journey. However, when it came to working with the DHB HOP planning and funding managers, the language needed to change again. When used solely within this community, the language of a journey was regarded as insufficiently professional. The final Triple V Implementation Pathway presented in the IN-TOUCH benchmarking programme was aimed principally at DHB planners and funders, as they were the ones who would contract for the programme. The language was, therefore, modified to be suitable for presentation to a DHB Board, as they were who planners and funders were accountable to.

The implementation pathway approach, which sought valid communication by gaining agreement on the vision, and then determining what successful implementation would mean to stakeholders, was well received in all DHBs. What failed to work well in any of the three DHBs in the first phase, even with the change to a journey metaphor, was the proposed detailed process for identifying
performance measures. From Goodman’s perspective, the principle of working within the attention span of the local audience was violated. This may have been because too much detail was being asked for; as has been noted, this is definitely a problem for performance management approaches. It may have been that the approach taken did not inspire the stakeholders, and that they did not have an ‘I rule’ experience (Sierra 2006). The results from DHB A suggest that the latter explanation may be the most accurate. The providers asked the DHB to tell them what they wanted to measure. The providers were really only passionate about performance measurement details when it impacted on their finances. Sierra talks about ‘passionate users’, and clearly, providers are passionate when it comes to managing their financial resources.

The third principle is that evaluation approaches should be guided by the questions asked, and often requires both a quantitative and qualitative orientation. The implementation framework approach honours this principle by using both quantitative and qualitative data. The quantitative data comes from assessment instruments such as the TARGET tool (in particular, the Nottingham Extended Activities of Daily Living which is embedded in TARGET), from survey questionnaires, and from analysis of the effectiveness of providers in setting suitable goals with clients. This quantitative information is the technical data which is then fed into discussion in an effort to develop a common understanding across the personal and social worlds. One of the key reasons for utilising the V-Model approach is that it provides a framework for the valid communication process described by Habermas; it enables quantitative and qualitative information to be triangulated. The IN-TOUCH information reported in Chapter V shows this triangulation through a mixture of quantitative data presented alongside information from interviews with managers, case managers and clients.

The fourth principle is that evaluation should be informed by the multiple social levels at which programme interventions are directed, and by the stages the development programmes are at. The Triple V Implementation Pathway, in combination with the management scorecard, ensures the inclusion of multiple social levels: client, family, service provider, planner, and funder. There are also six stages
of development and implementation in the original V-Model; however, over the development of the implementation pathway, it became clear that the six stages were not, in fact, strictly progressive; that is, the journey was unlikely to be a smooth linear one from Stage 1 to Stage 2 to Stage 3 to Stage 4 to Stage 5 with a grand finale at Stage 6. There needed to be feedback loops between stages (called steps in the V-Model), in particular, between Step 4 and Step 3, and between Step 5 and Step 2. The model needed to show that a recursive process was necessary. The feedback loop between Step 4 (implementation) and Step 3 (Action Plan) is the performance management process that ensures each stakeholder is actually undertaking the tasks they said they would take responsibility for. Basically, it is the step that checks to see that people are doing what they said they would do. The feedback loop between Step 5 (Results) and Step 2 (Objectives) is necessary because the results may not be what were expected, even if everyone fulfils their allocated tasks to the required standard. The assumptions made in Step 2 as the result of evidence and opinion may be wrong. If this is the case, there is no point in continuing with the programme, and eventually reach the Step 6 evaluation which will show that there were faults in the programme. If the purpose is ongoing improvement, then it makes sense to feed the information from Step 5 back to Step 2 so the objectives can be reviewed, and a revised action plan developed and adopted. The final revision of the Triple V Implementation Pathway used in IN-TOUCH (Figure 19) recognises that these feedback loops are necessary.

The Triple V Implementation Pathway also recognises that the six steps are unlikely to occur in a linear fashion. One of the factors apparent in working with DHBs and providers was that the development of the new services was not going to follow the model of a quick decision on a service specification, negotiation of a contract, and the provider going away and getting on with it. A model of relationship between the funder and the providers that aligned more with a stewardship model than an agency model (Cribb 2006) was needed. For that reason, the Triple V Implementation Pathway used in the IN-TOUCH programme recognises three phases: service specification, implementation and business as usual. The implication of these three phases is that the funder needs to be actively involved in Phase 1 and Phase 2, but may take on a less intensive role in Phase 3 when providers have shifted from
development and implementation to ongoing operations. What also needs to be noted in Figure 19 is that the language has moved away from the journey metaphor. At the end of Phase 1, during the work with DHB HOP planning and funding managers, there was a sense of unease with the lack of formality in the journey metaphor. This group of people had to include the diagrams we developed in their reports to their managers and Boards, so the language was modified to be more formal. This is a good example of how a model such as the V-Model can maintain its intent and approach, but have the language adapted to suit the audience.

![Figure 19: The Triple V Implementation Pathway](image)

The identification of discrepancies between expected and actual results at Step 5 leads back to Step 2 for an examination of the evidence behind the assumptions made in the design of the programme. This means that there may be much iteration before Step 6 is undertaken. Step 6 then becomes a true “Was this exercise worth it?” summative evaluation, with all formative and process evaluation processes sitting with the performance management implementation pathway. In terms of multiple
social levels, the balanced scorecard ensures that the client level is included alongside that of the funder and clinicians. The benchmarking approach, with technical data being fed over time into an ongoing discussion network, provides for all social levels, planners and funders, clinical staff, consumer representatives to be heard over time.

The fifth principle is that community evaluation should involve local stakeholders in meaningful ways. The evaluator or the evaluation process takes on a role as a coach, collaborator and builder of capacity. This specifically occurs in the implementation pathway process, because while IN-TOUCH involves DHB planners and funders through the function of collecting data and reporting results, it also has two other key functions: facilitating and sense-making. The facilitating function occurs because the IN-TOUCH programme is operated through the University of Auckland, and therefore sits outside the DHB; thus, it is seen as separate from internal politics. At the same time, they are sufficiently credible parts of the greater health system to be accepted as useful additions to the dominant coalition that is formed to implement the new service model. From a Viable Systems Model perspective, the IN-TOUCH programme can be seen to be assisting with coordinating, intelligence and monitoring functions.

During the initial work with DHB A, it became clear that people need to be invited into an experience that they value, rather than be faced with an experience in which they feel out of their depth and threatened. The feedback from the service providers made it clear that they perceived that one of the main functions of DHB planners and funders was to assist them and other key stakeholders to make sense of what was being planned and the role they would play (Pye 2005). Fulfilling a function as a sense-maker is one of the key roles of a leader (Weick 1995; Sharig 1998).

Planners and funders are responsible for leading the development and implementation of new models of health service delivery as they respond to national health policy demands as well as internal pressures to be cost-effective. They have, therefore, to be leaders of change, and help other stakeholders to understand and engage with that change. An incentive for the planners and funders to operate as sense-makers is the increased likelihood of providers responding favourably to their
plans rather than with an amygdala driven “fight or flight” response (Erhard, Jensen et al. 2009). This means that while the implementation pathway was first conceived of as a management concept to assist managers to manage a process of change, the experience with DHB A made it clear that another role for the planners and funders was to lead change.

The Oxford English Dictionary root definition of leadership is to guide and to bring by persuasion through argument or representation to a conclusion whereby people are induced to do something (Pye 2005). This role has been defined as being principally one of sense-making, which means making something sensible (Weick 1995), or one in which managers act as interpreters to help people find meaning in change (Palmer and Dunford 2008). If the measure of any piece of behaviour is the response to it, with following being a measure of leading, and leading the measure of following (there are people who are willing to follow the leader) (Mangham and Pye 1991), then the experience from DHB A shows that the implementation pathway did not work sufficiently well in assisting the planners and funders to lead service providers to a new way of operating. It did not work to bring people together “who in an evolving dialectical fashion construct and reconstruct patterns of response such that mutual expectations are fulfilled” (Mangham and Pye 1991, p46). The range of responses from the home care providers was too great, meaning that instead of a coordinated, focused, and favourable response with agreement on the vision and the actions required, there were random unpredictable responses (Smircich and Morgan 1982). This lead to the move towards a common language approach, and greater efforts to find performance measures that provided the triangulation of technical data with stakeholders’ social and personal worlds.

The further development of the process did help to resolve this issue, so that the IN-TOUCH benchmarking process was able to help planners and funders to lead home care providers through a sense-making process. This was accomplished by the delivery of the reports, and through facilitated meetings between planners and funders from different DHBs and between DHB planners and funders and their service delivery stakeholders. This facilitation allowed all stakeholders to consider the technical evidence, and then engage in discussion from their personal world
viewpoints as they sought a social world consensual understanding of what it all means. Planners and funders can, to some extent, step away from their control function and join with the others in seeking a shared belief. The IN-TOUCH benchmarking process supplies both facilitation and a mechanism to assist with sense-making.

As well as the principles from Goodman, the development of this implementation pathway also identified lessons to be heeded if the implementation pathway was to be useful in practice (Ovretveit 1998). The way in which the implementation pathway responded to these lessons is now explored.

6.6 Lessons for implementation

6.6.1 Ideology and the Viable Systems Model

This research did not have to deal with the first lesson, a situation in which the policy makers involved had ideologies that conflicted with the evidence. The DHBs engaged in this research were engaged because the policy makers involved, in this case the planners and funders, either believed in the evidence or understood that the evidence was believed by their DHB and the Ministry of Health. Either way, they wanted to see the evidence implemented by service providers in their DHBs. It is true that they were responding to Ministry of Health policy makers, but this is a good example of the recursiveness of the Viable Systems Model (Espejo and Gill 1997) in practice. To the MoH, the DHB planners and funders were part of one of the operational units. From a DHB perspective, the planners and funders were the policy arm, with the service providers being the operational units. In the case of this research, if there was evidence that the implementation pathway conflicted with the ideology of policy makers within the DHBs, they would not have become involved. If the pathway stopped them from responding effectively to evidence that conflicted with implementing the HOP Strategy, they would have withdrawn their involvement.

6.6.2 Transformative Learning

The discussion aspect of the implementation pathway is a device that acknowledges the second lesson, that policy makers and health clinicians are influenced by many
factors apart from information. Resistance to change has many causes (Waddell and Sohal 1998). One of the aspects of any change framework though is that there is no prescriptive approach that will always work. However, the way in which stakeholders are approached will either invite or discourage their engagement (Mezirow 1997). The lesson from transformative learning is that people’s experience has to be honoured, by asking, for instance, questions such as those in Table 16 (McWilliams 2007):

<table>
<thead>
<tr>
<th>Table 16: Questions for transformative learning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key questions</strong></td>
</tr>
<tr>
<td>Given your personal experience with care of this nature, what are your thoughts and feelings about this recent research evidence?</td>
</tr>
<tr>
<td>How do these findings fit with your: (i) Expectations and goals for the evolution of your own practice? (ii) Beliefs and values related to client care? (iii) Understandings of how practice should be? And (iv) Understandings of how practice could be?</td>
</tr>
<tr>
<td>How does this appraisal of your own experience of this particular practice approach make you feel? What does all you’ve experienced and talked about mean for you?</td>
</tr>
</tbody>
</table>

Source: McWilliams (2007)

Taking this transformative learning approach to the facilitation of meetings in which reports from the IN-TOUCH benchmarking programme are reviewed may be a useful mechanism for increasing engagement at all levels.

### 6.6.3 Risk management

The third lesson involves risk management. Planners and funders of DHBs are definitely risk managers. The engagement of DHBs in this research was helped by the fact that the planners and funders had been directed by the Ministry of Heath to implement the HOP Strategy. By being involved in this research they sought to mitigate the risk of failure in their implementation efforts. Beyond that, however, the implementation framework helps the mitigation of risk by: a) providing a mechanism for quality control through performance measurement and thereby performance management; and b) engaging all stakeholders in the process so that they share a commitment to it, and to the desired outcomes.
6.6.4 Logic and evidence

The inclusion of the results-based logic model (Watson, Broemeling et al. 2004) in the methodology provided an opportunity to deal with the fourth lesson, and avoid involvement in an argument over whether there was enough sound evidence for an approach. While the findings of the evaluations about the effectiveness of restorative focused home care may be considered by some clinicians as not conclusive enough in themselves to justify change, they do fit with the logic of a client-driven service. There is evidence that older people can regain or improve function (outlined in Chapter II, the Literature Review). There is evidence that older people prefer to stay living at home in their own communities (also outlined in Chapter II). By putting the implementation of the restorative model within the benchmarking implementation framework, all stakeholders are invited to be rational as well as to consider the evidence. They are also able to manage their risk by knowing that all assumptions can be re-assessed and changed as new evidence from day-to-day practice comes in.

6.6.5 Overcoming resistance or inertia

The planners and funders engaged in this research wanted to make things happen, but they were struggling with the fifth lesson from Ouvreit (1998), which could be called inertia or resistance. This was evidenced in DHB A, as providers said they wanted the new services to work, but did not want to do anything until they knew about the resources available. The implementation framework provides a mechanism for overcoming this inertia though engaging people in discussion. The concept is that if people engage in discussion and develop a shared belief in wanting to achieve an outcome, they will then be motivated to take the appropriate action (Simons 1995).

6.6.6 Propositional knowledge

The sixth lesson is that there is an assumption implicit in an evidence–based practice approach that people will have access to evidence, and that they will be able to understand the evidence. Neither of these factors may be true. The findings from research may be poorly communicated. People may have little time to access or read
Chapter 6: Discussion

research. The implementation pathway, when implemented as a benchmarking approach as in IN-TOUCH, provides an avenue whereby those people who have research evidence can introduce it into discussion. The evidence can then be considered alongside the craft and experiential knowledge that clinicians and other stakeholders bring to the discussion. This enables the development of propositional knowledge whereby stakeholders come to a consensus through critical reflection, critique, and debate about what is valid in a practice situation (Rycroft-Malone, Kitson et al. 2002). When research evidence is often not available at the time or place where decisions have to be made, the results-based logic model plus the use of a discussion model enabling the development of propositional knowledge allows sensible well considered decision making.

6.6.7 Stakeholder inclusion

The Theory of Communicative Action approach provides process to deal with the seventh lesson, one of inclusion that seeks valid communication between all parties engaged in a particular situation. The approach taken in the implementation framework was to involve all stakeholders in ongoing performance management that utilized performance measures that would also be useful in any later outcome evaluation. This is one way of ensuring that all those involved in the change process are actually involved in the evaluation. The IN-TOUCH process ensures that the voices of consumers and providers are presented along with hard data.

6.6.8 Process imperatives

As well as his five principles, Goodman (2001) also presented a number of process imperatives that need to be fulfilled to have success in a performance management and evaluation context.

Process imperative 1 involves managers’ use of communicative and strategic action to gain a shared vision. The implementation pathway assists them to do exactly that. As has already been described in this chapter, with the understanding given by the Viable Systems Model, one can see that DHB planners and funders are both operational elements for MoH policy, and policy drivers for the service providers
who are the operational elements of community services for older people. The vision is established by the policy makers at the MoH level. In their policy directing role, the planners and funders have to use strategic action. In terms of actually getting implementation, however, they need to get the buy-in of other stakeholders. Using the implementation pathway allows them to state the strategic action required, and then step back to be just another stakeholder involved in communicative action as they seek a way forward.

