

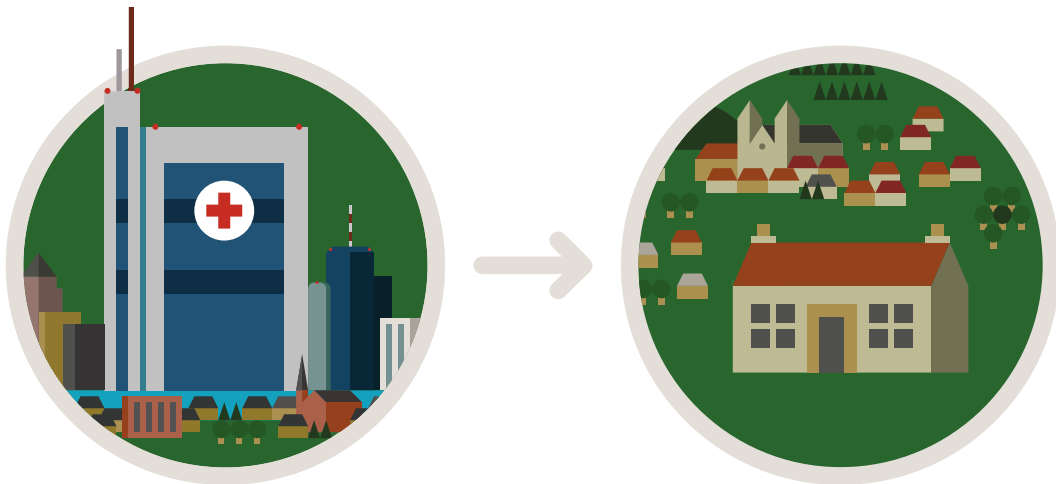
Hospital to Home Evaluation report

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Acknowledgements

Our thanks go to the Working Group participants, the Steering Group members and our many partners in Tayside who have been involved in the delivery and co-evaluation of this project. It was testament to their dedication to improving care that they would share with us their time, their experiences and their knowledge. We have heard some fantastic stories and seen some wonderful examples of true person-centred care. Thank you.



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Executive summary

INTRODUCTION

The Iriss *Hospital to Home* project was designed to identify and improve care pathways from hospital to home in the Tayside region of Scotland. Iriss worked with health and social care practitioners and people with experience of the pathway to identify issues to be addressed. This resulted in three broad [recommended interventions](#) from the project Working Group that could be adapted and embedded locally with local partners from the case study areas of South Angus and Dundee.

OVERVIEW

This evaluation concerns the final aim of the project: **To develop a series of co-designed service recommendations, designed to enable older people to experience a well-supported, co-ordinated and positive pathway from hospital to home.**

Using a co-evaluation approach with health and social care practitioners we evaluated how the project Working Group recommendations were used in the case study areas and the impact this had, both for those delivering the new pathways, and those receiving care.

The project recommendations were adapted and used in different ways across South Angus and Dundee with specific system changes being applied and tested. These were mainly adaptations that addressed co-ordinating care and improving communication and trust across different practitioner groups. These included: conducting multi-disciplinary team meetings in community and hospital; moving some social work function and assessment into the community; and assigning coordinators to manage the hospital/home transitions of an older person.

LEARNING POINTS

- Equally bring together the voices of health and social care practitioners and older people, carers and families to develop change – this gave us legitimacy and opened up new avenues of thinking and communication

- Build meaningful and strong relationships with delivery partners as early as possible – this gave us influential and enthusiastic practice champions going forward
- When recommendations align with current direction/strategy, it is much more likely that these can be developed, but don't be afraid to challenge this direction if necessary
- It is much easier to make service level system changes on smaller geographical scales where the numbers of patients/practitioners/facilities are not as vast
- Developing person-centred practice and thinking takes time – drilling down to personal outcomes as a result of service level changes requires careful evaluation



1. Introduction

The Iriss [Hospital to Home](#) project was designed to identify and improve care pathways from hospital to home for older people (over 65), and enable a more positive experience for all. The embedding phase of this project took place between October 2014 and October 2015 when we worked with practitioners in Tayside to establish how the [recommended interventions](#) from the project Working Group could be embedded and scaled locally. This report presents an overview of the findings from this last phase of the work and includes: links to the project's theory of change and associated activity; evaluation methods and learning; and reflections about embedding. There are links interspersed throughout the report that take you to the *Hospital to Home* project website and provide more detail on other aspects and outputs of the project.

CONTEXT

When the *Hospital to Home* project started in 2013, there was a growing concern that current models of health and social services needed to change to address the demands of an ever-increasing ageing population in a context of financial constraint.

In response to this demanding issue, the Scottish Government developed key policies for [Reshaping Care for Older People](#), drawing attention to improved services for care of older people through a shift in focus towards anticipatory care and prevention. For this purpose, the Scottish Government allocated a £300 million Change Fund (2011-2015). In addition, the Scottish Parliament introduced the [Public Bodies \(Joint Working\) \(Scotland\) Bill](#) (May, 2013) which aims to improve outcomes for older people through three key agendas: 1. Providing consistency in the quality of services they receive; 2. Ensuring people are not unnecessarily delayed in hospital; and 3. Maintaining independence by creating services that allow people to stay safely at home for longer.

During its inception, this project was specifically concerned with the design of a new positive pathway to improve the transition of older people from hospital to home, a by-product of which may be helping to ensure that these individuals are not unnecessarily delayed within hospital care. It focused

primarily on working with health and social care practitioners, older people and their families to improve the service delivery of care pathways in Tayside area of Scotland, and to produce a more positive experience for older people.

The key aims for this project as a whole were as follows:

- 1 To develop a greater understanding of the existing pathways already in place in Scotland, and to identify what was working about these and what needed improved.
- 2 To encourage and support national knowledge transfer between stakeholders of the current service interventions applied in the UK and how effective, or not, these have been in tackling the issue(s) around the transition of older people from hospital to home, as gaps in service provisions are discovered, shared and, ultimately, addressed.
- 3 To enable older people, and their family's voices to be heard by the appropriate health and social care professionals through co-production workshops. These workshops were designed to provide a greater understanding of how the current lack of a positive pathway for older people during their transition from hospital to home affects everyone involved – both in a professional and personal capacity.

This report is particularly focused on addressing the final aim:

- 4 **To develop a series of co-designed service recommendations, designed to enable older people to experience a well-supported, co-ordinated and positive pathway from hospital to home.**

To achieve these aims, a Working Group was set up in Tayside to bring together a range of frontline health and social care practitioners working in Ninewells Hospital, Perth Royal Infirmary, Arbroath Infirmary and the local community, alongside older people and informal carers who had experience of the local discharge process in the past twelve months. Engagement with this group was supported by regular strategic support from NHS Tayside's Older People Board and Dundee City Council's Discharge Management Committee. Thanks have to go to them for their continued involvement.

