Bridging the Gap

Facilitating Participatory Design Conversations to Strengthen Community-Based Support for People with Learning Disabilities to Prevent Care Breakdowns.

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January 2026

Abstract

As understanding has shifted to view learning disabilities (LD) as lifelong conditions, support for independent living has grown, leading to efforts to transition individuals from long-term hospital stays to living independently. However, previous attitudes persist, with transactional care remaining the main form of support, with a small population still perceived as too complex to live independently. On July 14, 2025, Ward 7A in North Ayrshire, an inpatient assessment and treatment unit, was closed. It was acknowledged that the environment was not suitable for ongoing treatment, as the ward was not intended for long-term stays. This limitation consistently reduced the ward's ability to provide effective care, making the service increasingly unsustainable for both the patients and staff. The closure reveals a gap in the care pathway, where insufficient preventive support in the community resulted in crisis-driven hospital admissions.

This research project aimed to examine how PD can help create design recommendations through speculative proposals to strengthen community-based support for people with LD. Using PD during fieldwork enabled the research to operate in a dynamic, complex environment, allowing participants to share and shape the project's understanding through their lived experiences. By framing engagement through a speculative lens, it encouraged participants to think beyond current constraints and assumptions, and to reconsider systems and services. It also helped them to explore long-term possibilities without being restricted by immediate feasibility, prompting them to generate transformative ideas.

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Research Question

How can Participatory Design help create design recommendations through speculative proposals to strengthen community-based support for people with learning disabilities to prevent care breakdowns?

Aim

To explore the value of PD through engagement with diverse stakeholders within care, community and third-sector organisations to identify viable care alternatives and facilitate conversations around a potential proposal.

Objectives

- To generate an understanding and trajectory of the current care landscape within North Ayrshire.
- Enable mutual learning and collective action.
- To extrapolate values for the future of services made by stakeholders.

Research Introduction

Historically, individuals with learning disabilities (LD) were marginalised from society, with some lacking the opportunity to see their families or attend educational institutions. As attitudes have evolved, significant strides have been made in moving large numbers of individuals from institutional settings into the community. However, a range of issues, including funding challenges, have contributed to shortfalls in community care provisions, hindering the positive impact of this decision. Therefore, reliance on statutory services to provide care and treatment remains when care provisions have broken down. This has led people to remain in the hospital longer than necessary. In 2022, the Coming Home Implementation Plan recognised this and made an urgent commitment to significantly reduce these placements by 2024 (Scottish Government, 2022). However, the Scottish Human Rights Commission (SHRC) states that there has been "little progress" and identified "clear failures" in upholding human rights standards (Scottish Human Rights Commission, 2025). The report additionally recommends transitioning from institutionalised environments to independent living support services (2025).

This study focuses on the geographical location of North Ayrshire. The research was carried out as part of a full-time Master of Research (MRes) program at The Glasgow School of Art. This postgraduate placement was funded by the Digital Health and Care Innovation Centre (DHI), in alignment with their strategic theme "Digital solutions as an enabler in shifting care from institutional settings into the home and/or community settings".

A Participatory Design (PD) approach is employed, prioritising participants' lived experiences to inform outcomes that will ultimately serve them. It promotes creative thinking and highlights the importance of involving all participants in the design process, making sure every voice is acknowledged and valued (McKercher, 2020). PD also aligns with Pragmatist principles, encouraging the development of new knowledge through a democratic process (Dixon et al., 2021). By encouraging creative engagement, PD can support discussions through a speculative lens. Encouraging engagement through considerations of the future enables participants and even the design process to transcend some of the complex constraints currently influencing them (Dunne & Raby, 2013). The fieldwork follows three phases of engagement structured around Wright's emancipatory social science framework (2010). This framework has three frames to inform the narrative: 'diagnosis', which critiques and understands the present; 'the theory of alternatives', which imagines what could be; and 'the theory of transformation', which focuses on how to get from the present to the preferred future. The engagement begins with semi-structured interviews discussing all three frames, but prioritises developing an understanding of the current care landscape. Informed by the interviews, the next phase conducts co-design workshops, which speculate on what could be. The final phase of engagement is evaluation sessions with participants from the co-design workshops, which aim to extrapolate recommendations and iterate on the co-design outcomes to determine how to get from the present to the preferred futures identified by participants.

