Co-design Partners in Care case study

Understanding experience from multiple perspectives – choice and decision making in acute care (Hutt Valley District Health Board)

Context

Demand for acute services is increasing across our local health system, with the Hutt Valley District Health Board (DHB) emergency department (ED) and Lower Hutt After Hours Medical Centre (after hours centre) experiencing increased numbers of people attending their services. Our primary care providers also note increasing demand for out-of-hours and same-day appointments. A key response to this increasing demand is ensuring our acute care services are coordinated and that our system is well designed.

Our team, on behalf of the Acute Demand Network of the Hutt Valley, explored the choices and decisions people make around accessing acute care. They found that these are more complex than often assumed and include aspects such as level of anxiety, previous experience, personal resources, and confidence in possible care options. This knowledge was then applied in a co-design workshop to develop messaging around acute care.

Aim

The aim of this work was threefold:

- To inform winter messaging for acute care.
- To test the value of co-design methodology to encourage co-design approaches in the Acute Demand Network programme of work.
- To inform a larger redesign process of the acute care system in the Hutt Valley.

Engage

Key leaders from across the sector (DHB and primary care) were consulted early for their input. The project aligned with priority areas for the organisation and therefore each responded positively.

We have recognised the need to keep ‘supporters’ informed to maintain their engagement, as well as to build trust and confidence over time.

It was helpful to be organised and clear about the process – gaining support through good planning and accountability steps.

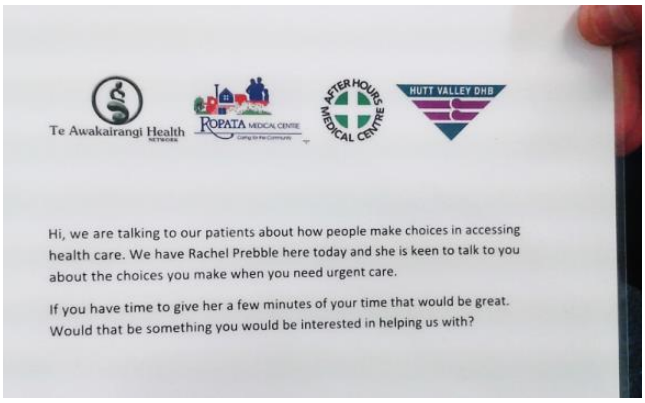
Each of the project team members has connections to different areas of the system, so we were able to use both formal and informal channels to engage staff in each setting. For example, general practices and the after-hours centre were engaged through a combination of formal presentation at their quarterly owners’ meetings, visits to the practice for discussion with leadership teams, information by email, and face-to-face discussion with reception staff, doctors and nurses.

The ED was engaged through their senior leaders, their quality team meeting and by communication channels from those leaders to staff. Reception and ED clinical staff were given

written and verbal information and there were informal discussions at the time of data capture about what was happening and why.

Scripts for reception staff were a particularly valuable tool, but often the greatest gain came from the interviewer being available to talk through issues, such as coordinating with patient flow through the department, to maximise opportunity for conversations.

The direct approach worked really well – talking to people and asking for their help, and backing that up with written information. Explaining the reason for the questions, what we would do with the information, and giving the option not to take part, were key messages.



Reception staff were great recruiters in the general practices. They were given written information by email in advance, then on the day they were given a script. Before starting we also talked them through what we were doing and why. A couple of times people were called in to the general practitioner (GP) before they had finished, but the GPs were great (they had also been briefed) and a couple of people came back to us after their appointments to finish our conversation.

At the after-hours centre we approached people in the waiting room, as there was only one receptionist and she was very busy.

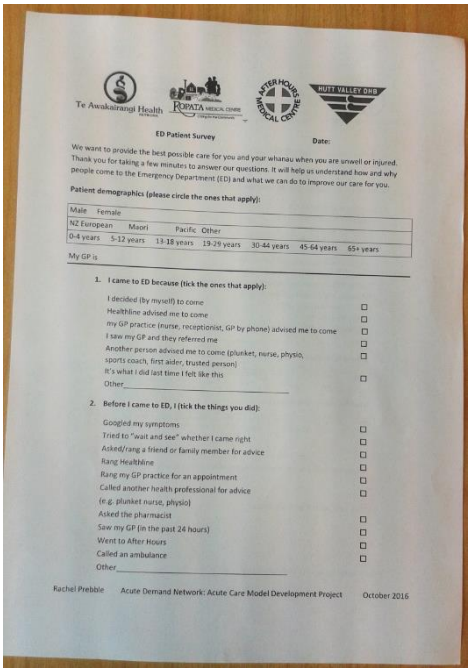
In the ED it was a mix of reception staff approaching people (especially for the written survey) and a project team member asking them directly if they would be prepared to talk to us.