2. Methodology and data collection

CONTRIBUTION ANALYSIS

We used an evaluation framework called [Contribution Analysis](#) (CA) to understand the impact of the *Hospital to Home* project in the Tayside area. CA is part of a family of evaluation approaches called theory-based evaluations – it uses a theory of change to show how a project is intended to work and the mechanisms of change which lead to its impact. There is further information about the rationale for using CA for this project in [Appendix 1](#).

In this evaluation, we have used multiple kinds of evidence to ensure robustness. In the project as a whole, we have aspired to blend a range of knowledge at different points in the process, but the focus is very much on the experiences from people who are, or have been, involved in the hospital to home process in Tayside.

Theory of Change

The *Hospital to Home* project was a three-year, multi-faceted, project that involved three distinct stages:

- 1 Pathway mapping and scoping
- 2 Co-designing interventions that improve care and support for older people
- 3 Embedding those interventions in Tayside

This theory of change articulates an overview of the three phases, paying particular attention to the co-design and embedding phases. This evaluation has prioritised understanding the embedding process. The full process is outlined in the diagram in [Appendix 2](#).

PROJECT STAGES

Stage 1 – Pathway Mapping And Scoping

The first stage of this project was an eight-month scoping period, during which the project lead, Fiona Munro, met with practitioners working across

Scotland to gain an understanding of the pathways already in place, what was working well and what could be improved. During this phase, practitioners were invited to participate in a pathway mapping activity to visually represent the pathways in their area. This provided insight into many pathways and processes across Scotland and the challenges associated with ensuring a positive experience.

An overview of this phase of the project, alongside thoughts and insights on the project from Peter Macleod (Director of Social Work at Renfrewshire Council and Chair of the Iriss Board), can be found in a [special episode of Iriss.fm](#). The outputs from this stage of the work is a [series of maps](#) offering 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. During this phase we also produced a summative [literature review](#) of the key problems and solutions, and a list of key resources for further reading.

Stage 2 - Co-Design Process

The co-design process used a double diamond approach: discover, define, develop and deliver. We held seven Working Group events across an eight-month period in 2014 to creatively define ‘issues’ and collaboratively develop a response that will improve care and support for older people (see [Appendix 3](#) for a fuller description of what these workshops entailed). These workshops consisted of a team of health and social care practitioners, older people with experience of the hospital to home pathway and their family members and carers. These were designed to work towards identifying practical interventions that could be made to the hospital to home process in Tayside that would improve this experience for those involved.

‘the way that you got people together and the way you worked with them, to get to the point of getting meaningful information about what people really want and what people really understand, I think that was the strongest point of all... I think that was a real refreshing way to do things’

—ASSOCIATE MEDICAL DIRECTOR FOR OLDER PEOPLE, NHS TAYSIDE

This stage was very much the heart of the project, as it was the bringing together of these voices and experiences that helped us to legitimise the interventions that were identified by the Working Group.

Stage 3 – Embedding And Scaling Out

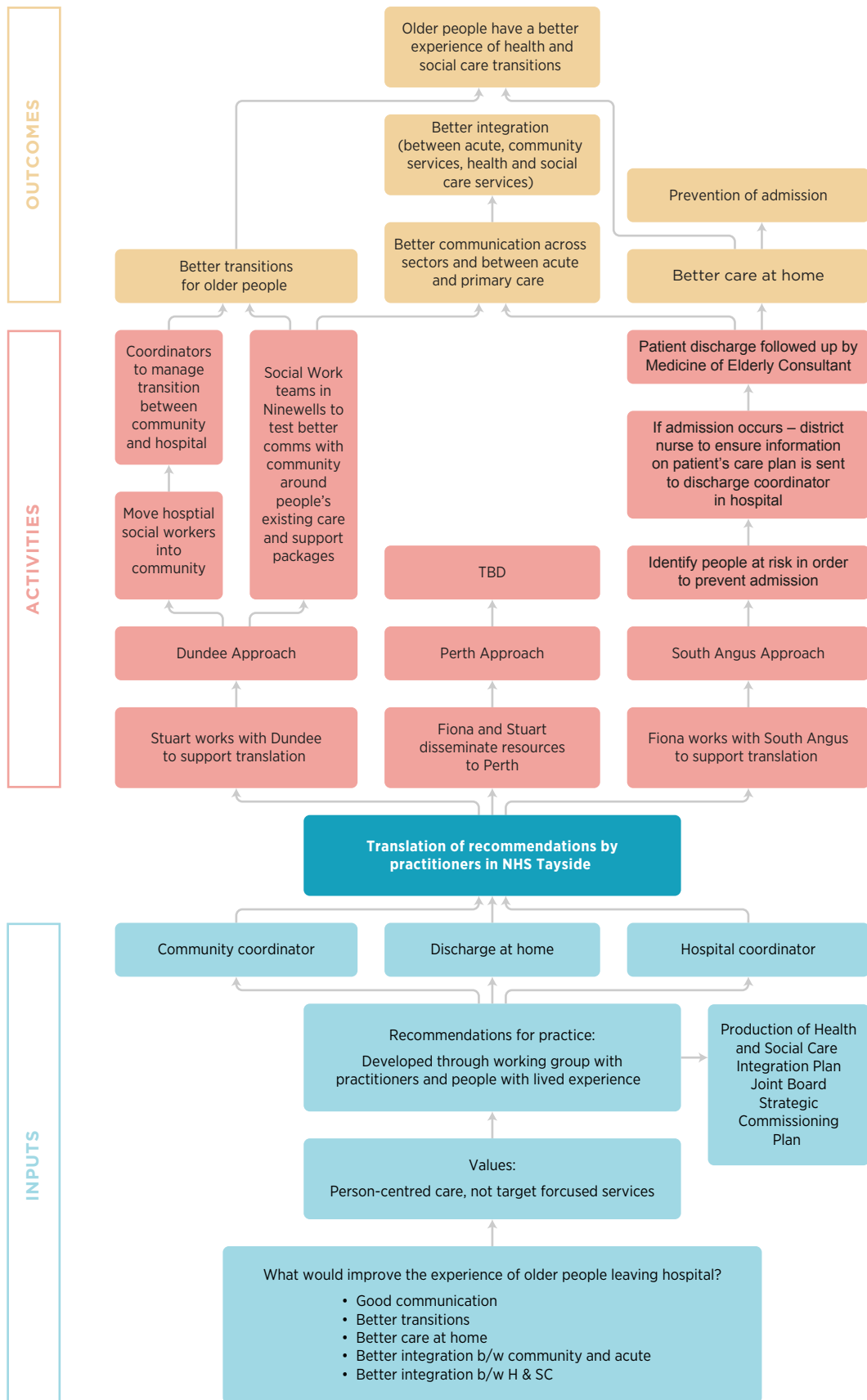
The embedding and scaling out process was designed to (1) ensure the successful piloting of the co-designed interventions; (2) share learning about the co-design process; and (3) improve understanding of older people’s experience of care and support when they travel from home to hospital and back again through references to the evidence based developed as part of this project.