Process imperative 2 requires managers to engage in true dialogue with the workforce. As the limits of acceptable action cannot be tightly specified, a stewardship model of engagement is necessary. The success of the implementation pathway in enabling true dialogic communication can, to some extent, be judged by what was not said rather than what was said. In the work with DHB A, there was considerable comment from service providers that indicated mistrust of the funder – an underlying tone that the funder wanted to get more work without paying more for it. This tone did not come through in DHB B and C, nor in the interviews undertaken in IN-TOUCH. As the funding issues had not been resolved, this may suggest that through the ongoing dialogue, service providers gained more understanding of the factors driving the DHB, and realised that this was truly an issue in which answers were being sought from them. This also shows that Process imperative 3, the gaining of shared meaning through discourse because health managers have little direct power, is also being aided by the implementation pathway and performance measurement system.

The IN-TOUCH programme is being funded by ongoing and new contracts with DHBs, and with one NGO home care provider. This ongoing demand for the programme demonstrates the requirements put forward by Goodman for Process imperatives 4, 5 and 6 have been fulfilled. Process imperative 4 identifies a difference between being useful and being wanted; Process imperative 5 presents an understanding that support from senior management and other key stakeholders is necessary if funding is to be found for any programme. Process imperative 6 requires that the management concept be enacted.
Process imperative 7 demands that the model be able to be further developed in an ongoing way. This happened in the research as Phase 1 turned into Phase 2’s development of IN-TOUCH, as well as the ongoing utilisation of the programme by additional DHBs. While the process, implementation of a programme following the Triple V Implementation Pathway alongside the development of a management scorecard with key performance drivers, remains the same in each application, the elements chosen as a focus and the words used may change in each situation to ensure appropriate contouring to the community.

Another issue important for success was raised in the Methodology section, getting all the key stakeholders to agree on a set of outcomes or goals they want from the programme, called for establishing a dominant coalition (Cyert and March 1963; Greve 2003). The implementation pathway aims to assist the planners and funders to establish such a coalition when implementing community health services for older people. The ongoing benchmarking programme then provides a method for the achievement of ‘satisfaction’, by assisting all stakeholders to establish a means for meeting the goal that is set. The goal is set on the ‘intention’ side of the V-model, while Steps 4 and 5 on the ‘outcomes’ side of the V-model provide the ongoing process for stakeholders to learn about what works and what doesn’t, especially with the addition of the recursive feature added in the revised V-model; with the flow between Steps 5 and Steps 2, all stakeholders are assisted to become ‘satisfied’ (Cyert and March 1963).

Finally, according to Leggat and Leatt (1997), the most useful aspect of any performance management approach is that it supplies data that leads to the improvement of the system. The implementation pathway, in its IN-TOUCH manifestation as a benchmarking process, is set up to do just that by providing a systematic approach to determine the data that is useful to the key stakeholders involved in a service, and then establishing an organised process for the collection, analysis, feedback, and discussion of that data.
6.7 Summary

Planners and funders within DHBs were required by their Boards to implement the HOP Strategy with no clear understanding of what that meant or how to do it. The health environment contains a network of stakeholders who are all important in either advancing or resisting the implementation of any new service. The implementation pathway provided a structured approach to engagement with these stakeholders. It did not seek to provide answers, but instead provided a method for valid communication, which through the IN-TOUCH programme facilitated ongoing discussion about the efforts that were made to improve service quality.
Section 2: Points of interest and limitations

6.8 Do we ever truly all agree?

This thesis shows that the answer to this question is probably “We don’t know.” As was pointed out in 6.2, defining what people have actually agreed to is difficult. It is not clear whether DHB planning and funding managers agreed to a belief in the HOP Strategy, or whether they agreed that the implementation pathway might be helpful in actioning the HOP Strategy, which is what their job required them to do. The DHBs required implementation, and the managers had to report on achieving it whether they believed in it or not.

As further pointed out in Section 6.2, one issue that arises when implementing community health services is gaining sufficient agreement to enable the service to be developed and delivered according to the principles set in place. For planners and funders, and NASC and home care managers, the requirement, therefore, is not that they believe in the HOP Strategy, but more that they believe and agree they have to ensure services are developed and implemented to make the HOP Strategy real for older people. This research shows that for DHB HOP Planning and funding managers, this was the case. At the national meeting, they agreed that the one-page representation of the HOP Strategy represented the strategy well, and that the management scorecard was a method for identifying whether it was being well-implemented. They also identified their belief that the HOP Strategy had to be implemented. This was not made obvious in terms of people openly stating: “Yes, I believe we have to implement the strategy”; it was demonstrated by the fact that no one stated that they didn’t. This fits with the consensus model that agreement does not require vigorous support, but that even if some people don’t agree with or like the approach, they have decided not to obstruct the group or project proceeding (Klapp 1957; Hanafin 2004).

Planners and funder managers are not, however, hands-on frontline service workers. In home care services for older people, the front-line workers are either the coordinators at NASC, the home care provider on an intermittent basis, and on a more regular basis, the neither well paid nor well educated home care workers. The
‘Levers of Control’ (Simons 1994) approach suggests that this workforce does need to believe in the HOP Strategy; they do need to believe that older people need to be able to have a sense of control and need to be helped to regain or retain mobility. Home care workers are not supervised at all times as they usually work in an older person’s home without another health worker present. To be able to trust that they will work according to the HOP Strategy vision, managers must, therefore, have some belief that the coordinators and support workers understand, believe in, and agree with a restorative approach.

The results from IN-TOUCH show little evidence that managers, coordinators, and the home support workforce express these attitudes and behaviours. No one actually asked the workforce, “Do you believe in supporting older people to remain independent and active and in control of their own lives?” What workers do believe has to be inferred from other evidence. The results from IN-TOUCH produce two questions: What indicates that workers have been informed about the basis of the restorative programme? and, How does one know that the workers agree with and work according to the principles of a restorative programme?

The answer to the first question is “Very little.” While 85 percent of NASC assessors had received the SMART training that presented the evidence for and the skills to apply a goal-centred approach, only 50 percent of the home care coordinators had this training. This is important because it is the home care coordinators who supervise the support workers who are the ones to implement many of the elements of the support plan. Only 16.5 percent of support workers were trained to Foundation Level 2 of the Career Force Industry Training Organisation (ITO) restorative home care focused course. The answer to the second question is also “Very little.”

A more positive way of looking at the results is that most NASC assessors were trained, 50 percent of home care coordinators were trained, 16.5 percent of support workers were trained, and some goals were SMART goals. In terms of the question that is the focus of this section, perhaps the best answer is, “Yes, it is possible to get sufficient agreement between all people involved in service delivery so that
appropriate services are delivered.” Achieving this level of agreement is not easy, so any implementation programme has to have a realistic timeframe and recognise the three phases of the Triple V Implementation Pathway.

6.9 The theory is easy, the practice is difficult

During the research, no participants voiced disagreement with the HOP Strategy. No participant said that older people needed to be told what to do, or that they should just sit down and be looked after. There may have been some form of political correctness in play, in that people may not have felt safe to speak in opposition. Regardless, all the planners and funders, NASC workers, and home care managers and coordinators who were involved never voiced opposition to the vision as an ideal. There was discussion about the challenge to achieve the vision if there was insufficient resourcing, but there was no opposition to the vision itself.

However, this lack of vocal opposition did not lead to smooth implementation. The IN-TOUCH results show that accurate implementation occurred sporadically rather than as the norm, which raises the issue of why there was so little success in implementation. Perhaps the answer lies in the issues that led to the V-Model becoming the Triple V Implementation Pathway. As shown in DHB A, the V-Model presented a journey from Intent to Outcome that was smooth, but unrealistic. DHB planners and funders were very clear that they could not simply develop a service specification and then leave the home care providers to go and deliver wonderful outcomes. There is a parallel here with the DHB view that the Ministry of Health had just handed the strategy implementation over to them, and ministry officials now expected to measure their success (and tell DHBs off when they weren’t successful). The DHBs knew this would not be a smooth, trouble free path even though the HOP Strategy was easy to understand.

The difficulty of moving from this agreement and understanding to successful implementation is supported by the literature on change management and implementation (Fixsen, Naoom et al. 2005). Getting people to agree on, persist with, and follow what is in the action plan is difficult (Waddell and Sohal 1998). What this shows is that it is possible to get people to discuss what they want to
happen, and to get them to agree on what measurements would prove to them that implementation had been successful. To this extent, it is possible to get valid communication. Ongoing work with IN-TOUCH is needed to see if this approach, when embedded in a benchmarking programme, can be made attractive enough that stakeholders would engage consistently over time.

The results listed the themes that were voiced by stakeholders across the three DHBs. Exploring these themes shows that the Triple V Implementation Pathway framework can be effective, but that does not mean it becomes easy. The theme of frustration with the funding model is a good example. The management scorecard developed in this thesis has some financial indicators. Planning and funding staff identified that they thought a case-mix funding model would be better than what currently existed, and service providers observed that the pay-per-hour model made it difficult for them to structure a flexible service. Finding a way to fund that allowed flexibility was not easy, but the Triple V Implementation Pathway framework did help everyone to be aware that the funding mechanism was an issue that could impede success. This is a very good example of why the Triple V Implementation Pathway is useful. It assists stakeholders to become more aware of restraints to good practice. It is also a good example of why three phases are necessary. Finding and implementing a successful funding model is a difficult task when funding and IT mechanisms require time and resources to be changed.

6.10 Technical data: the objective is actually subjective

The results showed that home care providers were concerned that they would be blamed by both families and health professionals for changes in the approach to home health services. At the same time, they wanted task clarity, recognised that the new approach was a challenge and had a degree of mistrust of the funder. The context for data collection is therefore not neutral. The Triple V Implementation Pathway recognises the subjectivity of data, and seeks to harness that subjectivity to support implementation. In the Habermas three worlds approach, technical data does not mean anything on its own. It is cold, hard, and meaningless until given meaning by people in their personal and social worlds (Arens 1994). While criticisms of performance measurement mention the problem of too much data, they also
mention the collection of data that is without meaning to those who have to collect it (Duignan 2002; Chan 2004). A lack of understanding about why data are being collected may lead to issues of poor compliance with the collection process or poor data quality. It is almost as if there are two choices. The first is measures and data that are meaningless and have no impact; the second is measures and data that enable people to combine vision and data to performance manage aiming at achieving valued goals (Simons 1994; 1995). The Triple V Implementation Pathway approach is aimed at the second. The discussion process in the IN-TOUCH benchmarking programme is an attempt to make data meaningful and subjective, both individually and socially, to the people affected by it.

Funders wanted performance management and measurement for two main reasons. The first was supportive and came from an understanding that providers needed assistance to develop effective services, and that the Triple V Implementation Pathway provided a means to collect data that everyone agreed represented information they needed, and wanted to discuss. The second reason was accountability, from two angles. The funders were accountable to their managers for ensuring money was well spent; this, in turn, meant they needed ways to hold providers accountable for delivery according to their contracts. The difficulty of showing this has been demonstrated in this thesis. For example, the misunderstanding of a term like ‘restorative’, where one provider clearly took the term to mean doing things for people while they recovered rather than as doing things with people, or helping people do things for themselves as the DHB intended. The DHBs want to measure the levels to which staff have been trained and be assured that older people have been assisted to keep functioning. While the service provider may also want this, they are also concerned with the costs of delivery. The key issue is that if data are to be used must be for a purpose. The data must have meaning in a subjective setting. The Triple V implementation Pathway provides a framework within which people are enabled to compare their subjective understandings of the meaning of data, with the hope that a shared social world understanding will be reached.
6.11 The journey is ongoing

The development of the three stages of the Triple V Implementation Pathway is an acknowledgement that while the metaphor of a journey was useful, it had limitations. The key one was that in a journey, a person heads towards a destination, and usually reaches it and spends some time there. In home care services, the destination of perfect home care is never reached. There is always more distance to go, which can be seen as an ongoing quality improvement process. However, the journey metaphor may be appropriate in that there may be several legs of a trip as one moves towards the final destination.

One impetus for the implementation framework and the development of the Triple V Implementation Pathway was the understanding of the planners and funders in DHB A that service providers could not simply be left to get on with developing and implementing the new service. While this displayed an element of mistrust that providers would change their behaviour unless encouraged and forced to, there was also an awareness that the asked for change would be hard to achieve. This led to the second V in the Triple V Implementation Pathway. The planners and funders were aware that one aspect of the assumed model of development they were working with was that once a service specification had been developed, and the provider had signed the contract to deliver what was in the specification, then the funder main responsibility was holding the provider accountable for delivery. The second V recognises that in a chaotic system in which everyone is working out what is necessary as they go, then joint venture approaches are more likely to be successful. A joint venture approach ideally enables the sharing of information without prejudice to the contract, with each party committed to finding a way to make the venture a success.

The difference between the second V and the third V is that in the second V both parties are working out the implementation issues, and resolving whether the service can, in fact, be delivered. In the third V, the provider is asked to report on their ongoing quality improvement to make the already functioning service even better. The first V has an end-point; the second V also has an endpoint, although often this needs to be recognised as years rather than months. The third V does not have an
endpoint, because quality improvement is always necessary, as staff, resourcing, client characteristics, and mix change.

6.12 Reflections

The prime reaction from both providers and DSAC was that they wanted to have a set process in place to manage the development and implementation of the new model of home care. They also wanted to know whether the new model of home care worked. What they did not want was to have to work through a complicated worksheet and process such as the one that was provided to develop a list of performance indicators and processes.

The home care providers involved were so resistant to the process that the approach taken in this first iteration of the implementation pathway proved to be very unsatisfactory. The first learning was that stakeholders may interpret the same words differently, and that agreement to a written statement may not actually be agreement about what has to happen. An example that has already been explored is understanding of the term ‘restorative’. It is also clear that if providers think they are already doing what is required, they may expect that only a minor tweaking is required. This becomes a major issue when a significant shift in provider culture is required. One of the issues facing any change process in health is to assist providers and recipients to understand that this is a quality improvement exercise driven by an increased knowledge base, and not a criticism of what they have been doing until now. People who work hard and think they are doing a good job – according to the older paradigm (in this case, the ‘do for’ people paradigm) – will need to be assisted to understand the requirement to change in order to know they are doing a good job under the new paradigm (the ‘do with’ paradigm).

Providers want to show they understand, even when they do not, especially when contracts and future funding are involved. When issues of accountability for achieving the requirements of a funded contract are at issue, the truthfulness of discussion between the providers and funders depends on the level of trust between them. Honest discussion will be very difficult if the funder has taken a strictly agency theory approach with the viewpoint that the only incentive driving the provider is the
desire to do as little work as possible for the funding available so as to increase their
profit margin. It may be necessary to offer some form of a stewardship approach in
which the funder identifies certain boundaries and performance targets, but trusts the
provider to manage their own performance within those parameters (Van Slyke
2005; Cribb 2006). That funding is clearly a driver is shown by the quotes about
funding from providers reported in Chapter V.