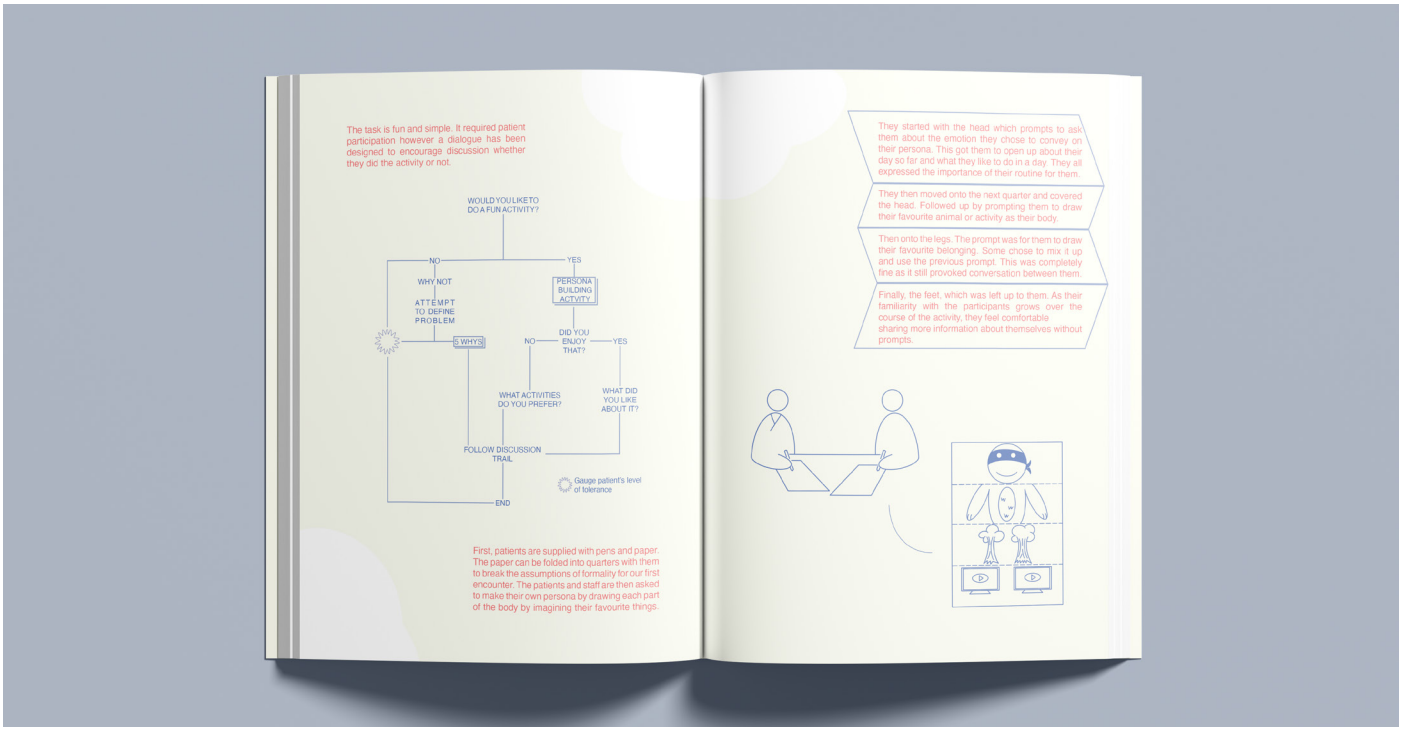


Figure 1: *Service Design Internship Deliverable.* 2023. Source: Author's Own

Motivation

During the summer of 2023, I had the privilege of working as a Service Design Intern at NHS North Ayrshire and Arran's Ward 7A, an inpatient facility dedicated to individuals with LD. This project emphasised the importance of building robust relationships between staff and individuals with LD, resulting in a framework (Figure 1) and an accessible, customisable journal as the project's deliverables.