In order to achieve these aims, the project leads undertook a series of embedding and scaling activities:

- **Informing:** presentations to a wide range of strategic audiences (at 19 events), Iriss.fm podcasts, updates on *Hospital to Home* website and the Iriss mailing list
- **Translation and facilitation:** Working with strategic leads in Tayside to provide continuity between the values and recommendations of *Hospital to Home* project and the piloted interventions within NHS Tayside (culminating in 12 meetings/events)
- **Co-creation:** Collaborative evaluation with health and social care practitioners in Tayside

LOGIC MODEL

The full logic model is shown below, connecting the links between the Working Group input, through the interventions made in the area, to the aspired outcomes. Throughout the project, we had involvement with practitioners from Perth and Kinross. However, for this evaluation, we focused on the areas of Dundee and South Angus where we were more actively involved in the implementation of some of the recommended changes.



Above Logic model connecting the links between the Working Group input, through the interventions made in the area, to the aspired outcomes

3. Conducting the evaluation

EVALUATION PROCESS

The evaluation was co-created by the Iriss project leads and a number of key embedding practitioner partners from the case study areas of South Angus and Dundee. This was designed in this way to try and collect a range of perspectives on the changes that had been made in the areas. The following data were collected and analysed:

Strategic Interviews across Tayside (designed and conducted by the Iriss project leads)

- Key senior health and social care managers in Tayside (four interviews)
- Working Group practitioners (three interviews)
- Working Group older people (two interviews)

Older People Interviews¹ (co-designed by Iriss project leads and embedding partner practitioners, conducted by partner practitioners)

- Dundee (five interviews)
- South Angus (eight interviews)

Practitioner Survey (co-designed by Iriss project leads and embedding partner practitioners)

- Dundee (16 respondents)
- South Angus (12 respondents)

Practitioner Focus Group (co-designed by Iriss project leads and embedding partner practitioners, conducted by a partner practitioner)

- Dundee (eight participants who have experience of delivering the new pathway)

¹ Older people going through the new pathways in South Angus and Dundee were identified by practitioners and approached for consent to conduct an interview with them in their own homes following their discharge. We provided each partner practitioner with an information sheet and consent form to use. The criteria for identifying older people suitable for interview was that they were going through the recent pathway changes; agreed to interview when approached in hospital; and had a level of capacity to provide informed consent.

We developed a series of interview questions, designed to prompt the older people interviewed to discuss their experiences in hospital; their hospital discharge; and their care once home. A practitioner from the hospital in which they had been receiving care used these to conduct the interviews with each older person identified within 48 hours of their discharge home.

WORKING GROUP RECOMMENDATIONS

These are the three interventions that were suggested by the Hospital to Home Working Group. Please note that these are just brief descriptions (see [the website](#) for the full rationale and explanation):

1 An admission co-ordinator to help older people as they are admitted to hospital

This coordinator would be responsible for gathering and recording all necessary information at the point of the older person's unplanned admission to hospital and ensuring that this information is passed on appropriately to the hospital staff.

2 A named practitioner following the older person

The group proposed that one practitioner take responsibility for all information shared with and about the older person. This person could also have the role of the admission and/or discharge coordinator, but crucially, this role should link up hospital and community care, keeping the older person at the centre of decision-making.

3 Discharge at home

A recommendation was made that older people be discharged from the hospital service once they are in their home and they are happy to be so, rather than at the point when they leave acute care. This was intended to overlap hospital and community care and make sure care packages were in place and the person was comfortable with this support before completely disconnecting from the hospital.

It should be highlighted that we did not expect these interventions to be taken forward in Dundee or South Angus in exactly the ways outlined. Instead, we expected them to be tailored and adapted to the situations and places that they would be implemented.

The purpose of this evaluation is to try and get a feel for whether the interventions made a positive change for the organisations and professionals involved in implementing those changes (system outcomes), as well as exploring whether these changes made a difference to the older people and the carers/family that experienced these changes (personal outcomes).

The next Case Study section gives an overview of the findings in each area, alongside some barriers and enablers to the data gathered that relates to these system and personal outcomes.



4. Case studies

It is important to highlight that the following case studies are based on a snapshot of some of the work that is going on in the areas that were directly and indirectly influenced by the Iriss project, with the evaluation taking place in mid-to-late 2015. With the [legislation to implement health and social care integration](#) in Scotland coming into effect on April 1st 2016, this is an area that is currently maturing and developing.

SOUTH ANGUS

The recommendations made by the *Hospital to Home* project linked in very closely with the Enhanced Community Support (ECS) model of working that was already due to be put in place in South Angus. While this meant that some of the changes were going to happen anyway (e.g. multi-disciplinary team meetings in the community) the practitioners that were interviewed highlighted that the project provided an increased focus on involving a broader range of practitioners, including social work and third sector within these meetings.

'This has greatly improved communication between Arbroath Infirmary, GPs and Social Work. I am often able to identify people in the community and give my health colleagues relevant information about the support they have in community.'

—RESPONDENT 4, SA PRACTITIONER SURVEY

Practitioners in South Angus developed multi-disciplinary team (MDT) meetings within the local GP practices to identify older people at risk of hospital admission in the area. These meetings took place weekly and involved practitioners working across all three sectors (health, social and third sector), coming together to collaboratively discuss the collective needs of individual people in need of care. Through this, they were able to work together to identify older people at risk of admission to hospital, and devise preventative strategies to support them in the community. These MDT meetings were recognised by practitioners as providing a number of benefits including improved relationships and enhanced routes of communication.

This was claimed to have led to reduced assessment times and improved access to other services. However, they also recognise that preventative approaches in the community may lead to additional pressure on community services and that additional support may be required in this area.

While MDT meetings had been part of the existing enhanced community support model of working, the aim to 'discharge from home' within 48 hours of leaving hospital had not. This recommendation was also put in place in South Angus. This was made possible through the existing role of the Nurse Practitioner, whose involvement is credited by the majority of the staff interviewed:

'on behalf of OT and Physio we've a better link medically now as well because sometimes we would see people at home and there would be a slight medical issue, we would have to contact the GP but we would never really hear back the outcome, whereas now we have [the named Nurse Practitioner] to liaise with and it is something that could probably be dealt with quite quickly at home and it stops it progressing into an admission.'