Discussing policy and development issues in depth may mean that researchers and
DHB planners and funders become involved in activities and use language that has
little meaning and there relevance to operational providers. Terms and approaches
that every day providers don’t understand easily might be used. This was clearly
stated by one provider:

*To sit here and go through nothing more than generalisations
as to how activities and outputs link up inputs and outcomes is
a little bit academic in this setting.*

Finally, although the templates used had a sound theoretical base, they did not work
as a mechanism for assisting communication. People felt overwhelmed and
threatened by a plethora of empty boxes that they were asked to fill in for each
aspect. This fits with the performance management literature which presents
evidence that the more complicated a system, and the more measures that are
involved, the less likely there is to be a positive effect on outcomes (Lansky 1996;
Duignan 2002; Inamdar, Kaplan et al. 2002; Kee and Newcomer 2008).
Section 3: Conclusions

6.13 Study limitations

This study took a participatory action research orientation with the researcher being an active part of the process of the development and operation of the Triple V Implementation Pathway. Therefore, the researcher was not a neutral observer working within a positivistic paradigm. The use of a variation of the Innovation Action Research Cycle, combined with critical research theory, has made a strength of this active involvement, as for this study there was a necessity to assist with developing a tool to support a change process, not just to evaluate it.

For this reason, the generalisability of the results is limited to the development of community health services for older people within a New Zealand setting, possibly even within a primarily European setting. Although Maori and Pacific Islanders were involved in the development of the HOP Strategy, the number of older Maori and Pacific Islanders is still a small percentage of each population group. The application of the critical success factors may, therefore, not be appropriate with populations outside New Zealand, or with Maori or Pacific Island populations; however, this limitation should not apply to the implementation pathway process, which is based on assisting communication between all relevant stakeholders.

The implementation pathway has been dependent on the active involvement of the researcher. This should not limit the pathway being successfully utilised by another person, but it may be that there needs to be certainty of their facilitative and communication competencies.

6.14 Future research

Because the implementation pathway is theoretically driven, there is justification to assume that the approach could apply to any community of people anywhere. The Triple V Implementation Pathway approach to enabling valid communication between different stakeholders should be applicable anywhere at any time; however, different societies that have different concepts of the role of the individual versus the role of the collective may have different visions regarding the needs of older people,
and what constitutes their well being (Fiske 2002). This means that non-European based societies may not support some of the assumptions behind the outcomes, critical success factors, and performance measures chosen in this research. Further research could test this within New Zealand with Maori or Pacific Island communities, as well as overseas in non-European countries. The management scorecard arrived at for the New Zealand HOP Strategy is a New Zealand management scorecard. Each community in other places would have to go through a process similar to the one described in this thesis to develop their own scorecard, vision, objectives, and action plan.

There is also a need for further development of the performance measures for the critical success factors. As the results section makes clear, the measures chosen for Phase 2 were not optimal, but were those that were possible to put in place at the time to allow the benchmarking process to proceed. Ongoing research needs to refine the measures for each critical success factor so that there are fewer proxy measures and the information gained enables people to drill down to gain better understanding of what constitutes successful home care service delivery.

The Introduction chapter states that “The implementation pathway provides planners and funders with a problemistic search approach, assisting them to set goals and then use performance management to receive feedback on success and risks, using benchmarking information to increase dialogue focused on quality improvement”. Community home care services for older people were focused on as a case study, because these services were undergoing a major shift in their service model. However, because a problemistic search approach was taken building on a sound theoretical base, it would seem logical that Triple V Implementation Pathway and performance measurement system would be applicable to other health services, other service sectors, and perhaps even non-service sectors. The Triple V Implementation Pathway, the approach of building a one-page representation of the intent followed by the development of a management scorecard with key performance areas and critical success factors relevant to that intent, and then the use of benchmarking using performance measurement are clearly approaches aligned to management approaches not the health sector. Therefore further research could
usefully trial and evaluate the implementation pathway and performance measurement approach in other sectors in which there are multiple stakeholders seeking solutions, with a lack of clarity between the stakeholders about what a stated vision means in practice. Working with a different sector with a different vision would mean finding a new common language with different critical success factors and performance measures to suit the context, whether home care in another country, or a completely different service anywhere.

6.15 Study conclusions

The implementation pathway developed in this thesis has provided a process that assists DHB planners and funders to manage the planning and implementation of restorative focused home care services. Having the Theory of Communicative Action as its basis has required that all stakeholders become involved in agreeing on the intent of the HOP strategy, which is what drives the new restorative approach to home care. It also required that planners and funders move beyond good intent, and develop action plans that are implemented and their success measured. It is the insistence of Habermas, in this case through the use of the V-Model (Sheffield 2005), on the triangulation of the personal, social, and technical worlds that takes the implementation pathway beyond a planning process.

This thesis also shows that it is possible to develop critical success factors, with performance indicators and measures, to provide the technical information needed to anchor the process in real world performance. However, this thesis has also shown there are numerous issues in obtaining technical data that is meaningful. Providers may be threatened by performance measurement, and believe that some measures are unwarranted interference in their business by the funder. Even when agreed upon, actually getting data is a hard task as it is a requirement placed on top of the already onerous operational daily activities of the provider.

Despite these issues, Phase 2 IN-TOUCH, demonstrated that performance measurement is possible as part of an implementation and quality improvement programme. Data was collected, reports that compared performance across DHBs and home care providers were produced and stakeholders were able to have dialogue.
with the researchers and other DHBs about what the data meant to them. There are ongoing changes being made to the data being collected as well as the form of presentation of the analysis of that data to DHBs and home care providers as a result of this dialogue between people’s personal and social worlds and the technical world.

After the research for this thesis was completed, the IN-TOUCH programme kept operating, with two additional DHBs joining. The continuation of IN-TOUCH shows that the process the implementation pathway and performance management and measurement system embodies is sound. The implementation pathway and performance measurement approach has thus been shown in this thesis to assist implementation of new service approaches and ongoing quality improvement in the New Zealand context for home care services for older people. Given the pressures on health services around the world identified in the literature review, this systematic approach to encouraging stakeholders to work together to continually improve service efficiency and effectiveness offers considerable value to health policy researchers and funders around the world. The theoretical soundness of the approach means that it should also be valuable in improving implementation effectiveness and efficiency in other health service as well as the non-health service sector.
Appendices

The following section relates to the following Appendices:

Appendix 1: The University of Auckland Ethics Committee
Appendix 2: Common language manual for DHB A
Appendix 3: Determining measures
Appendix 4: The IN-TOUCH manual
Appendix 5: The Assessment tools
Appendix 6: The IN-TOUCH report
Appendix 1: Ethics

13 November 2007

Mr Stephen Jacobs
Faculty of Medical and Health Sciences
The University of Auckland
Private Bag 92019
AUCKLAND

Dear Stephen,

Ethics ref. MEDI07005212

Title: Models of health and support services for older people: a proposal for benchmarking between District Health Boards to assist with the development of the new service approaches

Investigator: Mr. Stephen Jacobs

The above study has been given ethical approval by the Chairperson of the Multi-region Ethics Committee.

Approved Documents
- Printed dated 26 October 2007
- Manager Questionnaire III: Formative Monitoring of community Based Services for Health of Older People, version 3 dated 16 September 2007. These monthly surveys
- District Health Board Planning and Funding Questionnaire: Formative Monitoring of community Based Services for Health of Older People, version 1 dated 16 September 2007. Monthly data collection form and participant information for Home Based Support Services or Packages of Care Providers
- Coordinator Questionnaire III: Formative Monitoring of community Based Services for Health of Older People: Monthly data collection form for home based Support Services or Packages of Care Providers, version 3 dated 16 September 2007
- In touch Integrated Networks Towards Optimising Understanding of Community Health: NASC questionnaire dated 17 September 2007
- In touch Integrated Networks Towards Optimising Understanding of Community Health: NASC questionnaire version 1.1 dated 16 September 2007

Final Report
The study is approved until 31 October 2008. A final report is required at the end of the study and a report form to assist with this is available at http://www.healthresearch.govt.nz/epractice/ethics. If the study will not be considered as included, please forward a report form and an application for extension of ethical approval one month before the above date.

Amendments
Please advise if there are any amendments to the ethical approval given for the study and that these have been reviewed and approved by the Ethics Committee.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that ethical Committee approval does not imply any release from any current or administrative obligation by any Health care provider whose facility the research is to be carried out. The organisation may impose their own procedures regarding permission for approval.
Appendix 2:  Common language manual for DHB A

Common language manual for DHB A

APPLYING THE REAL TIME IMPLEMENTATION AND EVALUATION SYSTEM

THE STEPS

STEP 1: THE VISION
The Vision is the Starting Point. The Vision will answer the questions:
What is the intention of the programme that is to be implemented? Why do the stakeholders want this programme?

The Vision will be the result of consultation with stakeholders. If this has not yet taken place, so there is in fact no vision in place, then developing the vision is the first step. There may have already been a lot of discussion, but without anyone drawing everything together into a vision.
STEP 2: OBJECTIVES AND SUB-OBJECTIVES

OUTCOMES

Action 1: Identify Key Words That Relate to Desired Outcomes
From the vision statement and related documentation, identify the key words that relate to the outcomes stakeholders expect to receive from the implementation of any programme to achieve the vision, e.g. integrated, strengths-based, flexible.

Action 2: Identify Performance Indicators for each Desired Outcome
Each key word is an outcome (“vision outcome”) wanted by stakeholders from any programme that is implemented to achieve the vision. The task now is to identify what stakeholders need to know if they are to be satisfied that the vision outcome has been achieved. Whatever it is that would satisfy them becomes the outcome performance indicator(s).

Action 2a:
For each vision outcome establish a template based on a stakeholder perspectives framework (below). Each template identifies six perspectives:
Appendices

Perspectives 1 and 2 are those of the people receiving services – the older person and the family carer
Perspective 3 is the provider of services
Perspective 4 is the workforce
Perspective 5 is that of those interested in the finances – this will be primarily provider management and the funder
Perspective 6 is that of the stakeholders interested in the well-being of the population, that is, in comparing the outcomes of this programme to outcomes for other people with similar issues.

Working with key stakeholders, e.g. the funders, clients, providers, ascertain what they regard as the indicators of success

Information from the literature will identify what research and expert opinion regards as the core factors of success for each particular vision outcome. This can be combined with the information from stakeholders, ensuring that decisions made are based on a wide range of information.

Stakeholder Contribution

Action 2b:
For each vision outcome, identify the contribution each stakeholder is expected to make towards achieving the outcomes determined in Action 2a. Achieving the results wanted from the outcome indicators (the results expected from the programme) is the core purpose of a programme. To achieve those outcomes, stakeholders must provide inputs (resources) so that various activities can be undertaken to produce outputs. The outcomes of the programme are the result of these inputs, activities and outputs. To ensure that those inputs, activities and outputs are optimized so that the results are to be achieved, implementation (formative) indicators need to be put in place to show whether or not the inputs, activities and outputs which make up the Action Plan are in fact being delivered (Duignan 2002).

Again there are six key stakeholder groups identified:
The person receiving services. The key question here is: in a service model based on client control and the promotion of self-management, what role should the person play achieving the outcomes they desire.

The family carer. Again in a service model seeking to work alongside and support families, what role should the family carer play in achieving the desires of the person receiving services? How does this fit with the desires they have for outcomes for themselves?

The Provider. The perspectives from the Balanced Scorecard model – Internal Business (What should the provider be excellent at?) and Learning and Growth (What should the provider be improving?) should apply here. Theoretically, the answers to these questions will provide the activities the provider is expected to undertake, and the inputs they should supply. They will also assist with determining the outputs they are expected to deliver.

Workforce. While some of the issues for the provider will be supplying a competent workforce, workforce is such a major issue in terms of adequacy of supply and skill, that exploring what is required from the workforce will assist in determining required inputs.

Funder. The sustainability of providers and workforce depends on sufficient resource being available in a manner that supports the activities that are required if the desired outcomes are to be delivered. The Funder input is not just about quantity therefore, but also about funding approach.

Community. The community is the context within which the person and their family are supported. If the community, both voluntary and not-for-profit provider are not to be supplanted by the programme but supported and supplemented by it, then their contribution to the persona and their family must be recognised.

**STEP 3: ESTABLISH AN ACTION PLAN**

There are now inputs, activities and outputs identified for achieving each outcome vision. The Action Plan entails taking these elements for the funder and provider perspectives and turning them into an action plan. These are the elements that are within an area of control that is internal to the organisation – the funder cannot force a client or family carer to do anything, but it can determine the funding level and funding approach it will take in commissioning a service. It can write its requirements
into the contract with a provider. Similarly, the provider can control the elements in its Internal Business Perspective (the things the provider must excel at) and the elements in its Learning Perspective (the things the provider must show there will be ongoing improvement in).

**Action 3a: Develop an Action Plan**
Work with the provider to develop an Action Plan that ensures that the programme they are to deliver will contain the key activities identified in the inputs, activities and outputs.

**Action 3b: Measuring and Reporting**
Develop with the provider a process for how the achievement of the inputs, activities and outcomes are to be measured and reported on.

**Action 3c: Feedback Loops**
Develop with the provider a mechanism for monitoring and consulting on the results of these performance indicators.

**Action 3d: Establish Critical Success Factors**
The implementation indicators are vital for the funder in establishing a contract with the provider, as they are the identified core elements for the programme being purchased. However, they are not the same as outcome indicators, and there will be more of them than are necessary for other stakeholders. For reporting to the stakeholder audience outside of the funder – provider contract, a smaller number of key indicators clearly identified as being critical success factors needs to be identified.

**Using a Cause and Effect Diagram approach, identify the critical success factors.**
These factors are established using research evidence along with stakeholder input. They should be as far as is possible:

- causally related to the vision outcomes
- related to factors the provider or funder can do something about
- possible to collect information about
• sensitive to change in performance

**Action 3c: Establish Reporting:**
Develop reporting mechanisms that meet the needs of all stakeholders.

Reporting needs to require minimal compliance cost. This means that the information should either be readily available or else information the provider would wish to collect as part of their own quality improvement system.

Reporting should also ideally be pictorial to reduce reading and understanding issues.

**Action 3d: Establish the Ongoing Consultation and Feedback Loops**

**STEP 4: IMPLEMENTATION**

**STEP 5: RESULTS**

**STEP 6: THE ACHIEVEMENT**

To develop the Outcome Indicators and Measures, and then the Inputs, Activities and Outputs that need to be put in place to achieve the desired outcomes, each Vision Outcome is being explored from six stakeholder perspectives. For each Vision Outcome, fill in the performance criteria that YOU would expect each perspective to fulfil, then how you would measure that, and what inputs, activities and outputs you would expect from that stakeholder. There may be some repetition. However, it is important to gain an understanding of what performance indicators, measures, inputs, activities and outputs are expected for each stakeholder group for each Vision Outcome. Your views can then be combined with the evidence from the literature to ensure that the Action Plan and the ongoing Monitoring System are as valid as possible.