A challenge in the ED was that people were often quite uncomfortable and stressed in the waiting room, and would sometimes be called through quite quickly. We adapted the approach by using the Clinical Nurse Manager to identify people in cubicles who were stable and might be interested in talking to us.

Challenges of engagement included ensuring a range of times and days, and how to get a good cross-section of people. We thought quite a bit about where and when to engage people to manage this.

Capture

Our team took a multimodal approach to gather the views and experiences of patients and staff in a range of acute settings, over a period of two weeks. Settings were targeted to capture demographic variation of patients, with interviews carried out at different times of the day and days of the week to maximise the mix of respondents.



Patient conversations

- 24 at general practices.
- 11 at after hours centre.
- 22 at ED.

Pencil and paper surveys

- 56 at after hours centre.
- 72 at ED.

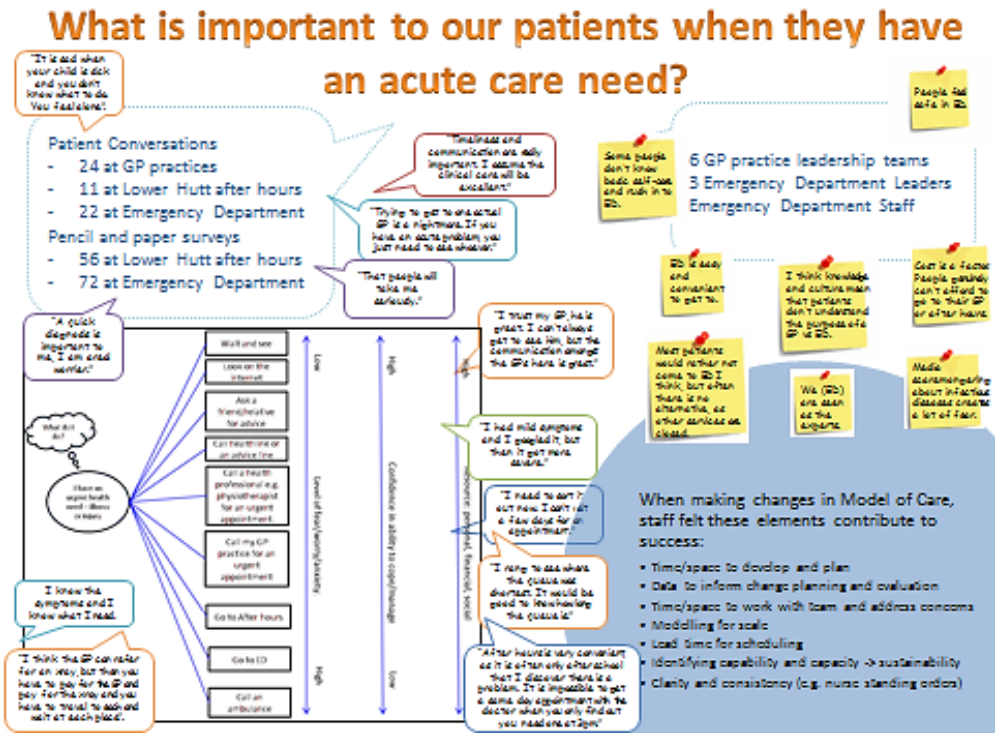
Group Discussions
- 6 general practice leadership teams.
- 3 ED leaders.
- ED staff.

What did we ask consumers?
- What was their decision-making process?
- Who or where did they ask for advice?
- What was their level of anxiety?
- Did they contact a general practice before attending ED?
- Was it because of convenience, time of day, urgency, difficulty getting an appointment with their GP (perceived or not) that they ended up accessing ED?
- What is important to them when they have an acute care need?

In the ED setting we used a mix of approaches, including a poster in the staff room with a key question, and Post-It notes for staff to add their comments.