—SA FOCUS GROUP PRACTITIONER RESPONDENT

'I think the link of a Nurse Practitioner who is hospital based, also going out in the community to follow people back into the community is very helpful.'

—SA FOCUS GROUP PRACTITIONER RESPONDENT

However, while the MDTs are recognised as improving the pathway and supported integrated ways of working, practitioners were less clear if this was the case for 'discharge at home'. Senior staff reflected that this might be because, at the point of interview, this recommendation was seen as a desirable aim and not a formal requirement, as the MDTs are, and not all staff were actively engaging in this objective. Those staff who were implementing this change recognised that it enabled them to become more aware of any complications at home following hospital discharge and potentially enabled them to reduce the need for readmission through early preventative approaches:

'We've been able to send patients home with large care packages who previously we would never have tried to discharge home. They would have gone to a care home. We may have reduced care home admissions from our hospital by about 50%'

—RESPONDENT 1, SA PRACTITIONER SURVEY

'I believe it gives the patient confidence that the same team who saw them in hospital and already knows their background /issues/concerns etc will be the same team to see them at home and follow on with the patient on their journey.'

—RESPONDENT 6, SA PRACTITIONER SURVEY

It was highlighted that the small size of Arbroath Infirmary made this possible. There was an increased likeliness that staff seeing patients at home following discharge had met them previously in the community prior to admission or in hospital. This was identified as providing continuity of care that may not be possible in larger hospitals.

Similarly, the recommendation that there should be an 'admissions coordinator' was explored in South Angus with the potential for existing 'discharge coordinators' to get involved in the patient journey earlier in order to facilitate this. However, this was never formalised and, as a result, changes were not made due to lack of staff capacity, heavy work loads and lack of buy-in from the staff working in the discharge coordinator roles.

As a collective, the older people/carer interviews in South Angus offered a range of insights into the care received by older people in hospital and at home following discharge through the new pathway. While some older people discussed person-centred care, others discussed gaps in their care that were not identified until the point of interview. Furthermore, some discussed their personal needs not being met while in hospital and having no way of addressing these. For instance, one participant discussed their disturbed sleep due to noise levels in the hospital. This may highlight a gap that the role of the 'hospital coordinator' – identified as a recommendation in the new pathway – would have potentially filled. However, as the older people were not specifically addressing their desired outcomes, it is difficult to ascertain if they would consider these to have been met.

The majority of participants discussed having good relationships with staff in both the hospital and the community following discharge. Words like ‘friendly’ and ‘trust’ were used to describe these relationships. In particular, older people discussed their positive relationships with the community-based carers that provide support following discharge.

‘I have the carers coming in in the morning. They wash and dress me and then one comes in at night round about seven o’clock... they’re a nice bunch’

–INTERVIEWEE 3, SA OLDER PEOPLE INTERVIEWS

The interviews revealed older people’s desire to be home; they expressed happiness following discharge. This was the case for almost all the interviews conducted in August and October 2015.

The interview data did not unpick why this was the case for the older people interviewed. However, the timings of the interviews were within 48 hours of the older person being discharged from hospital. This means that there may have been an element of ‘gratitude bias’ that skewed the responses, meaning that the relief at being home overshadowed the other experiences. In addition, maintaining a sense of independence and staying involved in their personal care also featured as an important outcome from the interviews.

In South Angus it was almost impossible to identify exactly where the project recommendations were solely responsible for changes in practice and experiences of the pathways. This was due to close alignment between the project recommendations and the existing direction of travel towards more integrated working and person-centred care. In this area, integrated working has clearly been embraced through the MDT meetings and there is strong evidence from the practitioner data that this is making a difference to the behaviour and experience of delivering services in the area. The existence of a Nurse Practitioner in the co-ordinator role has greatly helped join up the communication between the health, social care and third sector practitioners. The interviewees believed that this was beginning to make a positive impact on the older people’s experiences of the pathway.

DUNDEE

Dundee has adopted and adapted three recommendations from the original *Hospital to Home* co-design work. These have been implemented as:

- 1 Moving two hospital-based social workers to a community setting with the aim of connecting up care
- 2 Improving communication between social work and health practitioners to ensure more person-centred care and support (partly through Early Intervention Community MDTs)
- 3 Assigning a single named coordinator to each individual in order to enable consistency and clarity in their transition from hospital to home

The movement of the social workers effectively moved the point of assessment from the hospital environment to the home environment – a key point that was identified as an issue by the Working Group. This meant that the social worker could identify a person's needs once they were settled at home. One practitioner identified this as contributing to better person-centred care:

'Shifting assessment function from hospital to community has enabled SW [Social Work] to focus more on outcomes for service users once home from hospital'

—DUNDEE PRACTITIONER FOCUS GROUP RESPONDENT

As in South Angus, the staff in Dundee had taken forward the recommendation of MDT meetings. In Dundee, these were taking place in the hospital as well as in the community. It should be noted, however, that at the time of writing this report, Dundee had not been implementing MDTs for as long as South Angus. As a result, the strategic staff interviewed acknowledged that there had been less time for the operational staff to become 'accustomed' to these changes. In particular, it was evident that staff did not always know what their role was at these meetings and some did not feel valued or able to have input. This is a particular problem when attending these meetings as it is often time consuming for the practitioners. Reassuringly, staff from South Angus reflected that this had also been the case when they had first implemented the MDTs and that, over time,

practitioners within these meetings had begun to work together in a more joined up way to ensure the best possible outcomes for the older people within their care.

One of the roles of the community MDTs in Dundee was to identify vulnerable or frail older people and assign a named coordinator to that person. This was seen as a very positive change:

'When there has been an allocated worker prior to admission, the hospital social work is now carrying out a discrete piece of work to facilitate discharge, then passing back to original worker – better for consistency, better assessment information flowing between staff, therefore generally better outcomes for service users'

—DUNDEE PRACTITIONER FOCUS GROUP RESPONDENT

Despite this movement to more community-based assessment, staff in Dundee also reflected that they had not taken forward the recommendation for 'discharge at home'. While staff in South Angus had indicated that this was something they hoped to build on further and formalise in future, those in Dundee reflected that this was a concept that would not be possible to achieve at the moment, but again, was something to aspire to:

'One of the things that hasn't, if you want, been translated into embedded practice is, for example, the concept of discharge from home... I think that's something that, you know, we need to be mindful of and to pursue. I think that's going to require more of a change in many ways, not only culture but also, practice and that's going to take a while. In a way I think it's [the Hospital to Home project] planted the seed...'