My interest in healthcare design increased significantly after that experience, and my final self-directed project during undergraduate studies deepened my understanding in this area. As my experience grew, my focus shifted from the clinical environment to the community context, especially after my final-year project focused on transitions. The outcomes of that project were conversational tools (Figure 2) for approaching transitions using a person-centred approach, along with a database for care providers to customise, evolve and share their own tools for these discussions. Based on this background, pursuing an MRes through DHI's strategic theme centred on community care delivery was the next logical step, as it would enable me to specialise my research skills.

Figure 2: *Self-Directed Transitions Conversation Toolkit.* 2024. Source: Authors Own

Research Context

On July 14 2025, Ward 7A, an inpatient assessment and treatment unit in North Ayrshire, closed. The North Ayrshire Health and Social Care Partnership (NAHSCP) states that the service has been facing substantial challenges, which had impacted its ability to support individuals with LD effectively (North Ayrshire Health and Social Care Partnership, 2025). The director of NAHSCP spoke to news outlets, stating that the challenges include delayed discharge, which they see as an issue that needs to be addressed at a national level (Vanreenen & Taaffe, 2025). This emphasises the reality of limited local provisions within the narrative of policy aspirations, as the proper infrastructure is not in place to meet the goals of the Coming Home Implementation Plan (2022).

It is recognised that individuals receiving treatment were not in the most appropriate environment (2025), as the ward was not designed for long-term stays, which continuously hindered the ward's effectiveness in delivering care, making it an increasingly unsustainable service for the people who inhabit it and the staff working there (North Ayrshire Health and Social Care Partnership, 2025). The closure highlights a gap in the care pathway, as in some circumstances, opportunities were potentially missed to provide preventative support which could have avoided crisis-driven hospital admissions.

Although the closure of the ward has created immense disruption for patients and their families (Vanreenen & Taaffe, 2025), it presents an opportunity to reimagine what an integrated service could look like, as previous perceptions of institutional care no longer bind it. Therefore, there is an opportunity to facilitate collaborative discussions with NHS, social care and third sector professionals on what form and new role care could take to strengthen community-based support and prevent care breakdowns.

Literature Review

Introduction

Current literature from academic journals and reports was collected and evaluated in relation to the research question: How can Participatory Design help create design recommendations through speculative proposals to strengthen community-based support for people with learning disabilities to prevent care breakdowns?

In much of the literature researched for this project, the term 'Intellectual Disability' is used. Intellectual disability is a more internationally recognised term, while services local to North Ayrshire prefer the term 'Learning disability' (LD), as this term is commonly used across the UK. Therefore, the term "Learning Disability" is preferred over "Intellectual Disability."

The literature review begins with an examination of definitions and the historical context of treatment and attitudes towards care for individuals with LD. As perspectives have evolved to recognise that LDs are lifelong conditions, support for independent living for people with LD has increased, and measures have been taken to transition individuals from long-term hospital stays to independent living. However, previous attitudes have persisted, with transactional care being the primary delivery of care, including a small population that remains considered too complex to live independently. Recent reports have identified failures in adherence to Human Rights policy, which will be evaluated and further inform the scope and actions taken during this project.

Then, the effect of institutionalisation on care experiences will be examined, focusing on the real-world delivery of care in statutory services and the constraints that affect care delivery, such as delayed discharge, inappropriate placements, and the impact on transitions between care provisions.

The Participatory Design approach used in the research will be outlined. This description of the engagement will assist in evaluating the value and usefulness of proposing ideas to enhance community-based support.

Following that, the literature review will undertake a case study comparison to explore attempts at integrated care and community-based support. A discussion of viable alternatives to the current context of North Ayrshire will highlight the importance of this research approach and inform the trajectory of this research project.

The literature review will conclude with a summary of key findings and highlight gaps within the current literature. This helps to position this study as a response to these gaps.

The Legacy of Institutionalisation Informs the Prioritisation of Transactional Care

LD is defined categorically as an individual with an IQ below 70 from before adulthood, and requires additional support. People with LD can also present one or more other difficulties related to their health, such as autism, mental health issues, epilepsy and/or a respiratory illness (Abraham et al., 2021; Slevin et al., 2008).

