Co-designing pathways to support the transition from hospital to home

Background

This project worked with health and social care practitioners, older people, their families and informal carers to identify and improve care pathways from hospital to home and enable a more positive experience for all during this transition. The project had three stages: 1. Pathway Mapping; 2. Co-designing; and 3. Embedding.

Stage One: Pathway Mapping

The first stage was an eight-month scoping period to meet with practitioners across Scotland and to gain an understanding of existing pathways already in place, what is working well and what could be improved. Practitioners were invited to participate in a mapping activity to visually represent the pathways in their area. When discussing the pathway, practitioners tended to focus on the problems they faced when discharging an older person from acute care. This provided insight into many pathways and processes across Scotland and the challenges associated with ensuring a positive experience.

A number of practitioners, from all three sectors, were involved in this process. This led to a number of varying perceptions of the problems within the pathway and the associated causes, which made synthesising the practitioners' overviews difficult. As a result, the synthesised maps are not meant to represent what the ideal pathway should look like but rather they simply offer a high level view of what older people may experience when discharged from hospital in Scotland and the challenges associated with ensuring older people are discharged through a positive pathway.

Stage Two: Co-Designing

This stage involved running a series of seven monthly workshops in Tayside, which supported a range of health and social care practitioners working in Tayside to work alongside older people and informal carers who had recently experienced the local discharge pathway.

Stage Three: Embedding

The final stage ran from October 2014 until March 2015 and worked with practitioners in Tayside to establish how the recommended interventions from the co-design

working group could be embedded locally. The primary locations for embedding these recommendations are South Angus and Dundee. There are on-going discussions about how these changes could also be also be embedded in Perth and Kinross later in 2015.

Starting points

A working group was set-up with 15 health and social care practitioners, three informal carers and six older people all of whom had recent experience of the local pathway. Older people and carers were identified through Tayside's Celebrate Age Network (CAN), while practitioners were those previously involved in the initial scoping phase. The practitioners had first-hand experience of the pathways and working with people but also had permission to implement change.

The older people and informal carers in the group wanted to get involved so that their stories and personal experiences could be heard. The practitioners wanted to learn from one another and improve the services that they provide to people within their locality. Working with the older people and informal carers in this way was new to them and, over time, relationships formed and there was sharing of experiences and learning happening more naturally.

Three Masters of Service Design students from Duncan of Jordanstone College of Art and Design (DJCAD), University of Dundee also assisted with running workshops. These students were able to apply in practice the co-production

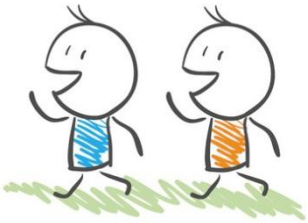
techniques which they had learned whilst studying and share different techniques with the working group.

Working together

Monthly workshop sessions from May until October 2014 used the Design Council's Double Diamond Methodology to establish the problems with the existing pathway and co-design solutions that could be implemented in practice. This process goes through four phases: Discover, Define, Develop and Deliver.

The Discover phase uses a series of activities to identify all of the problems associated with the existing pathway and was run over three workshops. One workshop focused on the Define stage where the key problems that the project could respond to were identified and service design tools were used to support this process. The Develop phase required two workshops to generate ideas that would tackle the problems previously identified. Finally the working group presented the co-designed solutions to health and social care leads in Tayside at the Deliver workshop.

These workshops were supported by homework activities completed by the group to maintain engagement. This worked really well and everyone in the group took the time to complete these activities and present it back to the group. Even when people couldn't attend a working group they would still share their work with the group to help inform the workshop sessions.



Challenges

Sometimes the older people in the group would be unwell or readmitted to hospital. The project team continued to support them through this period by keeping in touch and discussing their ability to remain involved on a regular basis. Building good relationships and maintaining regular contact was key to this process. For example, the first

workshop began in a non-traditional way: rather than having everyone in the group introduce themselves by role or experience, everyone was asked to bring an item that was special to them and to discuss that with the group. This instantly broke down barriers - everyone in the group was a person with shared values and no longer a group of practitioners and older people. Throughout the following sessions the group would reflect on this and how it had made them feel more comfortable.

There were a couple of new additions to the group as people identified roles that were missing e.g. pharmacy and GP. These additions were sometimes difficult, as the new members hadn't built the same relationships as the others. However, having informal breaks and lots of cake throughout the sessions helped to break down barriers.

Sometimes practitioners were unable to attend meetings due to work commitments, which was problematic as it meant they were not always up to date with what the group were working on. Although contact was maintained through regular updates and providing feedback from the sessions.