—CHAIR, OLDER PEOPLES STRATEGY BOARD, NHS TAYSIDE

With regards to the 'admissions coordinator', staff in Dundee acknowledged that this was a role that could be undertaken by the existing 'discharge coordinators'. They indicated that they are strengthening and reinforcing that link, however, this was not evident in the interviews conducted with practitioners.

As with the interviews conducted in South Angus, a desire to be at home was predominant in the interviews with older people in Dundee.

Participants also made reference to their acceptance of requiring additional support being home again, and that this support was being delivered. Many older people mentioned that they were 'happy' and 'impressed' with this care and the practitioners that were coming out to visit them. However, there were also extensive discussions (in the interviews) regarding the lack of provision of person-centred care – carers not knowing people's names or the reasons why they needed the support they were getting. There was also reference to the large volume of people entering their home following discharge and not knowing who had what role. One older person commented that he 'didn't know who was coming and going' at his house.

In particular, older people referred to the fact that the paid carers did not know why they had been in hospital and what their individual care needs might be following discharge. In one interview it became apparent that food was being delivered at inappropriate times; dinner was being served in the middle of the afternoon. Another older person stated that they now go to bed '90 minutes earlier' than they would like and are used to because this is when the paid carer visits them in the evening.

Some of the older people interviewed were able to clearly express their desired outcomes and needs, however, these were not always being met and had not been expressed prior to the interview. For instance, one participant expresses a desire that someone help them with their shopping, while another participant discusses being carried into their home without being asked if they would be able to walk, which they were able to do. This highlights a lack of communication and a lack of support in promoting independence.

There was also discussion about their personal experience of being in hospital. Participants communicated that they felt the hospital was understaffed and that they had no one to talk to about their care needs. Some of the older people interviewed even made reference to the emotional impact a hospital admission had on them, with words like

'anxious', 'depressed' and 'helpless' being used to describe their feelings. One participant discussed their frustration at their discharge date being repeatedly postponed due to lack of care packages in the community without explanation, a key experience that these interventions were trying to address. On the other hand, many of the experiences of hospital were extremely positive, with a significant amount of references to the attentiveness and care from staff and the smooth and timely move to their homes.

This quite clearly presents a mixed picture from the implementation in Dundee. The interventions in this area were not as mature as the interventions that were underway in South Angus. As 2016 progressed, there were plans to more fully integrate teams and working, and this was expected to enhance the interventions and the wider integration plans so that the changes would more strongly be recognised and felt by practitioners and the older people using services. As with South Angus, the *Hospital to Home* interventions were adapted and woven amongst other locality model changes that were underway in the area. As it stood at time of evaluation, the positive aspects of moving some social work function into community, the MDT meetings and the role of a named coordinator were having more impact on the system and service level than could be seen at the personal level of older people's experiences.

ENABLERS

Across both South Angus and Dundee the main enablers were, unsurprisingly, that the recommendations made by the project aligned closely to existing integration agendas. In doing so, the recommendations could sit alongside or influence existing process change already underway in Tayside. This provided staff with reassurance about the direction of travel and some reinforcement that the route taken was one that both practitioners and people would value.

That said, whilst the project recommendations aligned with local strategy, those interviewed recognised the unique role Iriss played in driving this work forward, providing national insight, bringing in new expertise and ensuring older people and informal carers were actively involved in the process. In

addition, it was also recognised that Iriss helped to keep driving the agenda for change forward by acting as a motivator.

'I feel that there has been a remarkable improvement in the thinking around the way services have been delivered, and I think some of that has been a result of the project sitting in various strategy groups, networks and forums. We've identified that people are putting a lot more thought into looking after people for longer at home and putting the people at the centre of care and more integrated working. So I do feel there's been quite a considerable impact that the project's made'

—WORKING GROUP PRACTITIONER 1

Summarising the influence of the Iriss work, one senior local authority manager said:

'So do I think the change would have happened? Maybe it would have happened. But do I think it would have happened in the way that it happened, and with the better understanding and willingness? Probably not.'

—SENIOR LOCAL AUTHORITY MANAGER, DUNDEE

Unique to South Angus, was the view that the small nature of community hospitals provides staff with more time, knowledge and better communication channels, making it easier for staff to plan and coordinate older people's care more effectively than in larger institutions. Staff in South Angus responsible for embedding change discussed how these relationships enabled them to offer staff working in the community more scope to engage with and shape the changes being made locally.

Another enabler was the importance of taking people through the journey, so that they could see the value of the co-design process and the legitimacy of the recommendations put forward by the Working Group.

'I think some of the ways of actually starting to think about the creative ways that brought things to people's attention. I think the interaction for some staff with patients or service users, whatever we want to call older people we serve,

was probably a unique process for a number of the people who would have been sitting in that room'

—SENIOR LOCAL AUTHORITY MANAGER, DUNDEE

The relationships that were built through the entirety of the project (through the pathway mapping and co-design stages) and continued in to the implementation stages in Dundee and South Angus meant that there was a stronger buy-in to the changes being made. This involvement developed individual 'champions' who helped take these changes on board and encouraged colleagues to develop them in the areas. Without them, and their involvement in *Hospital to Home*, change would not have been implemented nearly as successfully.

BARRIERS

Recurring barriers to embedding change continue to be IT; workloads; and financial/economic/political situations. In addition, staff in Dundee noted that the size of Ninewells Hospital and the number of staff involved in implementing change was also a significant barrier.

'some of the project parts have worked better in the smaller settings because you can build that in and you can get continuity of staff and how you might want to take that forward.'

—SENIOR LOCAL AUTHORITY MANAGER, DUNDEE

In particular, they mentioned the challenges associated with involving 'key players' working across different teams, departments and buildings and the lack of capacity to bring them together to discuss change and suitable courses of action. The implementations that have been made and influenced by the project (at the time of evaluation) were being tested in small pockets and were very much in their early incarnations. It was the hope of a number of senior managers interviewed and some of the practitioners that this would develop further as the integration of health and social care developed.

On one hand, while integration and the associated political agenda were highlighted, as enablers, on the other hand, they were also viewed as

barriers. This was due to the associated increase in workload and additional financial and economic pressures. Furthermore, increased political pressure resulted in a large number of small projects all working towards the same outcomes.

One senior manager also identified the ‘crack’ that can happen between the vibrancy of the Working Group and Steering Group discussions, and the journey that work then needs to be taken on to develop their recommendations into actions:

‘I did feel that at one point the project lost its way a bit and that was about us keeping people on board and continuity. Lost its way is maybe a bit too strong but there was a phase where we seemed to be doing loads and loads and loads of work. Then it felt like a gap and maybe I just lost a bit of touch with it all because the Steering Group thing finished at a point.’