Currently, individuals residing in hospitals are likely to have reached a crisis point or experienced a breakdown in care, which has led to their current situation. Ideally, this would be a short-term response until care arrangements are in place to allow the person to live a better quality of life in the community. However, as resources are lacking in the community, people aren't able to transition out of the hospital environment at the necessary time (Adams, 2023).

Although concepts of care for people with LD have evolved to emphasise independent living, attitudes towards potential solutions remain rooted in their institutional origins (2023). Historically, individuals with LD were separated from society, with some not having the opportunity to see their families or attend school. Statutory services are considered essential but should be the final resource in an individual's care pathway, used for care and treatment, rather than for individuals to live indefinitely (Department of Health, 2012; Abraham et al., 2021). However, due to a lack of community provisions, including inadequate funding, a shortage of qualified community staff, and lack of appropriate housing options established before the drive to deinstitutionalise the population with LD, statutory services around the country are still functioning not as intended, with people remaining in hospital for longer than their intended stay.

The Coming Home Implementation Plan recognised this as an inappropriate circumstance and made an urgent commitment in 2022 to considerably decrease these placements by 2024 (Scottish Government, 2022; Scottish Human Rights Commission, 2025). However, the Tick Tock Report states that "little progress" and "clear failures" have been identified in upholding human rights standards (2025). The report further suggests taking action to "replace any institutionalised settings with independent living support services" (2025).

The delivery of care described in the literature reviewed prioritises transactional care, which perceives individuals as recipients of care (French et al., 2017). Care models that prioritise this form of care aim to deliver intensive support for the minimum necessary duration, tailored to individuals' perceived needs, as outlined in a care package specified contractually. (2017).

This literature emphasises the importance of independent living in the community and the attitudes and efforts to achieve this goal, but it shows that the real-world provision of care is inadequate to meet this target due to the resources currently allocated to the community. This indicates that more emphasis should be placed on strengthening community-based support to enhance their capacity to deliver care and reduce the pressure on statutory services. However, it also highlights the necessity for a shift in attitude, as transactional care responses do not sufficiently support individuals with LD.

A Shift in Care Delivery Values

> *"If you are a person who requires stability, routine, a calm environment and familiar surroundings, then there is a huge risk that detaining you in a place like that will exacerbate the behavioural problems that cause you to be there in the first place."* (Adams, 2023)

The Scottish Human Rights Commission (SHRC) define institutionalisation through a shared interpretation and states that it is "the loss of personal choice and autonomy as a result of certain life and living arrangements being imposed" (2025), such as isolation from the community, the lack of control over daily decisions, and the same activities in the same place.

Extended stays in clinical facilities lead individuals, not just with LD, to exhibit signs of institutionalisation. Their independence diminishes due to limited activity opportunities and decision-making, which makes their transition back to community settings more difficult as they become overly accustomed to the treatment environment. A qualitative study highlights this issue, noting that participants experienced improved Quality of Life (QoL) in community settings, with more varied activities, greater leisure involvement, and enhanced social interactions with other service users and staff (Chowdhury and Benson, 2011).

However, Chowdhury and Benson (2011) later identified that QoL improvements may plateau as individuals form a home routine, allowing carers to become familiar and to start making predictions on their behalf (Young and Ashman, 2004, as cited in Chowdhury and Benson, 2011). Which, by SHRC's definition, is still a form of institutionalisation.

Institutionalisation is a significant factor influencing transitions to and between community services. Based on experiences of prolonged treatment in statutory services, individuals often regress and lose their independence. During the transition between care services, numerous changes occur, such as new staff and environments, which can be distressing. If the hospital is the last resort and the aim is to eventually leave that environment, care should form holistic support around traditional, clinical forms of care, allowing seamless interaction with them while still enabling a better QoL in the community.