The main issue was some practitioners in the group did not know how to listen to the older people and thought they were person-centred in their approach but had not truly worked in this way before. One example was when an older person in the group discussed how their care at home was poor. Several practitioners in the group kept saying 'but it should be like this' 'or like that' and so on… It reached a point where the older person – quite understandably upset – said 'I know how it *should* be, I'm trying to tell you how it *is'*. This was a turning point for the group and from that moment on they worked as a team.

Outcomes

The project has co-produced – through co-design – interventions which will help to ensure a positive pathway from hospital to home for older people in Tayside if successfully implemented in practice. Through working with older people and informal carers and valuing their knowledge and experience the interventions designed are person-centred. Equally as important, having the skills and knowledge of practitioners in the group means the interventions will also be feasible in practice.

One of the key learning outcomes from the Working Group sessions was the varying perspective of the pathway from hospital to home. Practitioners, as a group, illustrated the pathway as starting in the hospital and ending when the person is discharged and returns home or to a homely setting. Non-practitioners in the group, on the other hand, illustrated that they see the pathway starting and finishing at home.

Together the group were able to move their understanding from what 'should' happen to what 'is' happening. This only happened because of the equal value in everyone's voice. The group also enabled health and social care practitioners to begin to work in an integrated way and learn about each other's work and expertise.

> "A practitioner told me they didn't like a form that was to be used with older people as they knew it hadn't been designed with them and so how could it be person-centred. This was great feedback and truly showed the transformation of their thinking since being involved in the project."

"We now understand that shifting the perspective of practitioners to match that of the people within their care is essential in developing a person-centred pathway that focuses on the person's desired outcomes."

"I don't think we would have achieved what we have without starting in this way. Instantly we were just people in a room and not practitioners and service users."

The project focus was to work collaboratively and identify the key problems that prevent an older person from experiencing a positive pathway from hospital to home. This process identified problems at three key stages:

1. In Hospital
2. Leaving Hospital/Getting Home (Discharge)
3. At home (or Care Home)

In response to the problems at each of these stages, the group proposed a three-pronged intervention approach as follows:

1. An admittance coordinator
2. A named practitioner following the older person from hospital admission to home
3. Discharge at home

In South Angus, these changes are already being implemented, while in Dundee work is underway to establish what changes need to be made to implement this three-pronged intervention. Through developing good relationships with NHS Tayside's Older People Board and Dundee City Council's Discharge Management Group, this has helped to ensure the changes recommended by this project group will be put into practice. The process of working with older people, carers and practitioners has been welcomed and NHS Tayside and Dundee City Council are keen to implement similar processes in future.

Why is this co-production?

This project brought together the skills, knowledge and experience of both people who use services, informal carers and practitioners who are delivering services to **co-**

design interventions which will deliver better outcomes for all those involved. Without the involvement of all these stakeholders, there is not the right expertise in the room to develop a truly person-centred and practical solution.

Assets – older people and informal carers within the workgroup had an active voice through breaking down the barriers from the start and introducing everyone as 'people' rather than roles. This worked well and the group relied heavily on their experience and values when working through the design process.

Mutuality - everyone in the group was treated as equals. Practitioners were discouraged from mentioning their role and asked to only discuss their experiences. This prevented people being caught up in roles and authority. Experiences, whether personal or professional were equally valued and as the older people and informal carers opened up with their stories, practitioners in the group also started to share their personal experiences and not just the professional ones.

Networks – the group was encouraged to work together and to learn from one another. As a result of the project, members of the working group were supporting each other outside of the group. For example, one of the practitioners worked with an older person to improve her care at home; and some of the practitioners worked together to make change in their area following insight from older people on the group.

Catalysts – most people in the group took on their own responsibility to make change locally. A number of the working group members now sit on other working groups and some have given presentations on their experience of co-production. Some have joined advisory groups locally to make changes, while other helping to write strategy documents that will pave the way for changes in the home to hospital pathway to be put in place.

Lessons and learning

Breaking down barriers from the start enabled everyone to participate in the workshops as people, rather than practitioners and service users. Creating the opportunity for people to work towards a shared aim, interest and passion was very important.

> "It was an incredible opportunity to watch a divided group become a team working together to achieve the same aim."

Further information:

This case study was produced as part of the resource 'Co-production – how we make a difference together', developed by the Scottish Co-production Network, the Joint Improvement Team, the Health and Social Care Alliance Scotland and Governance International.

You can find out more about this case study from Fiona Munro, IRISS;

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