—SENIOR LOCAL AUTHORITY MANAGER, DUNDEE

It is always a challenge in a project such as this to continue the enthusiasm and momentum from the develop stage of the work, through to the delivery and scaling stage. Despite the early nurturing of relationships across the areas and strategic levels, the delivery of the interventions still had to be consistently legitimised and communicated to new people and partners as they were developed and implemented.

REFLECTION ON THE EVALUATION PROCESS

‘I felt that there was definitely a need for a better coalition between all the services, in keeping the patient really informed, asking for their views, considering their views, and really take it into focus and with a positive outcome.’

—WORKING GROUP PRACTITIONER 2

The sentiment outlined by the older person above, who was part of our Working Group, was central to the aim of the *Hospital to Home* project as a whole. While there were examples of person-centred care and support from the evaluation, there were also some examples of the absence of

person-centeredness. On a number of occasions, the interviews helped to identify a need for follow-on care and support for that older person. This creates questions about whether these needs would have been missed had it not been for the interview and what that reveals about there being gaps in the new pathways. As practitioners from the local area carried out the interviews, it enabled them to take action around that person's care.

The interview data highlights the ongoing desire of the older person to remain at home and their contentment as a result. Further review of the evidence on the best time to conduct an interview with a patient following a hospital discharge suggests that this should be done at least two weeks following discharge to ensure that the patient is able to reflect appropriately, as otherwise, this will be influenced by 'gratitude bias'. It's possible that older people's expressed desire to be at home was so prevalent in the data due to the interview timeframe, which was within 48 hours of discharge. This is something to bear in mind when analysing the data.

It may also have been useful to use an alternative method to conduct interviews in order to encourage interviewees to discuss their personal outcomes more openly. One approach is [Emotional Touchpoints](#), however, when this was suggested to the practitioners conducting the interviews it was met with some resistance due to it not working previously.

On reviewing the data it is clear that not all of the older people interviewed had enough capacity to engage fully with the questions. This is because part of the criteria for selecting older people was those who required additional community support and so they were particularly frail. As a result, there is concern that we are left speculating over a number of their desired outcomes as they answered 'yes' to a number of questions with no further details provided. In addition, the questions very much focused on getting the older person to reflect on their discharge experience and their care at home following that discharge. In the *Hospital to Home* project, it was highlighted that this linear view was flawed and that there should have been focus on how the person was living before hospital admission. When designing a co-evaluation in future, it would be useful to try and represent a

holistic picture of an experience, and to use more creative ways of capturing this where possible.

The Logic Model for the project very much reflected what we found in the evaluation in terms of staged outcomes. We are able to see some evidence of developed outcomes around better service communication and integration. However, at the moment, the long-term impact of better outcomes for older people in the pathway and the aspiration of preventing readmissions to hospital is harder to evidence confidently. It may take time for the implementations to mature and further care developments to be put into place.



5. Conclusions and recommendations

There was a clear desire from the staff responsible for implementing changes to improve the outcomes of the older people within their care. Across both case study areas, there were significant system changes being made that were beginning to influence the make-up of service provision at the level of the practitioner experience and knowledge. Many of these changes were around co-ordinating care and improving communication and trust across different practitioner groups. In that sense, it seemed that Iriss's main role had been to validate and support existing work in line with current direction that had significant local momentum already. This was not always a bad thing, as this direction closely aligned with the recommendations that emerged from the Working Group. However, it should not be ignored that our local partners had already committed to make changes and that, while the recommendations made by Iriss supported a number of these changes, those that did not, were not given the same commitment.

In addition to the specific Working Group recommendations, it was noted that Iriss played a significant role in ensuring that the voices of older people and informal carers were heard throughout the process and that this was not something that could have been achieved without Iriss's involvement. Those who had witnessed the process from a strategic level, and those practitioners and older people who were involved in this process, were positive about the outcomes produced and what they achieved.

The recommendations were seen to be making some positive differences on a service delivery level. Beyond that, it was difficult to determine whether the recommendations are improving personal outcomes for older people; the evaluation and interviews with older people who had gone through the new pathways were conducted so soon after changes had been implemented. Ideally, the evaluation would take place when the impact of the interventions were more mature, giving the opportunity for the changes to be more strongly felt by older people receiving care in the pathways.

KEY LEARNING POINTS AND RECOMMENDATIONS

- Equally bring together the voices of health and social care practitioners and older people, carers and families to develop change – this gave us legitimacy and opened up new avenues of thinking and communication
- Build meaningful and strong relationships with delivery partners as early as possible – this gave us influential and enthusiastic practice champions going forward
- When recommendations align with current direction/strategy, it is much more likely that these can be developed, but don't be afraid to challenge this direction if necessary
- It is much easier to make service level system changes on smaller geographical scales where the numbers of patients/practitioners/facilities are not as vast
- Developing person-centred practice and thinking takes time – drilling down to personal outcomes as a result of service level changes requires careful evaluation



Appendices

APPENDIX 1 – CONTRIBUTION ANALYSIS

Contribution analysis has been used in a range of contexts. At Iriss, we've used CA to evaluate co-design projects and to develop a theory of change for the organisation as a whole (www.iriss.org.uk/exploringdownstream).

Contribution Analysis is typically conducted in six stages (Mayne 2001²):

- 1 Determine the cause-effect issue to be addressed
- 2 Develop a theory of change and risks to its success
- 3 Generate evidence in response to the theory of change
- 4 Assemble the contribution story, and outline the challenges to it
- 5 Seek out additional evidence
- 6 Revise and strengthen the contribution story

Developing a robust theory of change is central to a successful CA evaluation. The theory of change is modelled through a set of tools called logic models (Rogers, 2008³) or results chains (Mayne, 2001). These tools act as a template for how a programme is intended to work. A successful theory of change should define all of the necessary and sufficient conditions required to bring about a given long term outcome.

Outputs from the evaluation tend to be narrative in nature and often read like a 'journey' (Patton, 2012⁴) from resources through activities to outcomes and outputs. Done well, these narratives should showcase the rich detail and complexity of the programme's context.

a. Benefits of contribution analysis

The use of contribution analysis is thought to provide a rigorous alternative to experimental models of evaluation that would typically use a counterfactual

2 Mayne, J (2001) Addressing attribution through contribution analysis: Using performance measures sensibly. *The Canadian Journal of Program Evaluation*, 16 (1), pp 1-24.