As individuals with LD transition and interact with various care provisions throughout their lives, a relational care approach could be adopted to better integrate care into their daily lives. Relational care perceives individuals as "active agents" in their own care experience, with a person-centred approach to empower them (French et al., 2017). The position paper from which this concept has been incorporated recommends developing asset-based care through a design approach. Asset-based care focuses on individuals' strengths and contributions to the community, helping build independence and identity. Regarding the role of design in relation to care, it can not only navigate systems and technologies but also engage with social interactions and experiences, especially through stakeholder involvement (2017). The literature further emphasises the importance of understanding people's care values and fostering an environment that enables these moments to be conceptualised.

Participatory Design

To reposition and shift the values of current care delivery, a Participatory Design (PD) approach is beneficial for understanding and improving the care context in North Ayrshire by involving stakeholders with lived experience providing care for individuals with LD.

PD prioritises people's entitlement to shape solutions that involve them, transcending their role in the design process from informing the outcome to actively participating in designing it (Donetto et al., 2015). In the context of public services, PD aims to engage people politically and socially to respond to social structures and cultural norms by addressing constraints such as disenfranchisement (2015).

When implementing PD methods in a healthcare setting, a critical approach to design practice and organisational processes is essential (2015). Leykum et al. (2009) emphasise the importance of viewing healthcare organisations as 'complex adaptive systems' due to their unique and constantly evolving nature. Donetto et al. (2015) suggest incorporating a political perspective when engaging with healthcare institutions, aiming to rethink the systems and power relationships within the sector. To do this, the research should be positioned as cross-disciplinary. Sanders and Stappers (2008) describe co-design as the creative collaboration between designers and people without a design background. Consequently, co-design, as a form of PD, is inherently cross-disciplinary and can help rethink systems to reposition and shift the values of current care delivery in North Ayrshire. PD allows practitioners to focus on broader aspects of interventions, including facilitating stakeholder group discussions, analysing group dynamics, and fostering reflection, rather than focusing on technical and medical details. Therefore, during the engagement process, it is crucial to enable mutual learning to reciprocate for the insights that will shape the project's outcome.

By engaging stakeholders throughout the PD process, this project aims to collectively and creatively conceptualise integrated care models to strengthen community care and prevent care breakdowns.

Integrated Care and Community-Based Supports

The following section will examine two case studies to provide insight into designing integrated care pathways that incorporate community-based initiatives. They both address challenges which are relevant to the North Ayrshire context. The first case involves a service model developed within a healthcare setting to prevent hospital admissions and reduce discharge delays. The second is a grassroots community initiative which aimed to enable individuals with LD to live independently in an urban environment.

The Birmingham Community Assessment and Treatment Service

With the move away from long-term hospital stays, an inpatient assessment and treatment ward in Birmingham was transferred to a 10-bed unit at an old hospital, supplemented by a few external beds in nearby facilities. This traditional inpatient care model was viewed as the best option for individuals who had reached a crisis point, at which point the community could no longer support them. However, frequent discharge delays caused bed blocking, preventing patients from leaving the unit and leading to further admission delays and breakdowns in placements.

Richings et al. (2011) identified that early intervention in a person's care could prevent unnecessary hospital admissions. After a year of renovations, the Birmingham Community Assessment and Treatment Service (BCATS) was established in February 2007. This new model utilised three departments: "assertive outreach, day assessment places and inpatient beds" (2011). The BCATS model (Figure 3) provided adaptable support to community teams through advice and supervision of individuals referred to the service, whether or not they were admitted.

Over the course of two years, this model served more people than the previous inpatient unit. The outreach department prevented 37% of referrals from needing admission and cut inpatient assessment durations by 28%. This model of care also inspired the development of the Intensive Support method, which was created in response to the Transforming Care report (Burrows et al., 2022). Nonetheless, delayed discharges persisted, with lengths of stay similar to the previous unit. Richings et al. (2011) argue that the BCATS model was capable of reducing delayed discharge symptoms, such as admissions and placement issues; however, the persistence of external constraints remained a concern for the service. Furthermore, Burrows et al. (2022) recognised the lack of service presence after discharge and noted that there was no evidence to suggest that BCATS remained operational after the report was published.

Figure 3: *Details the different stages of the BCATS Model.* 2011. Source: Richings et al.

