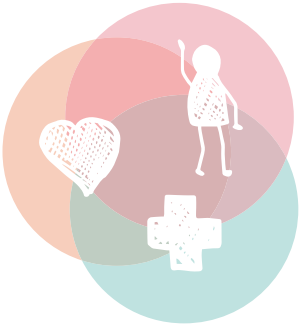
Care 'in between'

Exploring care needs between acute hospital and home in Moray

Project summary | February 2020



Dr Tara French, Yoni Lefevre and Sean Fegan

INNOVATION SCHOOL
THE GLASGOW SCHOOL OF ART

HEALTH & SOCIAL CARE MORAY

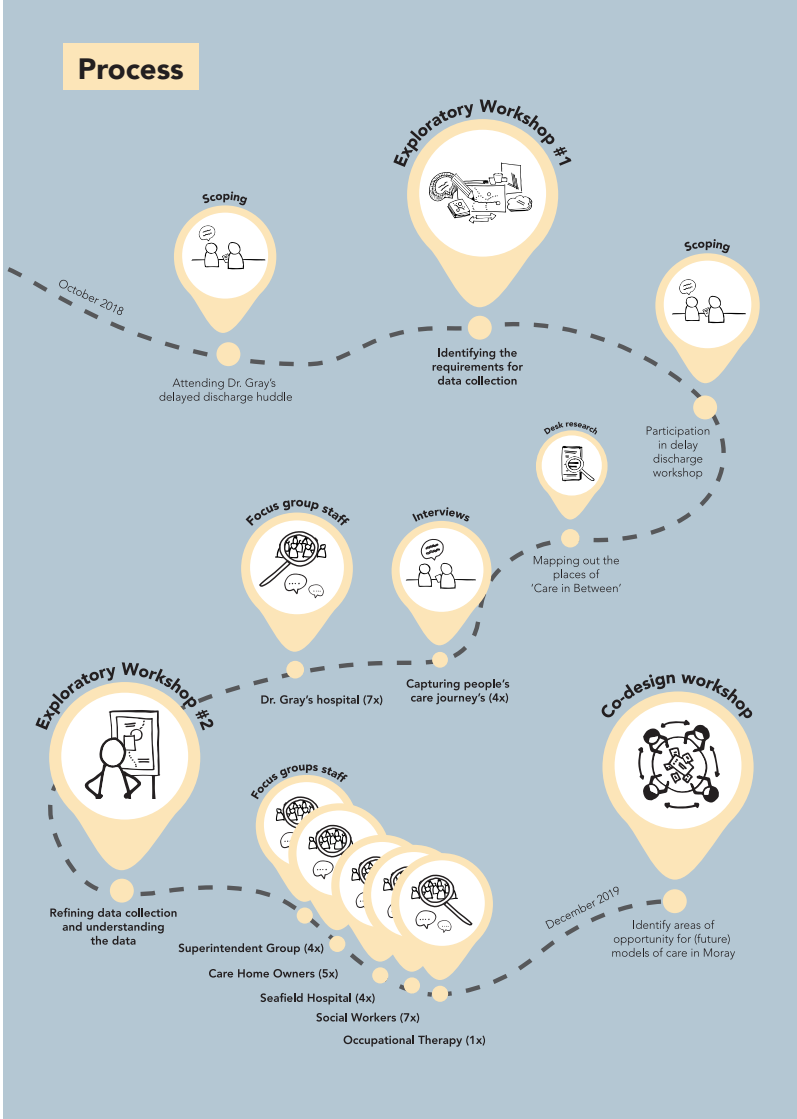
Project Aim

The project used a design-led approach to explore how care could be provided in a way that meets the needs of people in Moray (in between acute hospital and home), enabling sustainable change across the system. The process enabled all stakeholders to explore the current understanding of care 'in between' and the care needs in Moray, and to be open to possibility in terms of how care could be provided differently in the future. By collecting different perspectives on care needs, places of care and lived experiences, stakeholders were enabled to creatively explore future opportunities for sustainable care.

"What services do we need in the future for people who are not in secondary (acute) care and who are not able to be supported in their own home?"

More information about the project can be viewed on:
https://futurehealthandwellbeing.org/care-in-between

Process



Fieldwork and methods

1. Exploratory Workshops

Two exploratory workshops were designed to bring together stakeholders from health intelligence, public health, health planning and others who hold and have access to relevant data, in order to build an understanding of the current landscape of care in between. The first workshop (held in June) aimed to collectively define and identify key data requirements to understand the current care provision and care needs 'in between' hospital and home. The second workshop (held in September) aimed to collectively understand the data around each place of care towards understanding the care 'requirements' for Moray.