The perspectives are defined as:
The customer perspective - in this approach, separated into the Client perspective and the Family Carer perspective. How do these service users view the integrated health system?—[interpreted in this approach as: What impact does the programme have on the client’s achievement of their goals?]

The internal business perspective - At what must the provider excel?

The innovation and learning perspective - How can the provider/provision of care continue to improve?

The financial perspective - How does the programme look to the funders?

The community benefit perspective - How does the programme impact on the health status of those receiving the service as compared to similar populations not receiving the programme?

(Leggat and Leatt 1997)
### Measures for Each Vision Outcome

<table>
<thead>
<tr>
<th>CLIENT – (Vision Outcome)</th>
<th>PERFORMANCE CRITERIA</th>
<th>PERFORMANCE MEASURES</th>
<th>Inputs You Would Expect From Stakeholder</th>
<th>Activities You Would Expect From This Stakeholder</th>
<th>Outputs You Would Expect From This Stakeholder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family or whanau carer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Business</td>
<td>(provider must excel at these)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td>(Provider must continue to improve?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### EXAMPLE: OLDER PERSON outcomes expected in vision for Care Coordination Centre

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Potential Performance Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Person</td>
<td>Goals assessed Care Plan reflects goals</td>
</tr>
<tr>
<td></td>
<td>Individualised Package Monitoring in Place Changes occur as needed</td>
</tr>
<tr>
<td></td>
<td>Rehab potential assessed Rehab in care plan Care Plan actioned</td>
</tr>
<tr>
<td></td>
<td>Family involved as desired</td>
</tr>
<tr>
<td>Carer</td>
<td>Assistance to accept OP's goals Own goals assessed</td>
</tr>
<tr>
<td></td>
<td>Appropriate support provided Monitoring in place Changes occur as needed</td>
</tr>
<tr>
<td></td>
<td>Involved in rehab as desired</td>
</tr>
<tr>
<td></td>
<td>Involved as desired</td>
</tr>
<tr>
<td>Internal Business (must excel at these)</td>
<td>Goals Asssnt tool in place Goals assessed</td>
</tr>
<tr>
<td></td>
<td>Access to a range of services Client driven culture Linked to community Staff turnover low</td>
</tr>
<tr>
<td></td>
<td>Competence to assess rehab potential</td>
</tr>
<tr>
<td></td>
<td>Linkages to community</td>
</tr>
<tr>
<td>Learning (How continuing to improve?)</td>
<td>Ongoing training in goal assessment</td>
</tr>
<tr>
<td></td>
<td>Client involvement in governance/service development An item in the training programme Staff attendance at training</td>
</tr>
<tr>
<td></td>
<td>Training for assessors Training for care planners</td>
</tr>
<tr>
<td>Funding</td>
<td>Flexible funding approach supported Packages of care</td>
</tr>
<tr>
<td>Community</td>
<td></td>
</tr>
</tbody>
</table>

---


**Appendix 3: Determining measures**

The following are suggested data collection measures and processes. These stakeholders still have to discuss these, so there may be changes to the data to be collected, either nationally or locally.

<table>
<thead>
<tr>
<th>Long-term outcome</th>
<th>What is being measured?</th>
<th>How it is being measured?</th>
<th>What data is being collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People’s independence and participation in society is maximised</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effectiveness in delaying or preventing admission to residential care</td>
<td>Rate of residential care entry</td>
<td>DHB data</td>
</tr>
<tr>
<td></td>
<td>Effective in preventing unplanned hospital admissions</td>
<td>Rate of avoidable hospital admissions and re-admissions</td>
<td>DHB data</td>
</tr>
<tr>
<td></td>
<td>Rate of falls related hip fractures and other injuries</td>
<td>Rate of death</td>
<td>DHB data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>People are receiving the health and support services they need to maintain function</td>
<td>Home Care Quality Indicators, but in particular:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dehydration</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delirium</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment for reversible conditions</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Isolation</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uptake of flu vaccination</td>
<td>From InterRAI or equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client sense of control, safety, social involvement (OPUS-SC)</td>
<td>Annual survey</td>
<td></td>
</tr>
</tbody>
</table>
### Key Performance Area (Client and Family driven services)

<table>
<thead>
<tr>
<th>Strategic Process</th>
<th>What is being measured?</th>
<th>How it is being measured?</th>
<th>What data is being collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Giver Reaction Assessment Tool</td>
<td>NASC assessments and reviews. Reported 3 monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal carers sign off on their role in any service plan</td>
<td>Audit of 5% of care plans where informal carer involved NASC monthly report on number of clients for whom informal carers sign up to be partners in care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of carers receiving services</td>
<td>NASC monthly report on numbers of informal carers receiving services for themselves HBSS 3 monthly report on: number of informal carers assigned services by NASC who received them number of services for informal carers assigned by HBSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexibility of respite services</td>
<td>Survey of clients Complaints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment produces quantifiable data on needs</td>
<td>All parties use InterRAI assessment tool for reporting on client needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mapped to ICF</td>
<td>InterRAI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of service and support plans</td>
<td>5 % of NASC service plans reviewed in joint meeting between DHB Planning and Funding, NASC and HBSS each 3 months 5% of HBSS support plans reviewed in joint meeting between DHB Planning and Funding, NASC and HBSS each 3 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Key Performance Area (Effective and efficient services)

<table>
<thead>
<tr>
<th>Strategic Process</th>
<th>What is being measured?</th>
<th>How it is being measured?</th>
<th>What data is being collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients’ health and support services are coordinated / care managed</td>
<td>There is a process for ensuring that there is not duplication of service and that the client knows how to access services and get information</td>
<td>Co-ordination / care management system in place and operating effectively</td>
<td>Survey of stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clients / informal carers know who to contact</td>
<td>Survey of clients, family, primary health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of duplicate assessments of person</td>
<td>Survey of clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service plan details involvement of all services</td>
<td>5% of NASC service plans reviewed in joint meeting between DHB Planning and Funding, NASC and HBSS each 3 months</td>
</tr>
<tr>
<td>Social marketing supports the approach</td>
<td>There is a communication strategy being implemented in DHBs to ensure all stakeholders understand the new model and why it is being implemented</td>
<td>Plan in place</td>
<td>All stakeholders have a copy of DBH reports on progress at 3 monthly meetings with NASC and HBSS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints</td>
<td>Reviewed at 3 monthly meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rate of people accessing NASC with inappropriate referral information</td>
<td>Monthly reporting by NASC on reasons given for referral to NASC</td>
</tr>
<tr>
<td>Services are responsive and flexible</td>
<td>People receive the right services in the right time</td>
<td>Packages of care</td>
<td>Review of 5% of Service and Support Plans at 3 monthly meetings to ensure variation in packages to suit goals and needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waiting lists</td>
<td>Monthly reporting from HBSS on waiting times for allied health and other services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monthly reporting by AT&amp;R on waiting lists</td>
</tr>
<tr>
<td>All parties receive all information needed for the support plan to be developed and implemented</td>
<td>There is consistent and adequate information flow between stakeholders</td>
<td>Standardised dataset for sharing information</td>
<td>Agreed information sharing content and process agreed to by all parties</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints</td>
<td>Reviewed at 3 monthly meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Formal information sharing processes in place and actioned</td>
<td>Agreed information sharing content and process agreed to by all parties</td>
</tr>
<tr>
<td>Clients’ goals are assessed, set and aimed for in a service plan</td>
<td>Service interventions are driven by the goals of the older person</td>
<td>A standard process for setting goals, such as TARGET, is used</td>
<td>All parties use same goal setting process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Achievement of goals is assessed and compared to outcomes</td>
<td>Standard reporting process in place. Monthly reporting by HBSS to NASC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service and support plans are reviewed regularly</td>
<td>Review of 5% of Service and Support Plans at 3 monthly meetings to examine how goals and needs are being met</td>
</tr>
</tbody>
</table>
## Key Performance Area (A skilled stable workforce)

<table>
<thead>
<tr>
<th>Strategic Process</th>
<th>What is being measured?</th>
<th>How it is being measured?</th>
<th>What data is being collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workers feel valued</strong></td>
<td>Workers want to be doing their work and feel that they are respected</td>
<td>Staff turnover</td>
<td>NASC and HBSS report monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Annual survey</td>
</tr>
<tr>
<td><strong>Workers are trained and assisted to become skilled</strong></td>
<td>Workers receive the training they need to become qualified for their roles, and then the support to become skilled</td>
<td>Staff are qualified for their roles</td>
<td>Report six monthly on qualifications of co-ordinators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff enrolled in training</td>
<td>NASC and HBSS report 3 monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff completing training</td>
<td>NASC and HBSS report 3 monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff supervision</td>
<td>HBSS and NASC 3 monthly report by HBSS on supervision undertaken in previous months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>supervisor:staff ratio</td>
<td>HBSS report monthly on:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• number of FTE and actual staff per coordinator (supervisor)</td>
</tr>
<tr>
<td><strong>Workers are adequately remunerated</strong></td>
<td>The workforce receives a standard of income that recognises their input</td>
<td>Guaranteed hours for low-paid workers</td>
<td>HBSS report 3 monthly on:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• numbers of workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Numbers of workers with guaranteed hours within bands – 40, 35, 30, etc</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Average hours workers in each band work above guaranteed hours per week</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comparisons to other workers of similar skill levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DHB, NASC and HBSS agree on equivalent workforce</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HBSS report on take home rates of pay</td>
</tr>
</tbody>
</table>
## Key Performance Area (Funding is appropriate and affordable)

<table>
<thead>
<tr>
<th>Strategic Process</th>
<th>What is measured?</th>
<th>being</th>
<th>How it is measured?</th>
<th>being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are affordable</td>
<td>DHBs and providers are able to manage their budgets.</td>
<td>Cost per client</td>
<td>NASC report monthly to DHB on average costs per low, medium and complex clients, excluding agreed outliers, as determined by InterRAI.</td>
<td></td>
</tr>
</tbody>
</table>

| Funding supports flexible packages of care | Funding and payment systems do not limit the ability of providers to provide flexible services | DHBs have a process for rapid approval of outliers | Outliers are identified and managed by negotiation between the DHB, NASC and HBSS. Outliers are reported monthly to ensure they are not the norm. |

Healthpac systems are support flexibility and data collection

| Funding supports the training and supervision of workers | Funding is targeted to training and supervision | Targeted funding | HBSS reports percentage of funding used for training and supervision |
Appendix 4: The IN-TOUCH manual

IN-TOUCH manual for ‘Generic’ DHB

IN-TOUCH 2008 MANUAL

Template
IN-TOUCH manual for ‘Generic’ DHB

Contents

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1 Introduction

1.1 Purpose

The IN-TOUCH project has two main purposes:

- To implement a framework that assists planners and funders to develop new community services for older people based on evidence. The evidence however, needs to be useful and useable.
- To develop a performance management and measurement system that is not only acceptable to funders and planners, NASC and service providers but able to be used in an ongoing way, to assist quality improvement.

In order to achieve this we need to collect data that provides meaning for the key stakeholders; the clients and families, the home based providers, the needs assessors and the DHB. The model used for the framework for data collection is based on the model: A Management Scorecard with 13 Critical Performance Drivers. The 13 performance drivers are the basis for each piece of data that is to be collected either through a structured questionnaire / interview with managers, client TARGET and review assessment and client semi structured interviews. The premise behind the Management Scorecard is that if each of the 13 Critical Performance Drivers is in place, then the outcomes wanted (at the top of the scorecard) will be achieved. Outcomes are often difficult to measure, or cannot be measured for quite a while after a programme has started. Whether or not the Critical Performance Drivers are in place can be measured from the time the programme starts, providing valuable information to the provider as to whether or not they are operating sufficiently effectively and efficiently to achieve the desired outcomes.

Within the Management Scorecard there are four perspectives that focus attention on those aspects that have to be operating well if the desired outcomes are to be achieved. First of all, there has to be funding or the only services available will be voluntary and unpaid. The funding has to provide value for money if the funder is to meet their accountability requirements. Secondly there has to be a skilled and stable workforce or there will be no workforce available to deliver a service to the standard required. Thirdly services have to be client and family driven or they will not increase client independence and participation, which are major desired outcomes. Fourthly, services have to be effective and efficient or the cost per outcome (economy) will be too high.
1.2 Critical performance drivers

These critical performance drivers are under four main headings which are based on the balance scorecard.

**Funding that is appropriate and cost-effective**
- Funding supports flexible Package of Care
- Funding supports training and supervision for workers
- Economy, efficiency and effectiveness

**A skilled stable workforce**
- Workers are trained and assisted to become skilled
- Workers are adequately remunerated
- Workers feel valued

**Client and family driven services**
- Clients goals and needs are assessed
- A treatment and support plan is developed driven by client goals, managing within client needs and ability to maximise function
- Informal carers are involved and supported
IN-TOUCH manual for ‘Generic’ DHB

Effective and efficient services
  ➢ Client support is coordinated / care managed
  ➢ Services and treatment are delivered and are responsive and flexible

Across the four main drivers are;
  ➢ All parties receive, send, and receive required information
  ➢ Public information and polices support the approach

The data being collected via questionnaires / interviews and TARGETs fall under each of the 13 drivers.
## 2 Data collection

### 2.1 Critical performance drivers

The aim of this section is to illustrate the rationale behind each question in the questionnaires/interviews plus the TARGETS/reviews and how they match with the 13 Critical Performance Drivers. The questionnaires relate to staff who are working under the restorative home support model. The University of Auckland IN-TOUCH team understands that Funding and Planning, NASC and HBSS managers' time is limited therefore; the team aims to show that the data being requested is meaningful. Therefore, Table 1 includes; the Critical Performance Driver, what is being collected and how, plus how that data might be presented in the six monthly reports.

Results will be shown for individual NASC and HBSS providers within a DHB and then combined to give an overall DHB result, which will be necessary for benchmarking purposes with other DHBs. All results will be coded. Funding and Planning managers will be provided with their own codes by The University of Auckland. It will be the DHBs responsibility to then pass on the codes to their NASC and HBSS providers. For benchmarking purposes the DHBs involved in IN-TOUCH will have to come to a common agreement for DHB codes to be shared among them. The University of Auckland will NOT be giving out DHB codes to other DHBs. Ethics has been obtained from the Multi Region Ethics Committee.

<table>
<thead>
<tr>
<th>Critical Performance Drivers</th>
<th>What is being collected and how</th>
<th>What this may show in the reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Funding supports flexible packages of care.</td>
<td>All questionnaires/interviews ask whether the funding process allows for delivery of flexible packages of care.</td>
<td>Demonstrate whether this is occurring, if so how often is flexible packages delivered and what are the barriers.</td>
</tr>
<tr>
<td>2. Funding support training and supervision for workers.</td>
<td>All questionnaires/interviews ask whether there is funding for training for coordinators/assessors and support workers.</td>
<td>Look at funding for training in general. Supervision, meetings and peer review rates for NASC assessors, coordinators and support workers.</td>
</tr>
</tbody>
</table>

---

1 Funding and Planning interviews (6 monthly); NASC Manager Questionnaire (3 monthly); HBSS manager questionnaire (3 monthly); Client interview (6 monthly)
### 3. Economy, efficiency and effectiveness (cost and outcomes)

The allocated packages of care per client in the sample group will be requested and any changes to the package (plus deceased, discharge and residential care entry) will be updated every 3 months.