3 Rogers, PJ (2008) Using programme theory to evaluate complicated and complex aspects of interventions, *Evaluation*, 14, (1), pp 29-48.

4 Patton, MQ (2012) A utilization-focused approach to contribution analysis, *Evaluation*, 18 (3), pp 364-377.

or control case (Wimbush et al, 2012⁵). This is appealing in evaluations of social services where the phenomenon under evaluation is complex and context specific – as for example in the case of practitioner research.

A useful aspect of a contribution analysis approach is the opportunity for collaboration and learning. Both Patton (2012) and Wimbush and colleagues (2012) identify multiple opportunities for engagement in the evaluation process. Users of the evaluation are encouraged to participate in its design as well as the generation of evidence.

This participation is a cornerstone to the rigour of the process itself. The development of a theory of change is intended to be a dialogical process which includes producers of the programme and users of its outputs. The perspectives of these stakeholders on ‘how’ a programme is implemented and the possible changes it creates are the central elements of the theory of change. Without the contribution of these voices, the theory of change is reliant on the evaluator’s distanced and singular viewpoint.

This process supports the development of ‘collaborative capacity’ (Wimbush et al, 2012). It also creates opportunities for ownership of the evidence and encourages the development of evidence which is useful and relevant to the organisations involved and the programmes they develop and use (Patton, 2012). In the context of knowledge production, engagement and exchange, it also creates opportunities for reflective practice (Schön, 1983⁶).

b. Limits to contribution analysis

Definitive claims of attribution or contribution are difficult to make in the context of complex systems. Mayne (2001) suggests that the focus of evaluation in this context is more often directed towards increasing understanding of a programme and accounting for ‘what works’; it rarely “‘proves’ things in an absolute sense” (p5).

5 Wimbush, E, Montague, S and Mulherin T (2012) Applications of contribution analysis to outcome planning and impact evaluation, *Evaluation*, 18 (3), pp 310-329.

6 Schön, DA (1983) *The Reflective Practitioner: How Professionals Think in Action*, New York: Basic Books.

Some suggest that the focus on contribution, rather than direct attribution, 'is so weak that a finding of no contribution is highly unlikely' (See Patton, 2012 p376). Patton suggests that this is a legitimate concern and offers an eight-step metric for promoting rigour in contribution analysis (developed from (Woods, 2007⁷) to supplement his analysis.

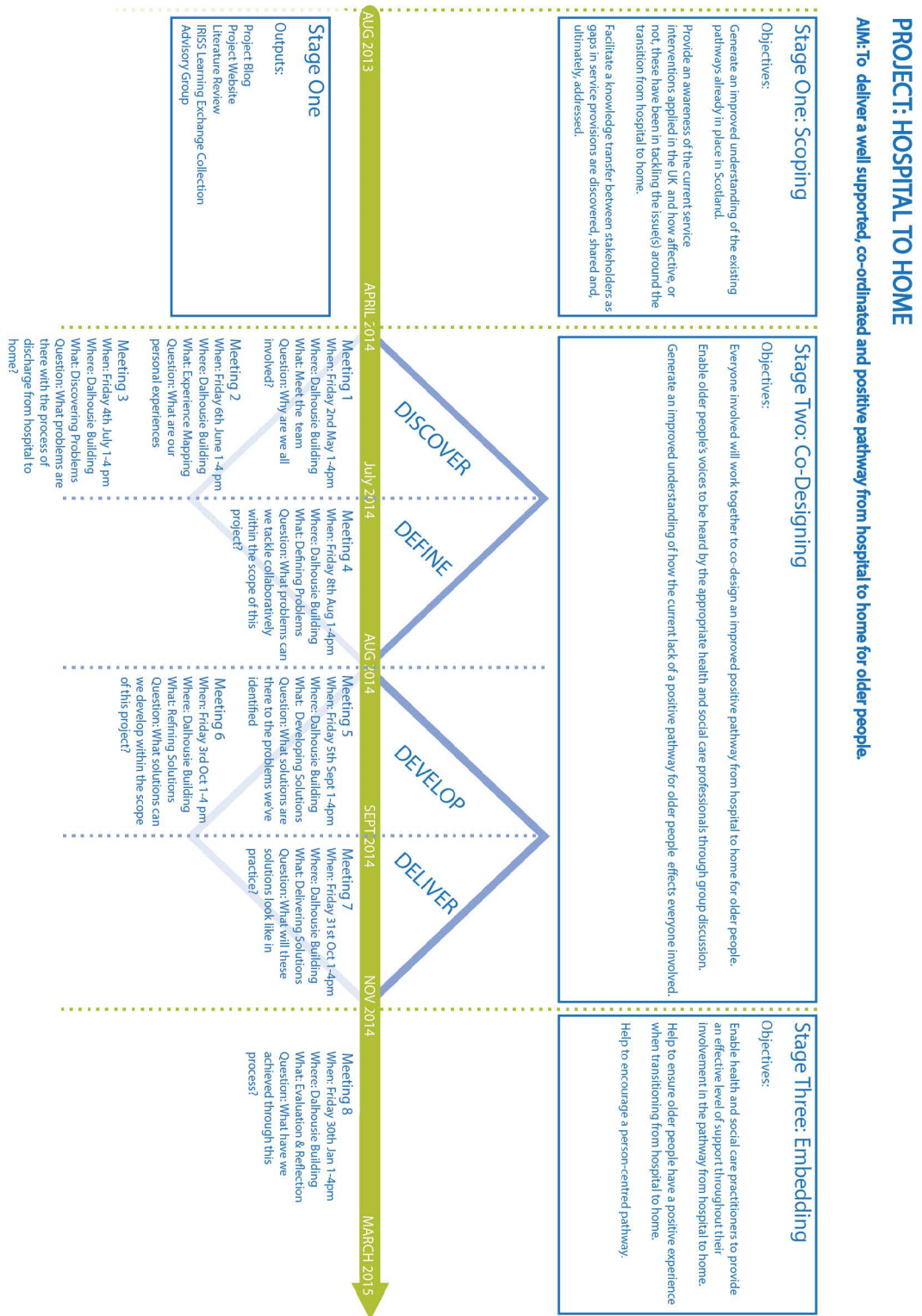
Patton suggests that the narrative of contribution can be considered sufficiently robust if multiple perspectives are included in the creation of the logic model, alternative explanations for change are thoroughly addressed and accounted for, and the process itself is reflective and iterative so as to be appropriately critical (for more detail, see p375 in Patton, 2012).

CA could be strengthened by a conceptualisation of different kinds of evidence or knowledge and how they might combine to support the CA approach. While Mayne acknowledges (2001; 2012⁸) that CA can be used in combination with a range of methods, there remain some implicit tensions around the question of robustness and which methods produce the strongest results.