This case study shows the value of integrating the community into care delivery, as it aimed to prevent hospital admission where possible through outreach and day assessment. However, the solution remained limited in transforming care provision for individuals with LD, as there was no shift in care values or reconceptualisation of the model in place before its adaptation, as the inpatient unit continued to present similar problems to those of the initial model. Given that the most significant impact came from care being delivered more in the community, with admissions reduced by more than a third, further improving the efficiency of the inpatient unit as fewer resources were required in this department, there is an opportunity to emphasise this further. This also underscores the need to shift to a relational care model rather than a transactional one to uproot the constraints that still persist.

Home in the Annex: A Case Study Looking at Community-based Initiatives

Something that is 'community-based' is a piece of urban infrastructure sustained by public action through government aid (Lemon & Lemon, 2003). These initiatives are inherently political, as action may be taken to advance legislation and policy that provide dedicated support in areas such as employment, housing, and public transport, allowing for greater involvement of the specific community, in this case, individuals with LD.

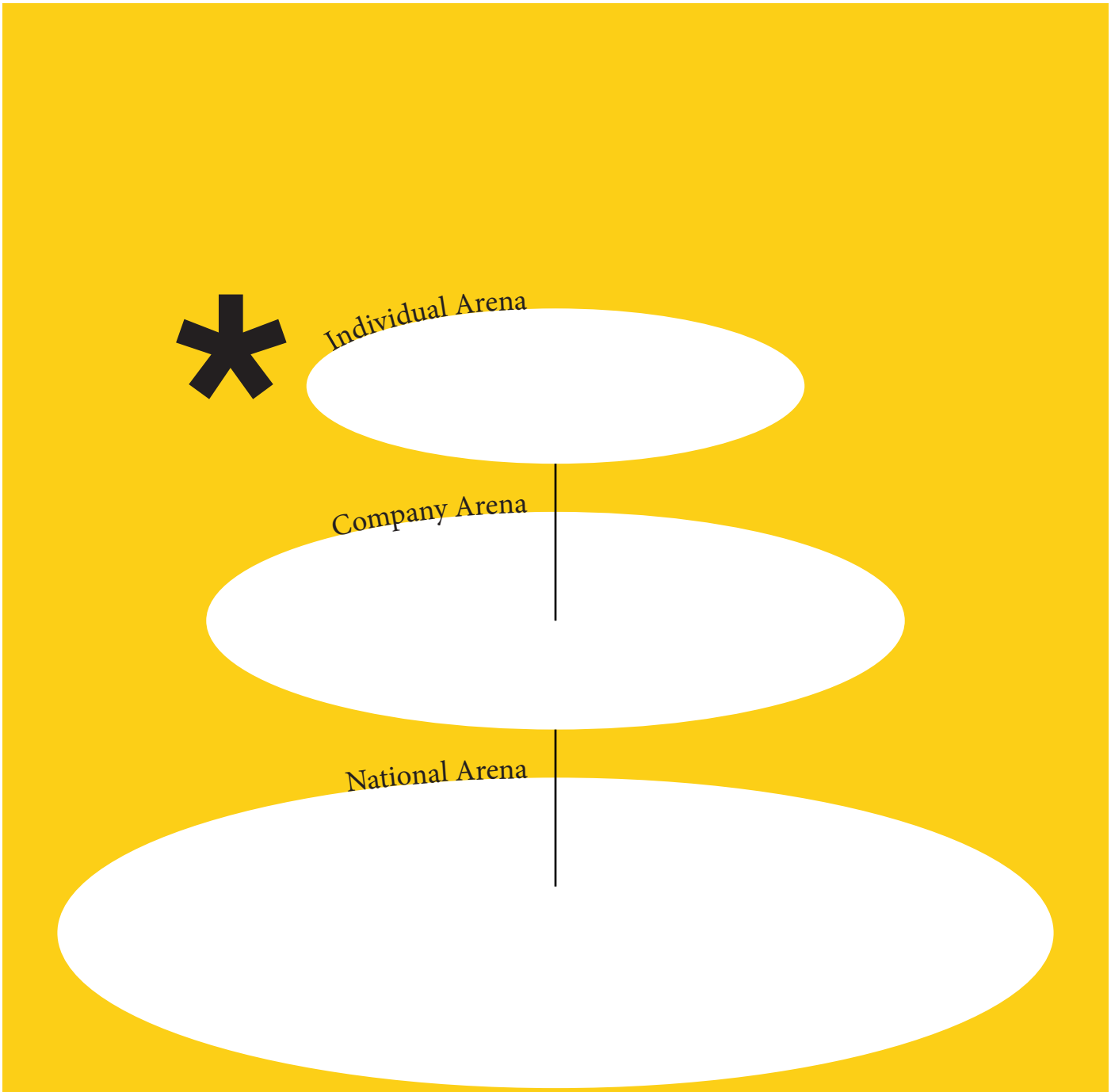
Lemon & Lemon (2003) discuss the landscape of the late 90s for individuals with LD in Toronto. The current trends at the time focused on "deficiencies, individualisation and service" (2003), with social service agencies receiving government funding for group homes, sheltered workshops, and day programs to promote integration. However, this push for 'normalisation' fell short because it offered limited housing and employment opportunities. Activists argued that group homes fostered segregation and that workshops were exploitative, hindering proper community integration.