See Table 2 for a full breakdown.

All TARGETS and reviews for the sample will be collected NEADL, EuroQol and distal goal will be entered by the research team.

Funding and Planning will be requested to provide the hourly rate for each of the 5 levels of care.

Changes in NEADL, EuroQol and distal goals will be shown for the sample group. NEADL, EuroQol and distal goals (SMART scoring) will be matched with levels of care.

Discharge, deceased and residential care rates for sample group will be shown.

Costing will be assessed with allocated packages of care and the hourly rates for the sample will be assessed.

### 4. Workers are trained and assisted to become skilled.

Both questionnaires include data on professional background of NASC assessors and HBSS coordinators. SMART training.

External training of support workers

SMART training rates for NASC assessors and HBSS coordinators. Professional profiles.

External training for support workers (such as ACE, Career force Foundation courses) rates.

### 5. Workers are adequately remunerated.

Pay rates for support workers and coordinators.
Guaranteed hours for support workers.
Travel costs.

General pay rates will be reported.

### 6. Workers feel valued

Total staff number and number resigned.

Turnover rates for NASC assessors, HBSS coordinators and support workers. Meetings / supervision and guaranteed hours also are indicators of ‘feeling valued’.
### IN-TOUCH manual for ‘Generic’ DHB

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Client’s goals and needs are assessed. Full copies of TARGETs and reviews for each client in the sample group will be sent to the IN-TOUCH research team. ALL distal goals at TARGET and review are SMART scored. Changes in allocated packages of care.</td>
</tr>
<tr>
<td>8.</td>
<td>A treatment and support plan is developed driven by client goals, managing within client needs and ability to maximize function. Client interviews and TARGET / Review distal goals. Clients will be asked if rehab services such as physio and occupational health are involved. Client interviews will be reported in a summarized form. Anonymity will be maintained as no names or identifying information will be used.</td>
</tr>
<tr>
<td>9.</td>
<td>Informal carers are involved and supported. Client interviews asking if someone else is living in the house / relationship to them. NASC will be requested to identify if any of the sample are funded for support because they are a primary caregiver. Client interviews will be reported in a summarized form. The report will note if some of the sample are primary caregivers. Anonymity will be maintained as no names or identifying information will be used.</td>
</tr>
<tr>
<td>10.</td>
<td>Client support is coordinated / care managed NASC questionnaire requests total restorative Home Support client figures and reviews achieved. Review rates for sample group will be assessed. Dates of TARGETs and reviews will be documented by the IN-TOUCH research team. Total number and the percent of reviews achieved will be reported for NASC. Sample review rates by each HBSS provider will be reported. ALL review rates will be indicated by Level of Care (4 client groups)</td>
</tr>
<tr>
<td>11.</td>
<td>Services and treatment are delivered and are responsive and flexible HBSS providers are asked if there is sufficient information from NASC to develop support plans for clients. Opportunity to comment is included. Both questionnaires ask about ability to provide flexible packages. Summarised results will be included in the reports (from questionnaires).</td>
</tr>
</tbody>
</table>
### IN-TOUCH manual for ‘Generic’ DHB

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding and planning manager interview will be asked about funding flexible packages.</td>
<td>Summarised results will be included.</td>
</tr>
<tr>
<td><strong>12. All parties send and receive required information</strong></td>
<td>Funding and Planning manager interview re understanding level of NASC and HBSS providers of restorative home support. General questions regarding what is working well or not working well with restorative home support will be included in the interview.</td>
</tr>
<tr>
<td><strong>13. Public information and policies support the approach</strong></td>
<td>Funding and Planning manager interview re general public / health professional (GPs) understanding of restorative home support.</td>
</tr>
</tbody>
</table>

In summary the following data will be collected:

- NSAC Manager questionnaire (at Baseline and then 6 monthly)
- HBSS Manager questionnaire (at Baseline and then 6 monthly)
- Funding and Planning Manager telephone semi structured interview (6 monthly)
- Client telephone semi structured interview (6 monthly)
- Target and Reviews from a sample of 100
2.2 TARGETs and Reviews

Table 2 describes the method of data collection for the TARGET and reviews. The two providers will provide a nominated sample for ongoing data collection. The total sample size from .... DHB will be (100 / 150). This sample group must be maintained for the duration of the project (12 months) so if a client is deceased, discharged or transferred to residential care that client must be replaced by a new client from the provider whose sample has changed.

Identification by NHI and name is necessary to ensure ongoing reviews are correctly matched to the correct client. The University of Auckland does NOT have access to the NHI database and confidentiality and anonymity is assured. The IN-TOUCH research team is ethically required to ensure this is maintained throughout the project and beyond\(^2\). Medical information is not required. The purpose of the enquiry is based on TARGETs and reviews.

Table 2: Data collection method for TARGETs and reviews

<table>
<thead>
<tr>
<th>Geographical area</th>
<th>.... DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>100 / 150 clients across the .... providers-</td>
</tr>
<tr>
<td>Sample selection</td>
<td>The sample from each HBSS provider will be selected across the different level of care groups i.e. a random selection across each of the four levels.</td>
</tr>
<tr>
<td>Initial sample list</td>
<td>ALL clients will be entered on to an EXCEL spread sheet with the following data entered for each client: NHI, Surname, Initials, DOB, Level of care and Hours of service (current hours per week). This will be sent to NASC and The University of Auckland. This is to ensure all parties have the SAME list of clients who will be followed up over 12 months. See example 1 below!</td>
</tr>
<tr>
<td>Initial TARGET and/ or Review</td>
<td>ALL first reviews or TARGET from the 1(^{st}) of July for ALL 100 clients MUST be sent into The University of Auckland. The forms must be fully completed (Nottingham EADL, EuroQoL, distal goals etc). The sample is all new clients to service from the 1(^{st}) July 2009. DO NOT SEND A LIST OF TOTAL SCORES the whole form MUST be completed and sent in. NOTE: SEND PHOTOCOPIES NOT ORIGINA L S.</td>
</tr>
</tbody>
</table>

\(^2\) On completion of the project all questionnaires, TARGET s / Reviews and associated paper work is archived for 7 years and then destroyed.

SMART IN-TOUCH 2009/IN-TOUCH Manual/ Template/2008/version 3
IN-TOUCH manual for ‘Generic’ DHB

Sample changes over time

IF any client on the initial list of 100 / 150 is discharged, becomes deceased or transferred to rest home care ALL parties (HBSS Provider, NASC and The University of Auckland) MUST be notified.

These clients MUST then be replaced with new clients so the SAMPLE LIST is maintained at 100 for the duration of 12 months.

Ongoing REVIEWS

ALL reviews undertaken for each client on the list MUST be sent into The University of Auckland. The ‘Client Three-Monthly Provider Review’ form must be fully completed (Nottingham EADL, EuroQOL, distal goals etc).

DO NOT SEND A LIST OF TOTAL SCORES. The whole form MUST be completed and sent in.

At review if there have been ANY changes to hours of service (current hours per week) the EXCEL spreadsheet will need to be updated with date of change made.

Example 1: EXCEL data requirements (Sheet One)

<table>
<thead>
<tr>
<th>NHI</th>
<th>Surname</th>
<th>Initials</th>
<th>Date of birth</th>
<th>Hours of service per week</th>
<th>Change of hours of service per week (date of change)</th>
<th>Level of care (1 to 5)</th>
<th>Date of first TARGET / Review</th>
<th>Date of second Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX111</td>
<td>BROWN</td>
<td>JOHN</td>
<td>01/01/50</td>
<td>2 (hh)</td>
<td>3</td>
<td>1/07/09</td>
<td>1/10/09</td>
<td></td>
</tr>
</tbody>
</table>

For purpose of communication it preferable that the DHB assign a contact person to liaise between the HBSS providers and The University of Auckland. This contact person would have the responsibility to follow up missing data and provide feedback to The University of Auckland any NASC or HBSS concerns.
### 2.3 Timelines

The timeline of data return is essential to ensure the report can be completed at a timely manner.

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Date</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>START date</td>
<td>1st July 2009</td>
<td>All new clients from this date to be entered into EXCEL.</td>
</tr>
<tr>
<td>BASELINE Questionnaires</td>
<td>2nd September 2009</td>
<td>HBSS and NASC Manager questionnaires to be sent and completed within one week.</td>
</tr>
<tr>
<td>SEND in TARGETs and Reviews date</td>
<td>1st October 2009</td>
<td>Within 3 months of start date send EXCEL list in to NASC and The University of Auckland and TARGET / Review hard copies to The University of Auckland.</td>
</tr>
<tr>
<td>THREE MONTH Follow up Reviews</td>
<td>1st October - 1st December 2009</td>
<td>Three months from start date ALL reviews due (send hard copies to The University of Auckland).</td>
</tr>
<tr>
<td>SIX MONTH Follow up Reviews ,Questionnaires and telephone interviews</td>
<td>29th January 2010</td>
<td>Six months from start date HBSS and NASC Manager questionnaires to be sent and completed within one week. ALL 6 monthly reviews due (send hard copies to The University of Auckland). Interviews will be undertaken from those selected from the sample group.</td>
</tr>
<tr>
<td>REPORT</td>
<td>March 2010</td>
<td>Report one if all data is in</td>
</tr>
<tr>
<td>NINE MONTH Follow up Reviews</td>
<td>28th April 2010</td>
<td>Three months from start date ALL reviews due (send hard copies to The University of Auckland).</td>
</tr>
<tr>
<td>TWELVE MONTH Follow up Reviews ,Questionnaires and telephone interviews</td>
<td>29th July 2010</td>
<td>Twelve months from start date HBSS and NASC Manager questionnaires to be sent and completed within one week. ALL 12 monthly reviews due (send hard copies to The University of Auckland).</td>
</tr>
</tbody>
</table>
IN-TOUCH manual for ‘Generic’ DHB

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>REPORT (FINAL)</td>
<td>Sept 2010</td>
</tr>
<tr>
<td></td>
<td>Report two if all data is in</td>
</tr>
</tbody>
</table>

Interviews will be undertaken from those selected from the sample group.

Returns

Questionnaires and Excel sheet return can be sent as an email attachment. TARGETs / Reviews need to be photocopied and sent by post or courier. See addresses below and please put:

Attention: Michelle Gundersen-Reid.

Postal Address: School of Nursing, The University of Auckland, Private Bag 92019, Auckland 1142.

Courier Address: School of Nursing, The University of Auckland, Level 4, ECOM House, 3 Ferncroft Street, Auckland 1142.

Telephone 09 923 2575

For Contacts and Support:

If any concerns please contact Trish Cox at trish.cox@auckland.ac.nz (09 923 2575) for admin support. Stephen Jacobs (s.jacobs@auckland.ac.nz) and Michelle Gundersen-Reid (m.gundersenreid@auckland.ac.nz) for project and report clarification.

3 Report

The report is to be written at 6 months and at 12 months. However, to ensure deadlines are met, data return and completion needs to be at the predetermined time frames as discussed under timelines. Data analysis and interviews take some time and if there are data collection delays the report will be delayed. The report will be sent to the Funding and Planning Managers and it is their responsibility to disseminate the report to their NASCs and HBSS providers.
Appendix 5: The Assessment tools

District Health Board Planners and Funders Questionnaire (V)
Three monthly data collection form

Please complete and return in one week

<table>
<thead>
<tr>
<th>IMPORTANT, Please ensure that you complete this box</th>
<th>Office use CODE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of DHB</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

Please Complete the Survey
## DATA COLLECTION FORM

1. In terms of restorative home support, which processes are working well? Describe what is making them work well.

2. Which processes are there difficulties with? Any ideas why? Any thoughts about some solutions?

3. Have you identified any stakeholders who are not involved in the process who need to be? What can't happen well because they are not involved? Do you have any thoughts about how to get them involved?
### Data Collection Form

**4. List the main actions to enable the key area needing improvement to improve**

<table>
<thead>
<tr>
<th>Action Description</th>
<th>Once monthly</th>
<th>Six monthly</th>
<th>Yearly</th>
<th>Other Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media, such as: radio, newspaper, television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group community meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One to one meetings with selected people within community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**5. What social marketing have you done around Home-Based Support Services?**

<table>
<thead>
<tr>
<th>Action Description</th>
<th>Once monthly</th>
<th>Six monthly</th>
<th>Yearly</th>
<th>Other Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media, such as: radio, newspaper, television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group community meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One to one meetings with selected people within community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**6. How often do you receive feedback from the public regarding these services?**

<table>
<thead>
<tr>
<th>Feedback Frequency</th>
<th>Once monthly</th>
<th>Six monthly</th>
<th>Yearly</th>
<th>Other Specify</th>
</tr>
</thead>
</table>

**7. Other comments**
<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement with statement (tick one box)</th>
<th>Please comment briefly</th>
</tr>
</thead>
<tbody>
<tr>
<td>8a I feel that NASCicare managers value my opinions on the direction of the service</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8b I feel that NASCicare management staff are open to well founded strategic initiatives</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8c I feel that NASCicare managers enthusiastically champion new ideas</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8d I feel that the two way communication channels between funding and planning and NASCicare management work at an optimal level</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8e I feel that once a strategic direction for NASCicare management is developed funding and planning should only have a monitoring role</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8f I feel that NASCicare managers are committed to ensuring restorative home support functions in the DHB</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8g I feel that this provider can be relied on to fulfill their contractual obligations</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8h I have faith that this provider will provide support to the process of implementing restorative home support</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8i I feel that the resources of this provider are adequate for implementing restorative home support</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8j I have no need to keep surveillance over the service provider after asking them to do something</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>8k There is feedback on performance from various sources which the provider and Planning and Funding share and discuss</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your time, now please place in enclosed courier pack.
## Carers Questionnaire

Data collection form for carers of older people

<table>
<thead>
<tr>
<th>To be completed and returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Carer</td>
</tr>
<tr>
<td>Name of Older Person</td>
</tr>
<tr>
<td>Date of birth of Older Person</td>
</tr>
<tr>
<td>Street address of Carer</td>
</tr>
<tr>
<td>Telephone number</td>
</tr>
</tbody>
</table>

Thank you for agreeing to complete this questionnaire.

This survey is primarily concerned with assessing any unmet needs with people who care for and support older people within the community.

All information generated from this survey will be treated with the utmost confidentiality without reference to your name. Your identity will be kept confidential. In the study documents you will only be identified by a study number.