2. Interviews: People receiving and providing care

A series of interviews and focus groups were undertaken in order to engage with people receiving and providing care 'in between'. An interview tool was designed to map a person's care journey from hospital to home. In addition, a focus group engagement tool was designed to engage staff around the current process, challenges, aspirations and care needs related to providing care. Group engagements with staff included: Dr Gray's hospital, discharge planning, community hospitals, care homes and social work.

3. Co-design Workshop

A co-design workshop was organised (December '19) to bring together health and social care stakeholders who are currently providing care in between, and also organisations who could play a key role in the future of care in between. The workshop aimed to share the current landscape of care in between based on the previous workshops and engagements, and to build from this future scenarios around how care in between could be provided in the future. Insights of previous interviews and focus groups about people's experiences of receiving and providing care informed the creation of four themed briefs (see paragraph below 'understanding the context') to explore more in detail during the co-design workshop. In total 51 people participated in the workshop and they were divided into smaller groups based on the four themes:

1. *Transitions from Dr. Gray's to home*
   Transparent assessment and communication
2. *Practicing person-centred care*
   Understanding roles and utilising appropriate skills
3. *Building resilience through prevention*
   Integrating support at the 'right' time
4. *Changing perceptions through awareness*
   Creating and communicating a new language for 'support'

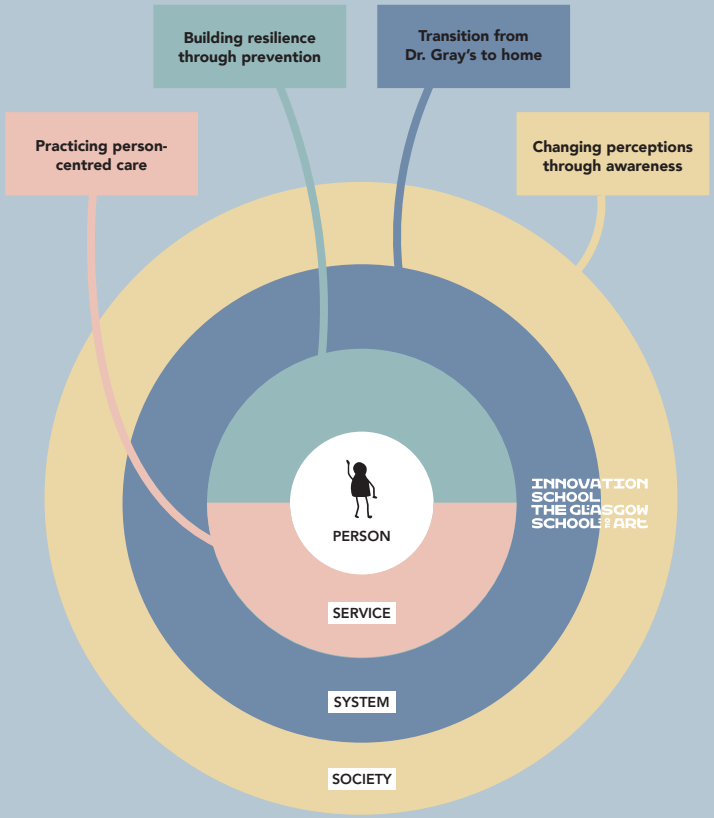
Conclusion

The journey and transition from hospital to a place of care 'in between' was a key focus in this project and is proposed as a priority area for future work. The findings of the project provide a body of evidence to support Health and Social Care Moray to build a future vision for care 'in between' in partnership with key stakeholders across the system and through engaging the community. Building a sustainable model of care 'in between' means understanding the implications for this space when there are impacts from other parts of the system. As a result, this project has developed a model of system-wide innovation to enable the development of a future model of care 'in between' by considering the impact of a 'destination home' approach in Dr Gray's, wider community-based prevention that is responsive not reactive, practicing person-centred care through a needs-based approach and shifting perceptions to support an informed population. Prioritising these areas going forward through a strategic set of transformational work programmes (outlined in the roadmap) will allow Health and Social Care Moray to build a model of care 'in between' that meets the needs of the people of Moray.

Building on the strategic vision theme of being supported at home or in a homely setting and the aspiration from people receiving and providing care to be supported locally, there is a need to explore future models of care where the journey begins at Dr Gray's. The vision of 'destination home' would involve exploring the culture and practice within Dr Gray's and the relationship to providers of care and support in Moray localities from a new perspective in order to reshape local care needs based on the experience of this journey and transition. The shift in perspective to consider 'destination home' at the outset has the potential to positively impact care pathways and transitions, as well as establish more coordinated working practices among staff.

Overall, the future of a sustainable model of care 'in between' is predicated on decision-making, leadership and ownership. Decision-making in order to begin the journey towards transformation and ensure this is prioritised and roadmapped appropriately; leadership in order to guide the pathway to change among key stakeholders and foster the collaborative approach that will be required to achieve a sustainable model; and finally, ownership to enable accountability but more crucially, to empower those who invest in this journey. The importance of decision-making, leadership and ownership should not be underestimated and is absolutely fundamental to the future of care 'in between' in Moray.