This case study explores a community-based initiative that helped individuals with LD achieve independent living. Home in the Annex began with six upper-middle-class families in one neighbourhood working together to enable their children with LD to live on their own. They advocated for their children's needs to remain local to their Toronto neighbourhood and secured government funding for consulting and mortgage assistance for housing. Training for independent living, including budgeting and cooking, was identified as essential (2003). The group collaborated with Community Living Toronto, which aligned with their goals, and supported a transition process into a two-bedroom accommodation for training purposes. Two individuals lived there for a year before moving on to new apartments, with other pairs taking their place. Ultimately, all six members lived independently, although each chose to live alone.

This model highlights that community-based initiatives are more likely to succeed in "well-designed cities and organised public institutions" (2003) and that governments must provide essential services. Home in the Annex thrived from funding from a New Democratic Party government, which prioritised leftist policies, thriving in an urban area with reliable public transport. At the same time, affluent families covered rising market rents. This raises the question of how successful a similar community project would be in North Ayrshire today with current political principles.

Kensing & Blomberg define three scales of influence, with all three needing to be designed to enable empowerment:

Figure 4: Depicts and defines the different arenas of influence. 1998. Source: Kensing & Blomberg



*1. Arena A: The individual project arena where specific systems are designed and new organizational forms are created.
2. Arena B: The company arena where "breakdowns" or violations of agreements are diagnosed and hitherto stable patterns of organizational functioning questioned and redesigned.
3. Arena C: The national arena where the general legal and political framework is negotiated which defines the relations between the various industrial partners and sets norms for a whole range of work-related issues.

Learnings

The BCATS model focused on ‘the company arena’, redesigning care pathways within a healthcare institution, but is hindered by political influences, with delayed discharge remaining a concern. Home in the Annex operated in ‘the individual project arena’, catering to a few specific individuals, whose success eventually required sustained support from their families’ private income.

From the comparison of the case studies, learnings can be extrapolated further to understand the context of care for individuals with LD. As attitudes towards LD have changed to recognise that it is not a curable condition, ideally, care is a form of support that will be interacted with over the course of a lifetime. Therefore, relational care and early interventions would be beneficial throughout that journey to prevent care breakdowns leading to unnecessary hospital admissions. Furthermore, support should be available regardless of whether an individual has reached the admission status; however, with government austerity affecting public organisations, statuses such as ‘crisis point’ act as eligibility criteria for acquiring adequate funding for care support, prioritising values that emphasise transactional care.

The second case study highlights the essential role of government funding in the effectiveness of that service. However, it also marks a political shift as symptoms of privatisation began to affect the viability of independent living for those people. The infrastructural setting also played a crucial role in the success of independent living, as access to amenities and public transportation significantly improved QoL.