Please answer the following questions and return the survey to:

*Address*

*The provider to complete please.*
### Caregivers Reaction Assessment

The carer’s reaction to the statement, please indicate:

1 = Strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel privileged to care for ......</td>
<td></td>
</tr>
<tr>
<td>Others have dumped caring for ...... onto me.</td>
<td></td>
</tr>
<tr>
<td>My financial resources are adequate to pay for things that are required for caregiving.</td>
<td></td>
</tr>
<tr>
<td>My activities are centred around care for ......</td>
<td></td>
</tr>
<tr>
<td>Since caring for ...... it seems like I am tired all the time.</td>
<td></td>
</tr>
<tr>
<td>It is very difficult to get help from my family in taking care of ......</td>
<td></td>
</tr>
<tr>
<td>I resent having to take care of ......</td>
<td></td>
</tr>
<tr>
<td>I have to stop in the middle of work.</td>
<td></td>
</tr>
<tr>
<td>I really want to care for ......</td>
<td></td>
</tr>
<tr>
<td>My health has become worse since I have been caring for ......</td>
<td></td>
</tr>
<tr>
<td>I visit my family and friends less since I have been caring for ......</td>
<td></td>
</tr>
<tr>
<td>I will never be able to do enough caregiving to repay ......</td>
<td></td>
</tr>
<tr>
<td>My family works together at caring for ......</td>
<td></td>
</tr>
<tr>
<td>I have eliminated things from my schedule since caring for ......</td>
<td></td>
</tr>
<tr>
<td>I have enough physical strength to care for ......</td>
<td></td>
</tr>
<tr>
<td>Since caring for ...... I feel my family has abandoned me.</td>
<td></td>
</tr>
<tr>
<td>Caring for ...... makes me feel good.</td>
<td></td>
</tr>
<tr>
<td>The constant interruptions make it difficult to find time for relaxation.</td>
<td></td>
</tr>
<tr>
<td>I am healthy enough to care for ......</td>
<td></td>
</tr>
<tr>
<td>Caring for ...... is important to me.</td>
<td></td>
</tr>
<tr>
<td>Caring for ...... has put a financial strain on the family.</td>
<td></td>
</tr>
<tr>
<td>My family left me alone to care for ......</td>
<td></td>
</tr>
<tr>
<td>I enjoy caring for ......</td>
<td></td>
</tr>
<tr>
<td>It is difficult to pay for ......’s health needs and services.</td>
<td></td>
</tr>
</tbody>
</table>
**IN-TOUCH**
Integrated Networks Towards Optimising Understanding of Community Health

**NASC Manager Questionnaire (IV)**
Three monthly data collection form

To be completed and returned within one week

<table>
<thead>
<tr>
<th>IMPORTANT*, Please ensure that you complete this box</th>
<th>NASC</th>
<th>DHB</th>
<th>Date:</th>
<th>Office use CODE:</th>
</tr>
</thead>
</table>

Answer the questions in terms of what you would do in dealing with service providers in your role of coordinating services for older clients.

**PLEASE COMPLETE FOR EACH PROVIDER**


<table>
<thead>
<tr>
<th>Provider name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 How much do you agree with the following statements as a NASC manager?</td>
</tr>
<tr>
<td><strong>NB:</strong> The questions related to funding and planning only need to be completed once.</td>
</tr>
<tr>
<td>5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree</td>
</tr>
<tr>
<td>Statement</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>1b</td>
</tr>
<tr>
<td>1c</td>
</tr>
<tr>
<td>1d</td>
</tr>
<tr>
<td>1e</td>
</tr>
<tr>
<td>1f</td>
</tr>
<tr>
<td>1g</td>
</tr>
<tr>
<td>1h</td>
</tr>
<tr>
<td>1i</td>
</tr>
<tr>
<td>1j</td>
</tr>
<tr>
<td>1k</td>
</tr>
</tbody>
</table>

* Data collection for NASC v 1
# Home Support Manager Questionnaire

Please complete every six months

This questionnaire relates only to staff working under the restorative model

---

Please complete and return in the supplied envelope within one week

<table>
<thead>
<tr>
<th>IMPORTANT</th>
<th>Name of Provider:</th>
<th>Office use CODE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHB:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions apply to all support workers, coordinators and clients within your restorative service

1a. In total, how many support workers, coordinators and clients do you have in your service? (number)

1b. How many support workers and coordinators have resigned in the past three months? (number)

2. For all coordinators, please provide their professional background by writing the total number belonging to each of the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse</td>
<td></td>
<td>Physiotherapist</td>
<td></td>
</tr>
<tr>
<td>Occupational therapist</td>
<td></td>
<td>Social worker</td>
<td></td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td></td>
<td>SLT</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. What are the hourly rate ranges of pay for support workers and coordinators?

<table>
<thead>
<tr>
<th></th>
<th>From $ per hour</th>
<th>to $ per hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. Support workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b. Coordinators</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Do you provide reimbursement for support workers travel time between client visits? (please circle)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. How many support workers receive guaranteed hours? (number)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6a. Does funding allow you to pay for support worker training? (please circle)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

HBSS Manager questionnaire/IN-TOUCH
### 6b. Does funding allow you to pay for coordinator training? (please circle)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 7a. How many support workers have received external training which leads to a qualification (e.g. ACE, career force)? (number)

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 7b. How many coordinators have completed SMART training? (number)

<table>
<thead>
<tr>
<th>Yes (tick)</th>
<th>No (tick)</th>
</tr>
</thead>
</table>

### 7c. Which of the following means of communication/methods of engagement does your organisation have with your Support workers (tick as many as applicable)

- Regular group meetings (i.e. at least quarterly)
- Regular individual meetings (i.e. at least quarterly)
- Staff newsletters (i.e. at least quarterly)
- Annual performance Appraisals by supervisor
- Organised social gatherings
- Staff satisfaction surveys
- Teleconferences
- Other (please name)

### 8a. Does the funding process allow you to deliver flexible packages of care? (please circle)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Note:** A flexible package of care involves flexible use of client hours. For example, a client who is allocated 2hrs of care per week may receive 0.5hrs one week and 3.5hrs the following week. A non-flexible package of care is funded on a per hour basis. For example, a client allocated 2hrs of care per week will receive this exact amount each week.

### 8b. How often are you actually delivering flexible packages of care? (please circle)

<table>
<thead>
<tr>
<th>None of the time</th>
<th>Some of the time</th>
<th>All of the time</th>
</tr>
</thead>
</table>

### 8c. What barriers prevent you from delivering flexible packages of care?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 9a. Do staff receive sufficient information from NASC to develop support plans for clients? (please circle)

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
</table>

### 9b. If no, please comment

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

----------END----------

*Return by mail or email as an attachment*

**HBSS Manager questionnaire/IN-TOUCH**
### Team Leader Coordinator Questionnaire (I)

**Monthly data collection form for Home Based Support Service or Packages of Care Providers**

Please return completed within one week

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>Office use CODE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB</td>
<td></td>
</tr>
</tbody>
</table>

Date:

---

Please complete the following table on approximate delays in access to allied health?

PT= Physiotherapy; OT= Occupational therapy; SLT= Speech Language Therapy; RN= Specific registered nursing hours

<table>
<thead>
<tr>
<th>Client name (or initials)</th>
<th>Referred to service</th>
<th>PT days delayed</th>
<th>OT days delayed</th>
<th>SLT days delayed</th>
<th>RN days delayed</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complex clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(complex clients are those with medium to high needs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>4</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-complex or community clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(non-complex or clients with low needs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please comment on the reason for delays (if any) for complex and/or non-complex or community clients

How many support workers were appointed in the last month?

How many have left in the previous month?

What are the three things that could be changed to make things better for you?

1.

2.

3.

Thank you for your time, now please place in enclosed courier pack.
**IN-TOUCH**
Integrated Networks Towards Optimising Understanding of Community Health

**NASC**
Assessor Questionnaire (VI)
Once only data collection form

To be completed and returned within one week

<table>
<thead>
<tr>
<th>IMPORTANT</th>
<th>DHB</th>
<th>Office use CODE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please ensure that you complete this box</td>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

Complete once or please ask new staff to complete. Write name every time this is completed.

1a Name of NASC assessor

<table>
<thead>
<tr>
<th>Age Please indicate</th>
<th>20 to 30</th>
<th>31 to 40</th>
<th>41 to 50</th>
<th>61 to 60</th>
<th>61+</th>
</tr>
</thead>
</table>

1b Professional background (please tick)

- Registered nurse
- Occupational therapist
- Enrolled nurse
- Other (please specify)

1c Number of years since qualified?

1d Highest level of education at secondary school

- Secondary school please specify
- Graduate degree please specify
- Post graduate qualification please specify
- Professional qualification please specify

2a Have you undertaken the SMART training (please tick)? □ Yes □ No

2b Do you feel that you require more training around assessment, goal facilitation and developing support plans? □ Yes □ No

The Initial Assessor Questionnaire v1
Appendices

3 How much do you agree with the following statements regarding your training needs as a NASC assessor?

5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement with statement (tick one box)</th>
<th>Please comment briefly</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a I feel competent in the use of TARGET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b I feel that my older person assessment skills are appropriate for a NASC assessor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3c I can interpret the goals arising from TARGET into a support plan with ease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3d I have an excellent working relationship the service providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3e Service providers listen to my feedback regarding clients and respond appropriately</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4a How many non-complex DHB clients are you responsible for?

4b How many complex DHB clients are you responsible for?

Do you work with allied health when goal setting and planning care? If so how?

4c

5a In what situation do you do a joint visit (Please indicate below)?

<table>
<thead>
<tr>
<th>New clients</th>
<th>Highly complex clients</th>
<th>Clients with concerns</th>
<th>Support worker has client related concerns</th>
<th>Never need to</th>
</tr>
</thead>
</table>

The Initial Assessor Questionnaire v1 2
### 6. How much do you agree with the following statements regarding your training needs as a NASC assessor?

5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement with statement (tick one box)</th>
<th>Please comment briefly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6a</strong> I feel confident about asking the service provider to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6b</strong> I have no need to keep surveillance over the service provider after asking them to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6c</strong> I deliberately withhold some information from the service provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6d</strong> I check with other people about the activities of the service provider to make sure they are not trying to “get away” with something.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6e</strong> I give the service provider all known and relevant information about important issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6f</strong> I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Statement</td>
<td>Agreement with statement (tick one box)</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>How much do you agree with the following statements regarding your training needs as a NASC assessor?</td>
<td></td>
</tr>
<tr>
<td>5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td>5</td>
</tr>
<tr>
<td>7a</td>
<td>I feel confident about asking the service provider to do something</td>
<td></td>
</tr>
<tr>
<td>7b</td>
<td>I have no need to keep surveillance over the service provider after asking them to do something</td>
<td></td>
</tr>
<tr>
<td>7c</td>
<td>I deliberately withhold some information from the service provider</td>
<td></td>
</tr>
<tr>
<td>7d</td>
<td>I check with other people about the activities of the service provider to make sure they are not trying to &quot;get away&quot; with something.*</td>
<td></td>
</tr>
<tr>
<td>7e</td>
<td>I give the service provider all known and relevant information about important issues</td>
<td></td>
</tr>
<tr>
<td>7f</td>
<td>I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client*</td>
<td></td>
</tr>
</tbody>
</table>

* Please note that the asterisk (*) indicates that there is a specific condition or note related to the statement.
<table>
<thead>
<tr>
<th>Provider name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Agreement with statement (tick one box)</th>
<th>Please comment briefly</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>How much do you agree with the following statements regarding your training needs as a NASC assessor? 5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>I feel confident about asking the service provider to do something</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>8b</td>
<td>I have no need to keep surveillance over the service provider after asking them to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8c</td>
<td>I deliberately withhold some information from the service provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8d</td>
<td>I check with other people about the activities of the service provider to make sure they are not trying to &quot;get away&quot; with something. *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8e</td>
<td>I give the service provider all known and relevant information about important issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8f</td>
<td>I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 9 | How much do you agree with the following statements regarding your training needs as a NASC assessor?  
5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statement</strong></td>
<td>Agreement with statement (tick one box)</td>
</tr>
<tr>
<td>9a</td>
<td>I feel confident about asking the service provider to do something</td>
</tr>
<tr>
<td>9b</td>
<td>I have no need to keep surveillance over the service provider after asking them to do something</td>
</tr>
<tr>
<td>9c</td>
<td>I deliberately withhold some information from the service provider</td>
</tr>
<tr>
<td>9d</td>
<td>I check with other people about the activities of the service provider to make sure they are not trying to &quot;get away&quot; with something. *</td>
</tr>
<tr>
<td>9e</td>
<td>I give the service provider all known and relevant information about important issues</td>
</tr>
<tr>
<td>9f</td>
<td>I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client*</td>
</tr>
<tr>
<td>Provider name</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>How much do you agree with the following statements regarding your training needs as a NASC assessor?</td>
</tr>
<tr>
<td>5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree</td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Agreement with statement (tick one box)</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>10a</td>
<td>I feel confident about asking the service provider to do something</td>
</tr>
<tr>
<td>10b</td>
<td>I have no need to keep surveillance over the service provider after asking them to do something</td>
</tr>
<tr>
<td>10c</td>
<td>I deliberately withhold some information from the service provider</td>
</tr>
<tr>
<td>10d</td>
<td>I check with other people about the activities of the service provider to make sure they are not trying to “get away” with something. *</td>
</tr>
<tr>
<td>10e</td>
<td>I give the service provider all known and relevant information about important issues</td>
</tr>
<tr>
<td>10f</td>
<td>I watch the service provider attentively in order to make sure he/she doesn’t do something detrimental to the client*</td>
</tr>
</tbody>
</table>
How much do you agree with the following statements regarding your training needs as a NASC assessor?

5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement with statement (tick one box)</th>
<th>Please comment briefly</th>
</tr>
</thead>
<tbody>
<tr>
<td>11a I feel confident about asking the service provider to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11b I have no need to keep surveillance over the service provider after asking them to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11c I deliberately withhold some information from the service provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11d I check with other people about the activities of the service provider to make sure they are not trying to &quot;get away&quot; with something. *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11e I give the service provider all known and relevant information about important issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11f I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12</th>
<th>How much do you agree with the following statements regarding your training needs as a NASC assessor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>strongly agree, 4 = agree, 3 = neutral, 2 = disagree, 1 = strongly disagree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agreement with statement (tick one box)</th>
<th>Please comment briefly</th>
</tr>
</thead>
<tbody>
<tr>
<td>12a I feel confident about asking the service provider to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12b I have no need to keep surveillance over the service provider after asking them to do something</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12c I deliberately withhold some information from the service provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12d I check with other people about the activities of the service provider to make sure they are not trying to &quot;get away&quot; with something *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12e I give the service provider all known and relevant information about important issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12f I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

----------END----------

Thank you for your time, now please place in enclosed courier pack
Appendix 6: The IN-TOUCH report

Northland DHB, Counties Manukau DHB, Capital and Coast DHB, Nelson Marlborough DHB and South Canterbury DHB

IN-TOUCH is a joint District Health Board / University of Auckland initiative to benchmark restoratively focused Home Based Support Providers and NASC

Stephen Jacobs Michelle Gundersen Reid, John Parsons, Matthew Parsons, Kate Weidenbohm, Diane Jorgensen

March 2008
Appendices

Introduction

The IN-TOUCH (Integrated Networks Towards Optimising Understanding of Community Health) project began in October 2007. Five DHBs (Northland, Capital & Coast, Nelson Marlborough, South Canterbury and Counties Manukau) currently involved in the project commenced the study over a two month period between October and December 2007. The return rates for some DHBs have been 100% while other DHB one Home Based Support Service (HBSS) providers have failed to engage in the project. As a consequence some of the response rates are low, particularly for some DHBs. However, the data is still able to provide clarity around the effectiveness of the current change in service delivery.