System-wide innovation



A model of system-wide innovation for care 'in between', French and Lefevre (2019)

Themes

Theme 1: Data measurement and evaluation

Currently people's care needs are not recorded in a way which is easily accessible and makes it difficult to truly understand people's support needs and practice person-centered care across places of care and services. The data that is recorded and reported is predominantly for audit and performance purposes and there is a need to review the types of data that are recorded and the purpose of the recording to ensure that data can be used for evaluation to drive innovation, improvement and transformation. Participants highlighted the need to identify and capture where improvements can be made but also use data to understand and communicate the bigger picture, good practice and what is working well.

Theme 2: Navigation and coordination across the system

Supporting people to be able to access the right information can allow them to effectively navigate the system. This can help in situations such as connecting older adults living alone to local support and it was acknowledged that more support is needed to enable rapid access to services in situations of crisis and sudden onset symptoms. Having a 'wide MDT' was also suggested, as well as providing signposting and mechanisms to recognise 'red flags'. The importance of having time to listen and reassurance was also highlighted.

Theme 3: Building trust and understanding other roles

The need to build trust and gain an understanding of roles across the system was a key theme across the project with key implications for assessments and how people who require support interact with and access the most appropriate professional or service provider.

Theme 4: Honest and courageous conversations

Having robust conversations about where the person would prefer to receive support after discharge is not easy, but by providing clear and realistic options about people's discharge destination this can help to manage expectations (individual and family) as often care is perceived to be a 'quick fix'. At the workshop participants shared that Mental Health professionals are experienced in having honest, and often 'difficult' conversations because building a trusting relationship is crucial. It was also acknowledged that involving family members in conversations can be difficult given patient confidentiality and sometimes people do not want their family to know. Participants also shared the importance of strengthening relationships at all human levels from the individual, to family, the community, the professional and government, to support prevention and self-care.

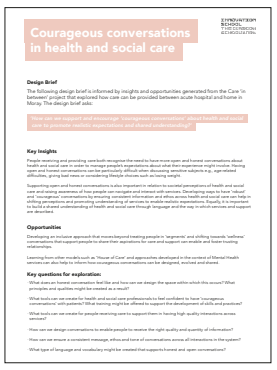
Roadmap for implementation

A roadmap to guide implementation and future work to support Health and Social Care Moray in the future of care 'in between' was developed by consolidating the learning and insight generated across the project. The roadmap is based on five key areas that have a set of actions for 'now' (short term) and 'next' (long term) which can be viewed in full on the website.

Tools to explore the future of care 'in between'

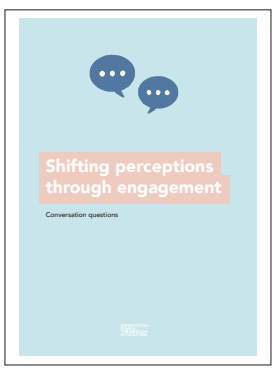
1. Courageous conversations - Design Brief

The conversation brief is a design brief which outlines a future project which could be taken forward by Health and Social Care Moray (in collaboration with a design innovation student) in order to develop ways to support staff to engage in 'courageous conversations' with people who receive care. The brief outlines the key insights and opportunities, as well as a series of questions which could be explored through a co-design process.



4. Shifting Perceptions Through Engagement

A series of conversation questions have been designed to support Health and Social Care Moray to develop an engagement strategy and methodology to engage communities across Moray around the future of care 'in between'. The booklet provides key insight and questions that can be used in a group setting to form an engagement plan to help support communication with communities.

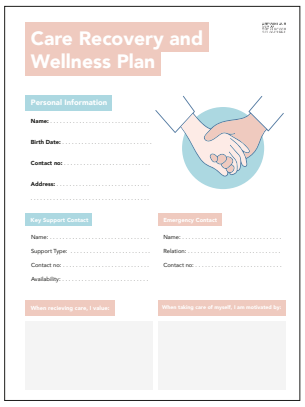


2. Care Community Connector

The Care Community Connector is a speculative persona and job description of a future role based in Dr Gray's that supports people to transition to home through connecting the person to local support and services. This speculation is designed to support Health and Social Care Moray to critique the future should this role exist and consider the types of roles that already exist within the system that could be adapted to support the purpose and responsibilities identified.

3. Care Recovery and Wellness Plan

The Wellness and Recovery Plan is a speculative communication tool designed to support communication with the person receiving care and enable shared decision-making. The tool has been designed to show the types of information that would be valuable to include in a plan that would enable people to understand their journey, how they could support themselves and the types of support that they may require as they transition to home.



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