We used a mix of qualitative statistics for the survey information and thematic analysis for the conversations and group discussions to identify the key themes, emotions and touch points.

An acute demand clinical network set up by the Hutt Valley DHB in early 2014 was used to provide input, oversight and governance for the project, supported by an alliance leadership team and senior sponsors from many of the contribution organisations. Meetings were held with these groups to elicit their input/feedback on ideas as they formed up.



Understand

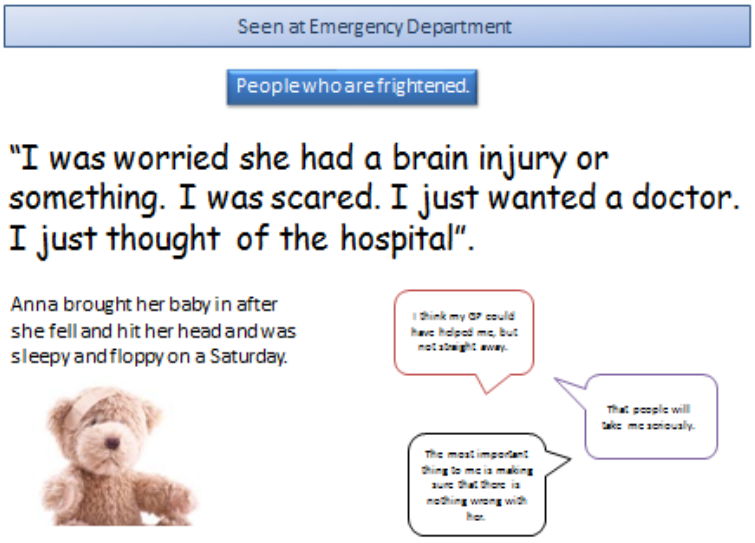
We found that our consumers used a range of factors in deciding which service to access to meet their acute care needs. A majority of our consumers went to ED because they believed it was the right place for them to be – that they thought they might need hospitalisation, that they were anxious for their or their child's safety, that it was the only option open, that they expected to need an x-ray out-of-hours. A small group described coming to ED because they could not access primary care and felt it was too urgent to wait.

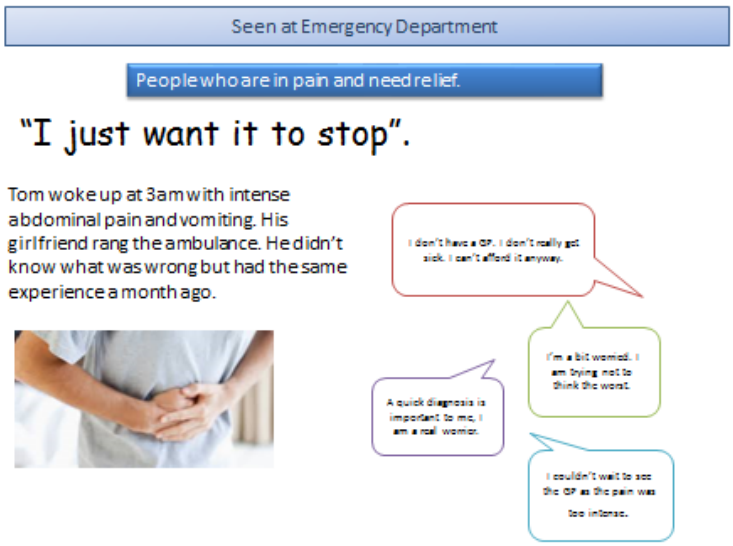
Many consumers sought advice from another person such as a family member, friend, or allied health professional (eg pharmacist) and many had waited to see if they would come right. Anxiety levels were reported as higher for those who attended ED than those who chose other options for care. A significant number of consumers described confusion and lack of knowledge about the different options available and which could be appropriate for them.