The data in this report was collected by the following methods:

- Initial Questionnaires;
- NASC spreadsheets and;
- Completed TARGETs.

Analysis undertaken for this report included quantitative methods using Excel and qualitative data was coded using thematic analysis, adding depth to the quantitative findings. Each DHB and HBSS provider has been coded to protect confidentiality.

The report is structured under three main sections:

1. Packages of Care
2. DHB (NASC and funding and planning)
3. Home Based Support Services (Coordinators and Managers)

NOTE: Please apply to Michelle Gundersen Reid for your DHB and / or Provider code

1 In this report, home care providers are referred to as Home Based Support Service providers
**Section one: Packages of care**

The following results were derived from data provided by NASC (Needs Assessment Service Coordination), HBSS (Home Based Support Services) and completed TARGETs (Towards Achieving Realistic Goals in Elders Tool). The NASC data included information on the complex / non-complex split, allied health referrals, the size (hours per week and duration) of package of care. In addition reasons for delays in accessing allied health are described. The TARGETs were able to provide information on NEADL (Nottingham Extended Activities of Daily Living) and EuroQol (Quality of Life health assessment tool) scores for the non-complex and complex clients. The distal goal for each TARGET client has been entered and scored using the SMART tool (Specific, Measurable, Attainable, Realistic and Time-orientated tool). For three DHBs the distal goals have also been classified according to ICF classification (*International Classification of Functioning, Disability and Health*, known more commonly as ICF). At the time of this report not all of the DHBs had sent the data required to measure across all five DHBs.

**Case mix**

![Bar chart](image)

*Figure 1: Percentage of complex and non-complex clients per DHB*
The split of complex and non-complex clients for three DHBs show that there are more non-complex clients in each DHB; however DHB 012 has more complex than non-complex clients.

Size of package of care

![Bar chart showing the median number of hours per week for POC for complex and non-complex clients across five DHBs.]

Figure 2: Size of package of care (hours per week) for complex / non-complex per DHB (error bar = 1 SD)

The size of package of care (hours per week) shows that complex clients are allocated more hours of care than non-complex across five DHBs.

Allied Health input

These figures were obtained from the spreadsheet from NASC. Figure 3 shows the number of allied health referrals per 100 complex clients (Physiotherapy and Occupational therapy) by NASC at time of assessment. Figure 4 shows the number of allied health referrals (Physiotherapy, Occupational Therapy and Speech-language Therapy) per 100 non-complex clients. Figures 5 and 6 are based on allied health referrals per 1000 hours.
Figure 3: Referral rates to Allied Health for complex clients per DHB per 100 hours

Figure 4: Referral rates to Allied Health for non-complex clients per DHB per 100 hours
**Figure 5:** Referral rates to Allied Health for complex clients per DHB per 1000 hours

**Figure 6:** Referral rates to Allied Health for non-complex clients per DHB per 1000 hours
HBSS coordinators were asked to estimate the approximate delay in access to allied health in the Initial Team Leader Questionnaire (I). Many of the coordinators had difficulty completing this information. A total of 11 HBSS team leaders attempted to complete this questionnaire. While some coordinators were able to give actual figures for days waiting other coordinators either wrote ‘waiting’ or wrote nothing. However, if going by the dates of referral to service it could be assumed that when the questionnaire was completed the names listed were still waiting for allied health services. This was checked with one coordinator who agreed that this interpretation was correct for the data that they returned. Which service in particular the client was waiting for was mostly not documented. For those coordinators in one DHB who did complete this data, the following delays were being experienced:

Table 1: Days delayed waiting for Allied Health Service for DHB 012

<table>
<thead>
<tr>
<th>DHB / Provider</th>
<th>Complex</th>
<th>Non-complex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physiotherapy</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>012 / LG</td>
<td>39 to 46 days</td>
<td>23 to 39 days</td>
</tr>
<tr>
<td>012 / LB</td>
<td>17 to 55 days</td>
<td>Not stated</td>
</tr>
</tbody>
</table>

Due to the fact the data was not completed fully (only one DHB) it would be difficult to make any significant observations however, a number of worthy comments\(^2\) were made regarding reasons for delays across three DHBs;

“Reason for physio delay was dedicated physio contracted hours did not start until mid September and therefore backlog of client needed to be addressed as priority”. (012)

“Difficulty in securing adequate numbers of OT’s and physio’s to meet demand” (012)

“Delays occurred due to the various systems not being in place or prepared .i.e. trained support workers not available”. (016)

\(^2\) These comments were written in the Initial Team Leader Questionnaire
IN-TOUCH

"Unsure why there has been a delay with the physiotherapy referrals" (018)

TARGET

The NEADL (Nottingham extended activities of daily living scale) and EuroQol (Quality of health assessment tool) scores from each TARGET (Towards Achieving Realistic Goals in Elders Tool) was entered and the following results were obtained from four DHBs.

The NEADL is a baseline assessment and is scored out of 66 with a high score equating to a greater level of independence. It would be expected that complex clients would have lower scores than non-complex clients.

![Bar chart showing NEADL scores for complex and non-complex clients across four DHBs](image)

Figure 7: Median average NEADL for complex / non-complex split for DHB (error bar = 1 SD)

The median average for NEADL indicates a lower score for complex clients across four DHBs.
The EuroQol is a quality of life assessment tool that is used in TARGET. In this tool the higher the score the greater the indication that a client views their quality of life as poor. Therefore it could be expected that complex clients would have high scores and a perceived poorer quality of life than non-complex clients.

Figure 8: Median average EuroQol for complex / non-complex split for DHB (error bar = 1 SD)

The Median EuroQOL scores show that the difference in perceived quality of life between complex and non-complex clients for DHBs 001 and 012 complex clients have higher scores than non-complex clients. However, DHB 018 results indicate that non-complex have a higher score than complex clients. DHB 004 shows there is no difference between complex and non-complex clients for perceived quality of life.
Analysis of client goals

Each distal goal was scored using SMART: Specific, Measurable, Attainable or Achievable, Realistic and Time-oriented tool.

Table 2: Examples of goals and SMART classification

<table>
<thead>
<tr>
<th>Goal</th>
<th>S</th>
<th>M</th>
<th>A</th>
<th>R</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve mobility and walk for longer distances</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>To maintain current level of fitness</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>To be able to negotiate internal steps by 17-3-08</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I wish my pain would go away</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

The results indicated that in four DHBs goals are attainable and realistic. However, in general three DHBs did not make the goal specific and two out of four DHBs failed to make the goals measurable or time orientated.

Figure 9: Percentage of goals classified as Specific, Measurable, Attainable, Realistic and Time-oriented per DHB
Each goal was then classified according to ICF classification (International Classification of Functioning, Disability and Health). The *International Classification of Functioning, Disability and Health*, known more commonly as ICF, provides a standard language and framework for the description of health and health-related states. ICF is a multipurpose classification intended for a wide range of uses in different sectors. It is a classification of health and health-related domains - domains that help us to describe changes in body function and structure, what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance).

These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. In ICF, the term *functioning* refers to all body functions, activities and participation, while *disability* is similarly an umbrella term for impairments, activity limitations and participation restrictions. ICF also lists environmental factors that interact with all these components.

Studies show that diagnosis alone does not predict service needs, length of hospitalisation, and level of care or functional outcomes. Nor is the presence of a disease or disorder an accurate predictor of receipt of disability benefits or likelihood of social integration. This means that if we use a medical classification of diagnosis alone we will not have the information we need for health planning and management purposes.

The coding used is separated into the domains described above. To aid with the interpretation a more detailed description will now be provided:
<table>
<thead>
<tr>
<th>Body functions</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental functions</td>
<td>To sleep for 6 hours per night by 21-11-07</td>
</tr>
<tr>
<td>Sensory functions and pain</td>
<td>To be pain free by 7-12-08</td>
</tr>
<tr>
<td>Voice and speech functions</td>
<td></td>
</tr>
<tr>
<td>Functions of the cardiovascular, haematological, immunological and respiratory systems</td>
<td>To manage shortness of breath better by April 08</td>
</tr>
<tr>
<td>Functions of the digestive, metabolic and endocrine systems</td>
<td>keep weight under control and eat properly</td>
</tr>
<tr>
<td>Genitourinary and reproductive systems</td>
<td></td>
</tr>
<tr>
<td>Neuromuscular and movement related functions</td>
<td></td>
</tr>
<tr>
<td>Functions of the skin and related structures</td>
<td></td>
</tr>
<tr>
<td>Body structures</td>
<td></td>
</tr>
<tr>
<td>Structures of the nervous systems</td>
<td>No goals have been identified that fit this domain</td>
</tr>
<tr>
<td>The eye and related structures</td>
<td></td>
</tr>
<tr>
<td>Structures involved in voice and speech</td>
<td></td>
</tr>
<tr>
<td>Structures of the cardiovascular, haematological, immunological and respiratory systems</td>
<td></td>
</tr>
<tr>
<td>Structures related to genitourinary and reproductive systems</td>
<td></td>
</tr>
<tr>
<td>Structures related to neuromuscular and movement related functions</td>
<td></td>
</tr>
<tr>
<td>Structures related to movement</td>
<td></td>
</tr>
<tr>
<td>Skin and related structures</td>
<td></td>
</tr>
</tbody>
</table>
Table 4: ICF activities and participation classification

<table>
<thead>
<tr>
<th>Activities and participation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning and applying knowledge</td>
<td>To play organ again at Margaret Wilson rest home with support by 3-08</td>
</tr>
<tr>
<td>General tasks and demands</td>
<td>To knit continuously for one hour</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>To mobilise safely and to be able to drive to shops once per week by 6-08</td>
</tr>
<tr>
<td>Self-care</td>
<td>To regain independence with personal cares and household tasks</td>
</tr>
<tr>
<td>Domestic life</td>
<td>To go clothes shopping by 11-08</td>
</tr>
<tr>
<td>Interpersonal interactions and relationships</td>
<td>To attend friends wedding in Kaikoura in March 08</td>
</tr>
<tr>
<td>Major life areas</td>
<td>To save as much as I can for Wellington Free Ambulance</td>
</tr>
<tr>
<td>Community and social life</td>
<td>To be able to go to RSA twice per week by 11-08</td>
</tr>
<tr>
<td>Environmental factors</td>
<td></td>
</tr>
<tr>
<td>Products and technology</td>
<td>To have home fitted with rails to prevent falls in the future</td>
</tr>
<tr>
<td>Natural environment and human made changes to environment</td>
<td></td>
</tr>
<tr>
<td>Support and relationships</td>
<td>To accept the need for an increase in services to better support Peter to care for her</td>
</tr>
<tr>
<td>Attitudes</td>
<td></td>
</tr>
<tr>
<td>Services, systems and policies</td>
<td></td>
</tr>
</tbody>
</table>

The following graphs show how the goals were classified across three DHBs over month 1 and month 2 (DHB 001 also was classified for HBSS provider three month review). The first graph (Figure 10) shows all the classifications for all three DHBs that provided the data for analysis, followed by separate graphs per DHB.
Figure 10: ICF domains for each goal at Month 1 and 2 for DHBs 012, 018 and 001.

The majority of the goals were classified under general tasks, mobility, self care and domestic life. For DHB 001 support and relationships were another common goal. When reviewing the goals per DHB a similar trend is evident; see next pages.
Figure 11: ICF domains for each goal at Month 1 and 2 for DHB 012
Figure 12: ICF domains for each goal at Month 1 and 2 for DHB 018
Figure 13: ICF domains for each goal at Month 1 and 2 (plus HESS review 1) for DHB 018
Section two: DHB

This section describes the results of interviews and questionnaires with NASC staff and funding and planning staff\(^3\). These examined the relationships across funding and provider arms of the DHB and also between NASC and HBSS. The NASC manager rated statements in relation to the providers they work with and Funding and Planning. Each of the five DHB NASC managers completed this questionnaire.

NASC managers were asked to rate the following statements for each HBSS provider they work with. The following is an indication of how they rated each statement; a range of responses is in brackets.

Table 5: Relationship with service provider’s, median level of agreement and range of response

<table>
<thead>
<tr>
<th>How much do you agree with the following statements as a NASC manager?</th>
<th>Median level of agreement(^*) (range) (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel confident about asking the service provider to do something</td>
<td>5 (2-5)</td>
</tr>
<tr>
<td>I have no need to keep surveillance over the service provider after asking them to do something</td>
<td>4 (2-5)</td>
</tr>
<tr>
<td>I deliberately withhold some information from the service provider</td>
<td>1 (1-4)</td>
</tr>
<tr>
<td>I check with other people about the activities of the service provider to make sure they are not trying to &quot;get away&quot; with something.</td>
<td>1 (1-3)</td>
</tr>
<tr>
<td>I give the service provider all known and relevant information about important issues</td>
<td>4 (4-5)</td>
</tr>
<tr>
<td>I watch the service provider attentively in order to make sure he/she doesn't do something detrimental to the client</td>
<td>1 (1-4)</td>
</tr>
</tbody>
</table>

\(^*\) 5 = strongly agree, 4 = agree, 3 = neutral, 2 = disagree and 1 = strongly disagree

\(^3\) NASC Manager Questionnaire(V) and Funding and Planning Questionnaire (V) or telephone interview
A few of the NASC managers supported their rate of agreement with a statement. The NASC Managers did not feel that they were totally confident they would get a positive response when asking the service to do a task for them. Comments such as: “don’t always get a can-do response” and “not always done as requested” were the predominant response. People felt that mostly they did not need to follow up to make sure requests were being done, except for unusual circumstances and all were passing information which was relevant to the service provider. All information which the NASC feel is required by the service is provided to enable the providers to do their jobs. All NASC Managers watch and keep their ears and eyes open for anything detrimental to the client, saying “I do listen when staff bring issues about this provider” and “I keep an eye and ear open to be sure, it is part of the managing of the services. I would discuss if I had concerns”.

Figure 12 shows the rating for each NASC manager in response to statements about Funding and Planning.

![NASC relationship with Funding and Planning](image)

**Figure 14: NASC relationship with Funding and Planning across 5 DHBs**

No comments were written in this section by any of the NASC managers.
Funding and Planning

Although some DHBs felt it was too early to tell which processes were working well, some positive comments were made such as: “Staff involved in implementing have taken on board the restorative concepts”, “regular project meetings with all stakeholders”, “parallel development of a Maori model for HBSS” and “using ‘usual’ DHB allied health services ... reducing duplication.”