7 Woods, DD (2007) *Revealing Analytical Rigor: A Strategy for Creating Insight into the Information Analysis Process*. Available at <http://academic.research.microsoft.com/paper/13513837.aspx>.

8 Mayne, J (2012) Contribution analysis: Coming of age?, *Evaluation*, 18 (3), pp 270-280.

APPENDIX 2 – HOSPITAL TO HOME STAGES AND TIMELINE



Above The *Hospital to Home* full process diagram. This graphic can be downloaded from: <http://s.iriss.org.uk/24luE1f>

APPENDIX 3 – CO-DESIGN STAGES AND WORKSHOP ACTIVITIES

Discover (Workshops 1-3)

- 1 Introductions: ‘What’s important to me’
 - These conversations focused on ‘people’ and not roles and enabled relationship building across the group
- 2 Pathway mapping
 - The group was divided into two parts: practitioners and older people and each was asked to map their pathway from hospital to home.
- 3 Experience maps
 - Participants were asked to map their service experiences which produced useful learning about the emotional experience of the pathway and the challenge of differentiating between experience and feelings.
- 4 Conversation mapping
 - Participants were asked to describe their conversations with other people in the system of care and support which provided useful learning in terms of communication challenges.

Define (Workshop 4)

- 1 Exploration of the circular pathway from home to hospital and home again
 - Individuals described their pathway and then, as a group developed a list of the problems and prioritised the most pressing issue to be addressed
- 2 Matrix mapping
 - Mapped the list of refined issues according to a matrix of importance and interest
- 3 Group discussion about the pathway and barriers to integrated, and person-centered, care and support
 - This process provided an important turning point for the group where multiple perspectives were valued and agreement on the need to develop shared understanding

4 Key issues identified

- Group discussion to narrow list of issues down to two: communication and care at home including a rationale for why these needed to be addressed.

Develop (Workshops 5-6)

1 Analysis at Iriss

- The project leads began analysing issues in order to support the working group to develop interventions, with support from the team at Iriss to reflect and refine. This resulted in three key questions to pose to the working group

2 Developed solutions with the working group

- Developed two interventions: personal advocates and discharge at home
- The group felt that there was a need for improved communication and a continuing link with the hospital team even after return to community-based services

Deliver (Workshop 7)

3 Present solutions to the Older People's Board at NHS Tayside

- Very productive discussion that moved from 'it costs too much' to 'how much would it cost not to do it' which prompted a range of embedding/scaling-up activities – discussed below

APPENDIX 4 – INTERVIEW, FOCUS GROUP AND SURVEY QUESTIONS

1.0 Interview Questions – Participants Involved in Working Group

- Q1. Can you remember what your aspirations for the changes in Tayside were?
- Q2. Can you remember any concerns/worries/hesitations about the possibility of taking this work forwards and embedding it in Tayside?
- Q3. Do you have any evidence for this? i.e. have you had any experience of changes around the discharge process recently?
- Q4. How did you find the co-design process?
- Q5. Looking back is there anything you'd want to tell us about this process? (anything you would change/improve/keep the same?)

2.0 Interview Questions – Staff involved in Project at a Strategic Level

- Q1. What, if anything, has NHS Tayside/Dundee City Council adopted from the recommendation made by Iriss's work locally?
- Q2. How are these recommendations being adopted in practice?
- Q3. What are the barriers and/or enablers to embedding change locally?
- Q4. How have you found the process of working with Iriss?

3.0 Interview Questions – Patients in Dundee and South Angus

In addition to the interview questions below, the following data was also documented:

- Length of stay
- Reason for Admission
- Delayed discharge Y/N?

- Q1. Can you tell me if you were supported in the community prior to your hospital admission?
- Q2. Can you tell me about your experience / your story of going into hospital?
- Q3. How/why did you go to hospital?
- Q4. Can you tell me if you felt like you had a key contact/advocate whilst you were in hospital?
- Q5. Can you tell me a bit about your experience of being in hospital? What happened there?

- Q6. Did you feel like you had enough time to prepare for discharge? How were you supported? How did you get home?
- Q7. Can you think of something that worked well for you?
- Q8. And something that didn't work that well?
- Q9. What's the most important thing for you when being discharged back home?
- Q10. Did this happen?
- Q11. Can you tell me a little bit about why it was important for you to go home?
- Q12. What's so good about home that the hospital doesn't have?
- Q13. Do you feel confident about being back at home?
- Q14. Is anyone supporting you at home? What do they do?
- Q15. Do you understand their different roles?
- Q16. Do you feel that they know enough about your experience?
- Q17. Do you have any further comments you would like to add?
- Q18. How have you found these questions?
- Q19. Do you think there is anything else we should ask?

To the carer/family: (if present at time of the interview)

- Q1. Do you feel your needs/knowledge have been considered in this journey?

4.0 Staff Focus Group Questions

The staff focus groups had three themes:

- 1 How has the process worked?
- 2 Does the new process affect integrated working?
- 3 Does the new process affect person-centred care?

Specific questions:

- Q1. What do you think of this pathway?
- What's good about this pathway?
 - What could make this process better?

Q2. What does integrated working mean to you?

- Are you working in a more integrated way in this pathway?
- Are you able to access information, meetings, resources from your partners?
- In terms of integration, what's good about this pathway?
- In terms of integration, what could make this process better?

Q3. Do you think you're delivering person-centred care?

- Does this pathway improve your ability to deliver person-centered care?
- What could be improved about this pathway to encourage person-centred working?

Conclude by asking for open question:

Q4. Was there anything we didn't ask or anything you'd like to add?

5.0 Survey Questions – Dundee

In Dundee, two hospital social workers are now based in the community.

Q1. How has this impacted the way you work?

Q2. Please provide an example.

Q3. Does this change enable better outcomes for older people?

Q4. Please provide an example.

In Dundee, there are now Early Intervention Community MDTs.

Q5. How has this change impacted the way you work?

Q6. Please provide an example.

Q7. Does this change enable better outcomes for older people?

Q8. Please provide an example.

6.0 Survey Questions – South Angus

In South Angus, there are now Community Based MDT meetings to identify older people at risk of admission to hospital.

Q1. How has this impacted the way you work?

Q2. Please provide an example.

Q3. Does this change enable better outcomes for older people?

Q4. Please provide an example.

Older people tell us it's important to have a discussion about their needs once they return home. In South Angus, we now visit people within 48 hours of discharge to ensure their needs are met.

Q5. How has this change impacted the way you work?

Q6. Please provide an example.

Q7. Does this change enable better outcomes for older people?

Q8. Please provide an example.



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