I came to ED because... (could choose more than 1)	Number of people	% of total
I thought I might need to go into hospital	21	31%
I thought I would need an x-ray or blood tests	14	21%
I didn't know what else to do	5	7%
Other	5	7%
I can't wait until tomorrow	4	6%
I couldn't get an appointment with my GP	3	4%
The ED staff are specialists and will know what I need	3	4%
I thought I might die	3	4%
I can't afford to go to the GP	2	3%
It is easiest to get to	2	3%
I could come after work	2	3%
Last time the ED staff were great and sorted out my problem	2	3%
I didn't think my GP would have an appointment	1	2%

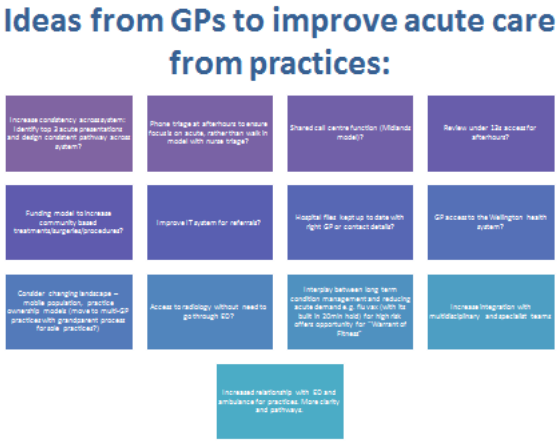
There was a clear sense that people where making their best endeavours, both in electing where to go and when to seek help. Frequently our system did not meet these needs in the ways they needed, sometimes at a practical level (for example parents who discover a child is unwell after school or day care, but primary care options stop at 5pm) and at times with a lack of understanding about what primary care can offer (for example believing that ED is needed for simple procedures that can be done at a general practice).

This led to either frustration and/or an escalation to higher levels of care, such as visit to the ED. There was a consistent theme around how often people accessed services based on their perception of where these would be most likely met, that is, where they thought the skills, facilities and resources would be available. Frequently their decisions were informed by previous experience, or advice they received from health professionals, their family/whānau or advice lines such as Healthline. Examples of these are set out below:





We developed six of these patient stories, which identified differences in the elements of decision making for different cohorts of consumers, and in their subsequent choice to attend their general practice, after hours centre or the ED. The cohorts reflected a combination of personal circumstances, such as age, or stage of life stage (eg parents with young children) and the nature of the health need (eg exacerbation of a long-term condition or acute injury).

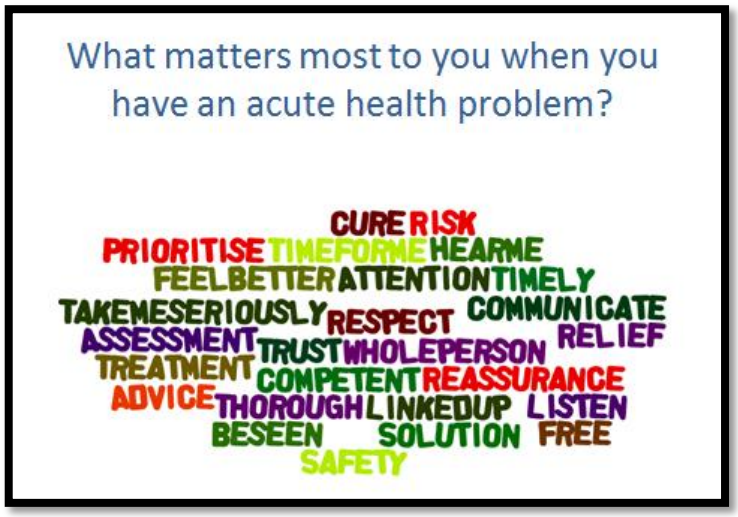


Our primary care practices talked about the pressure of acute demand. They talked about the importance of any changes to our acute care system needing to be well thought out, and practical to implement in a busy business setting.

The poster in the ED staff room elicited comments conveying a strong sense of frustration for many ED staff. They identified lack of knowledge about health as one factor bringing people to ED. They also noted resource challenges – cost and the availability of alternatives out-of-hours as factors.

In previous years our messaging in winter, when demand was highest, followed traditional patterns. However they were frequently put together by health professionals seeking to direct people away from hospital services. The messages were not necessarily clear to consumers, who were left confused and so tended to revert to their usual approaches. The messages often sought to move the demand around without dealing with issues that could be managed by the person themselves, at home.

The voice of the consumer was not evident apart from in a limited number of surveys at a provider level. These often sought comment on what was, rather than inviting a dialogue about what might be. As part of our work, we asked consumers what is important to them when they have an acute care need.