The processes where Funders and Planners noted difficulties have been divided into four themes:

Staffing and training incorporated comments about the difficulty in recruitment and retention of support workers, the lack of provider’s flexibility (by the DHB), the NASC (NASC and CCC) needing to “come up to speed... as leaders and trainers” and not relying on the DHB. Access to SMART training for coordinators and new NASC staff, and support worker training, were noted as difficulties also.

Support workers. There were issues surrounding reimbursement for driving costs, “little operational policy issues like this transportation policy may stop things.” Other issues related to what the support worker was capable of and rigidity surrounding allocation of hours, or particular days for tasks.

Clinical input was difficult in some cases, due to “the low referral to nursing units, so HBSS can’t get nurses as they don’t have enough work for them.” The nurse’s roles and how they interact with the coordinators are confusing, and “the need for clinical oversight of some clients may override previous allocation of clients on a locality basis.” Some providers and the NASCs are struggling with information overload from the involvement of OTs and PTs.

Delivery of goals is worrying some providers because they feel that “the DHB will judge them on whether or not the TARGET goal is achieve...rather than seeing the goal as client motivation”
There was a diversity of thoughts when discussing if all stakeholders were involved. These ranged from all being involved, to various lack of involvement with nurses, PHOS, GPs, AT&Rs, and consumers. Plans are in place to include the above, however, there is some concern about the duplication of AT&R services at one DHB. Information and training seem to be the main actions to improve the areas needing improvement, such as communication between; NASC and providers, and DHB and contract managers, and that “the message from the DHB is consistent and ongoing.” Other action areas mentioned were DHB server security and transport policy improvements.

Marketing ranged from nil or one newspaper article, to consultation at community meetings in the development stage, and all people in the system being given information. One NASC had “fortnightly stakeholder meetings in different parts of the DHB...and informed the Minister of Health.” Feedback is gained from the public “not often”, during “public consultation in development”, to “twice monthly sector meetings.”

Other comments were raised such as: deciding not to commence marketing with a “big bang” until further into the process. Changes in processes, such as, the “knowledge about how to do this” and supervision and delegation of District Nurses raised National issues about standards. As confidence in goal setting increases it was suggested that this will raise more issues.
Section three: HBSS

This section describes the results obtained from HBSS managers and coordinators. There are four sections under HBSS: coordinators and clients, coordinators relationship with NASC, service improvement and training needs, and support workers.

Coordinators and clients

In the initial Coordinator questionnaire respondents were asked to give ‘estimates’ in relation to time spent with clients (DHB, MoH and ACC). Of the 29 coordinators who completed the questionnaire three did not complete the question “what percent of the time is spent with the following clients (DHB, MoH, and ACC)?” Note: Figure 15 is by provider not by coordinator.

---

Figure 15: What percent of time is spent with the following clients (DHB, MoH, and ACC) by Provider.

---

4 Initial Coordinator Questionnaire (IIb) and Initial Manager Questionnaire (IIb)
The average hours worked per week was completed by all respondents in the Initial Coordinator Questionnaire (IIa) and hours worked ranged from 20 to 40 hours per week. The estimates of time on direct client contact either by phone or face to face varied from 100% of the time to 20% or less of their time. Of the sixteen coordinators across the DHBs who worked 40 hours a week the average time spent on direct client contact was 49% of their time.

Note, Figure 16 and 17 is by provider not by coordinator.

![Median number of hours worked per week by coordinators in each HBSS providers](image)

**Figure 16:** Median hours worked by coordinators per week per HBSS providers
Figure 17: Median number of hours of direct client contact either by phone or face to face

The coordinators were asked to write how many non-complex and complex DHB clients they are responsible for and whether they work with allied health when goal setting and planning care. The following, Figure 18 and 19, gives the mean averages (and Standard Deviation) for the number of non-complex and complex clients.

Figure 18: Mean averages and standard deviations for the numbers of non complex DHB client’s coordinators are responsible for (error bar = 1 SD)
Figure 19: Mean averages and standard deviations for the numbers of complex DHB client’s coordinators are responsible for (error bar = 1 SD)

Coordinators (N=25) who completed the Initial Coordinator Questionnaire (IIa) when asked whether they work with allied health when goal setting and planning care gave the following response; 12 stated ‘yes’ and 13 stated ‘no’. Four coordinators gave no response to this question.
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Coordinators relationship with NASC

The following question asked each coordinator from each HBSS providers to rate how much they agree with the following statements in relation to their relationship with NASC:

Figure 20: Provider LG relationship with NASC / care managers

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1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree
Figure 21: Provider LB relationship with NASC / care managers
Appendices

Figure 22: Provider RB relationship with NASC / care managers

Figure 23: Provider RD relationship with NASC / care managers
Figure 24: Provider RA relationship with NASC / care managers

Figure 25: Provider RC relationship with NASC / care managers
Figure 26: Provider AA relationship with NASC / care managers

Figure 27: Provider PG relationship with NASC / care managers
**Figure 28: Provider PA/B relationship with NASC / care managers**

**Figure 29: Provider PE relationship with NASC / care managers**
Figure 30: Provider DE relationship with NASC / care managers

Figure 31: Provider DF relationship with NASC / care managers
Figure 32: Provider PD relationship with NASC / care managers

The following are comments that were made regarding the use of the TARGET tool and their relationship with NASC by coordinators from DHBs 012, 016 and 018.

The NASC were generally praised with regard to the relationship with the coordinators, for example, “always helpful and obliging,” however contacting them is proving a problem with many, “limited phone lines into NASC makes it frustrating at times.” The coordinators feel they have more involvement with the clients than the NASC, their input is valued and the level of liaison between themselves and the NASC is improving.

Service improvement and training needs

In the Initial Team Leader questionnaire the coordinators were given the opportunity to write what were the three things that could be changed to improve the service. See Table 6 for the responses received in the 6Team Leader Questionnaire (IIa) on the next page.

6 Data from the Initial Team Leader questionnaire (I)
Table 6: Changes reported by HBSS providers caused by new model of service delivery

<table>
<thead>
<tr>
<th>Provider</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LG</td>
<td>Clear process between hospital discharge and input of allied health. Have referred clients because units in POC (package of care) and find they have already had visit from DHB Allied health. No communication exists.</td>
</tr>
<tr>
<td>RB</td>
<td>Goal ladders that reflect home based support services, rather than just OT or physio input. Better discharge planning from DHB inpatient wards.</td>
</tr>
<tr>
<td>RA</td>
<td>When existing clients are being assessed for the pilot that the NASC and provider visit together. Goals to be what client would like to work towards with measurable outcomes.</td>
</tr>
<tr>
<td>PD</td>
<td>A simple and clear focus to show that “TARGET” request received and accepted. A simple focus to indicate service provision to be given. Separate out new Target cases at moment some double up which concerns already established cases. i.e. adds at least three new people to a client. i.e. coordinator, support worker, assessor.</td>
</tr>
<tr>
<td>PA/B</td>
<td>TARGET referrals, being able to interact with the NASC i.e. discussion around clients, they appear to be under pressure. Not working under old and new systems concurrently (we have had x 1 referral from the NASC where the assessment tool used has been the SNAF). Having payment authorities in a timely manner (i.e. cannot put in services under a verbal). Having the TARGET/ SNAF when a referral for services sent to enable us to plan care accordingly. Having all the information is vital to be able to provide appropriate support and having it sent when requested.</td>
</tr>
</tbody>
</table>
Most coordinators stated that they have undertaken SMART training (n=23), with only six indicating they have not received this training. Seventy two percent (n=21) feel they require more training around assessment, goal facilitation and developing support plans; the remainder (n=8) do not feel they need further training.

HBSS coordinators were then asked to rate the following statements using a Likert scale regarding their training needs in relation to TARGET and their relationship with NASC. Each provider/coordinate response is given; see next pages.

\[ \text{\textsuperscript{7}} \text{ 1 = strongly disagree, 2 = disagree, 3 = neutral, 4= agree, 5 = strongly agree} \]
Figure 33: Provider LB coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC
Figure 2: Figure 34: Provider LG coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC.

Provider LG coordinator LG 3 only completed one response and LG 2 wrote no reply to the last statement.
Figure 35: Provider PA/B coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC.
Figure 36: Provider DF coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC.
Figure 3: Figure 37: Provider RB coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC.
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Figure 38: Provider RD coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC

Figure 39: Provider PE coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC
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Figure 40: Provider RA coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC

Figure 41: Provider RC coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC
Figure 42: Provider PD coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC.

Figure 43: Provider AA coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC.
Figure 44: Provider PG coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC

Figure 45: Provider DE coordinators responses concerning use of TARGET, assessment skills, and relationship with NASC

For each statement the coordinator was also given an opportunity to comment. The following is an outline of what was documented;
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Some coordinators didn’t feel totally confident with TARGET, partly because they were still learning while one felt it “did not always reflect the true needs of the client.” Some coordinators felt that their longevity working in the field of older people gave them enough skills to feel confident about their assessment skills. When examining the interpretation of goals most of the comments were about being part way through their training. Others comments about the difficulties included “goals are not related to what support worker can do to support the client,” and “issues with relevance of the goals.” Team meetings also showed that the process was in the beginning stages with comments like “not yet established.”

HBSS managers were also requested to provide the number of support workers and overall percent of the total work force trained to Foundation Level II on the Careerforce framework (see Table 10).

Table 7: The number of support workers and percent of total workforce trained to Foundation Level II

<table>
<thead>
<tr>
<th>Providers</th>
<th>How many support workers trained to Foundation Level II (N=)</th>
<th>What % of your work force have been trained to Foundation Level II (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LG</td>
<td>43</td>
<td>23%</td>
</tr>
<tr>
<td>RB</td>
<td>20</td>
<td>18%</td>
</tr>
<tr>
<td>RD</td>
<td>16</td>
<td>32%</td>
</tr>
<tr>
<td>RA</td>
<td>16</td>
<td>17%</td>
</tr>
<tr>
<td>RC</td>
<td>24</td>
<td>13%</td>
</tr>
<tr>
<td>AA</td>
<td>30</td>
<td>6%</td>
</tr>
<tr>
<td>PE</td>
<td>15</td>
<td>6.25%</td>
</tr>
<tr>
<td>PB</td>
<td>8</td>
<td>10%</td>
</tr>
<tr>
<td>DF</td>
<td>34</td>
<td>43%</td>
</tr>
</tbody>
</table>

Support workers
The providers were requested in the Initial Team Leader Questionnaire (i) to supply figures on support worker turnover. All the providers who responded to this question stated they appointed more support workers than they had resigned.

Table 8: Support workers who were appointed and those who resigned in the last month

<table>
<thead>
<tr>
<th>DHE</th>
<th>Support Workers appointed</th>
<th>Support Workers resigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>012</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>018</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>016</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>004</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

In the Initial Manager Questionnaire (IIA) HBSS managers were asked to provide data on staff turnover in ‘the last three months’; how many support workers, coordinators and resource coordinators were recruited and how many resigned. The following data was able to be compared with total staff numbers provided in a previous question. However, two providers while giving figures for staff recruitment and resignation did not provide total staff numbers. Overall, all providers (n=12) recruited more staff than had staff resign over ‘the last three months.”
Figure 46: Percentage of support workers recruited in the last three months per HBSS provider

Figure 47: Percentage of support workers who resigned in the last three months per HBSS provider
Each HBSS manager was asked how many hours in total are worked by their support workers annually by funding streams; DHB, MoH and ACC. The following figures were provided by ten managers across the five DHBs (n=10).

Figure 48a: Number of hours in total worked by support workers annually –DHB, MoH and ACC by Provider

Figure 48b: Number of hours in total worked by support workers annually –DHB, MoH and ACC by Provider
Each HBSS manager was requested to write the number of support workers in each working hour categories; ‘less than 5 hours per week’, ‘6 to 10 hours per week’, ‘11 to 20 hours per week’, ‘21 to 30 hours per week’, ‘31 to 40 hours per week’ and ‘more than 40 hours per week’. Two managers did not complete this section of the Initial Manager questionnaire (IIA).

![Number of support workers in home care and hours worked per DHB](image)

**Figure 49: Number of support workers working in each ‘hour’ categories per DHB**

The HBSS manager was then requested to complete the number of support workers with guaranteed hours per working hour categories as described above. Of the 12 managers who completed this questionnaire only six providers have guaranteed hours though only in small numbers with the exception of one HBSS provider who had 40 support workers with guaranteed hours across each working hour category.
Figure 50: Percentage of support workers with guaranteed hours per week per HBSS

In the Initial Coordinator Questionnaire (IQA) the question ‘In what situation do you do a joint visit?’ with a support worker allowed the coordinator (N=29) to make more than one response. The situations in which a coordinator might conduct a joint visit were; ‘new clients’, ‘highly complex clients’, ‘clients with concerns’, ‘support worker has client related concerns’ and ‘never need to’. The Figure 51 below indicates the frequency for each situation the coordinators indicated they would do a joint visit with a support worker.
Figure 51: In what situations are joint visits conducted by coordinators per DHB

Three coordinators from DHB 004 indicated that they ‘never need to’ do joint visits wrote “not needed as yet” (n=1); “if we need to – very occasional” (n=1) and “very rarely” (n=1).
HBSS coordinators were asked in the Initial Coordinator Questionnaire (IIa) to indicate how frequently they have team meetings with support workers (See Figure 52). Comments in ‘other’ category were “as required”, “2 monthly” and “one to one only”. Three coordinators wrote “never”.

![Graph showing frequency of support worker team meetings](image)

**Figure 52: How often you have team meetings with support workers (n=29)**

HBSS coordinators were also asked how often they assess support worker competency; eight coordinators indicated ‘other’ but did not specify the frequency.

![Graph showing frequency of assessing support worker competency](image)

**Figure 53: Frequency of assessment of support worker competency (n=21)**
The majority of the HBSS coordinators assess support worker competency 6 monthly or annually.

In the initial Coordinator Questionnaire [IIa] the coordinators were asked how often they meet, in general, one-to-one with a support worker.

Figure 54: Frequency of one-to-one meetings between coordinator and support worker (n=29)

Of those respondents who ticked the ‘other’ category and provided responses, the majority (n=9) indicated the frequency “varied” and “was as required”; one stated “when a problem arises” and another stated when “the support worker requests contact”.

Each HBSS manager in the Initial Manager Questionnaire (IMQ) was asked to write the hourly pay rate range for support workers and coordinators. All 12 managers completed this section of the questionnaire.

Figure 55: The median support worker pay rate and hourly pay rate range (error bar = 1 SD)

Figure 56: The median coordinator pay rate and hourly pay rate range (error bar = 1 SD)
References


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Cornwall, J. and J. A. Davey (2003). *The Impact of Population Ageing in New Zealand on the Demand for Health Services and Disability Support Services (DSS), and the Implications for the Health and Disability Support Workforce: Background paper prepared for the Ministry of Health*. Wellington, New Zealand Institute For Research on Ageing (NZIRA) and the Health Services Research Centre (HSRC), Victoria University.


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