Improve

Utilising the knowledge gleaned from the capture phase, two activities have been carried out to improve our acute care service provision:

1. The information was fed back to the wider network and to staff across the acute care system. This enabled some myths to be 'busted' and prompted significant discussion as to what needs to be considered in a redesign of acute services in the Hutt Valley.

2. A co-design workshop was run in early June, which included consumer, primary and secondary care participants. The information from the capture phase was used to develop a reference for the workshop participants, and to develop advertising and messaging around acute care/ED use this winter. The workshop participants redesigned the winter communications messaging, including for posters and newspapers, to reflect what we now know about decision making and choice for patients with acute care needs. As you can see below, there are marked differences between the 'before' and 'after' posters.

Winter messaging 2016

Winter messaging 2017

Measure

While it is too early to tell whether our revised winter communications messages will have an impact, the fact that there was a co-design approach to developing the messages is a measure of the success of this project. Before beginning this work, a proposal to include a consumer voice on

the Acute Demand Network was met with comments such as 'Why do we need a consumer voice on the network?' and 'We already have a lot of people'. Members of the network found the information from the surveys and interviews so valuable, that they now see the benefit in having a consumer as part of ongoing work.

The results of the surveys and interviews have now been widely shared across leadership and staff throughout the health system in the Hutt Valley. Current programmes looking at community integration of services and the development of primary care 'home–type' models of care have drawn extensively on the knowledge gained throughout this project.

Overall outcomes

- Embedding consumer input: It is likely that all future acute demand initiatives will include input from consumers. This experience has highlighted the value of their contribution and we are looking at ways we can include consumer representatives on a number of the work streams active across the various priority areas.

- Winter messaging: This is very different to previous years and has a much more positive, empowering set of messages, focused on better equipping people to make informed choices. There was also discussion in the co-design group about where and when to use messaging with additional mechanisms, such as messaging around the hospital campus, integration of messaging into staff interactions with patients, discharge, and follow-up letter.

- Access to acute slots in primary care: Practices we have visited confirm their commitment to this aspect, with more than 20 practices now having formal processes around triage and the allocation of these same-day slots.

- Healthcare Home: Work is underway in the Hutt Valley to implement Healthcare Home, under the oversight of the Acute Demand Network. This initiative will have a number of elements aimed at improving consumer choice and access. Implementation is likely to be led by people involved in the current co-design work, and as a result, will be influenced by these models and approaches.

- The objective outcomes of this work will be measured over time, largely around the level of acute demand the system faces. Due to the underlying demographic growth and health pressures we expect that rather than dramatic shifts in demand, we may see a levelling-off of demand and a shift around services as people make more informed choices. A key measure will also be around the range of options that become available to people with acute problems and the way they use these services.

Working as a co-design team

Working to bring co-design into the redesign of a whole system of care was a challenge in terms of the complexity and number of different stakeholders. In order for the work to be meaningful, we needed to engage with consumers and staff over a number of sites, settings, times and contexts.

However, the results have enriched our network immensely and have introduced a new way of thinking about service design and development. Our integrated winter planning programme now has consumer involvement, as do other work programmes under the Acute Demand Network.

Our clinical staff have a more sophisticated understanding of how consumer decision-making and choice occurs, and our approach to communicating with our community has changed as a result.

With the changes to the Hutt Valley DHB team, the core project team has had to shift to a model seeking to influence rather than directly lead the changes. The strong foundation built in the first phase, with a clear set of recommendations that the new staff have followed (with support from senior management) have ensured the initial work has not been lost.

As noted, the experience gained in the co-design work has proved to be very useful to a number of our team who have gone on to apply these to other areas of work. For example, significant changes are being considered around service design for people accessing rheumatic fever and palliative care services in the Hutt Valley. Again, these are 'works in progress', but good examples of how the methods can be more widely applied as people gain confidence and experience in using them, as they shift around the health system.

A restructure at the Hutt Valley DHB and the departure of key staff to take up other roles within the region has meant some changes to our team. We have needed to use the time we had available and our networks to maintain the momentum, and to draw on others' efforts to complete some aspects of the work. Overall, we have still had a positive experience and have gained a lot from the co-design training. It is not unusual for our health system to encounter changes to teams as we often work on change initiatives spanning a period of years.

The project team

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