Although independent living would be preferred, a service like Home in the Annex could not thrive in North Ayrshire without its private financial backing. Over 50% of the LD population in North Ayrshire resides in areas ranked among the top 20% of deprived areas in Scotland, with 28% living in areas ranked among the top 10% (North Ayrshire Health and Social Care Partnership, 2025). Therefore, a solution such as the BCATS model positioned closer to the community would be better suited to this project’s local context. However, the value systems behind both case studies should be re-evaluated to consider individuals with LD as active members of the community rather than recipients of care.

It is clear that prioritising transactional care will continue to limit QoL for individuals with LD. Therefore, this project aims to explore themes of relational care to strengthen community-based support through the PD process, with stakeholders with lived experience caring for individuals with LD, to rethink systems and produce recommendations for future services.

Current Gaps

This Literature Review examined academic journals and reports on care for individuals with LD and compared case studies that presented viable alternatives for integrated care models more closely aligned with the community.

The initial effort began by framing and thinking through approaches and solutions to alleviate distress during transitions between services. However, with recent developments in North Ayrshire's Ward 7A, the issue no longer centres on transitioning from statutory services to community services, but instead on preventing care breakdowns within the current community services to eliminate the reliance on statutory services to take on that additional responsibility.

People end up in institutionalised positions because there is insufficient community support in place before their admission. They then remain in the hospital for a prolonged period because external resources remain inadequate. Therefore, the gaps remain between the current provisional support services, which have in the past been unable to prevent people from being admitted to the hospital. Much of the literature has focused on deinstitutionalisation after admission and care in relation to statutory services. However, less has been devoted to strengthening community-based models from a community perspective.

Existing literature and knowledge inform the assumption that statutory services exist as safety nets. With the closure of Ward 7A, the question remains: how do care pathways adapt when that safety net is removed? Clinical support still needs to be in place for unforeseen circumstances, but this form of care could be developed to offer preventive support. However, external constraints exacerbate problems within their fundamental functions, preventing them from operating correctly. This means that, as Ward 7A is closed, if a new service were to be developed, it would suffer the same problems as the previous service, which lie outside the individual and company arena.

These gaps highlight the need to explore integrated care through strengthening community-based support to prevent care breakdowns. Through PD engagement with those who deliver care for individuals with LD, this project aims to explore concepts that enable individuals with LD to be supported without reliance on institutional solutions.

Methodology

*Visual structure adopted by Crotty's Social Research Framework.

Figure 5: *The Foundation of Social Research.* 1998. Source: Crotty

Introduction

The purpose of this chapter is to set out the knowledge and assumptions that will inform the fieldwork engagement of this research project. The structure in which this will be explained will utilise Crotty's framework from The Foundations of Social Research (1998). This framework (Figure 5) effectively structures the layout of this chapter, as it provides linear guidance to build a narrative from broad concepts to their practical application to help strategise engagement to answer the question: How can the PD help create design recommendations through speculative proposals to strengthen community-based support for people with learning disabilities to prevent care breakdowns?

The first section will explore the epistemological stance. Explaining how knowledge is believed to be constructed will help shape the subsequent sections. Social Constructivism is clarified and explored through the Stanford Encyclopedia of Philosophy's naturalistic approach to the epistemological stance (Mallon, 2024). By categorising the factors of influence on how knowledge is created and the factors being influenced, a statement is defined that is most relevant to how this stance is put into practical action.

The Theoretical Perspective works dynamically with the Epistemology. By defining Pragmatism in contrast to a traditional, scientific research perspective, this section helps to underpin and justify the methodology utilised in engagement. This section examines different generations of pragmatist thought, such as Peirce (Magee, 2001) and Mead (1934), to inform the researcher's approach. Dewey's principles (Dixon et al., 2021), which ground the theoretical perspective, will help narrow and structure the methodology.

Justified by previous sections, the methodology acts as a guide to the overall research strategy. This segment of the chapter will explore Participatory Design through its historic origins (Teal & French, 2020). By aligning it with the theoretical perspective and examining the practicalities of undertaking this creative process, the methodology will reveal the values and principles essential to the design of engagement methods, helping identify values and recommendations for the future of services in North Ayrshire.

The description of the practical methods employed during fieldwork will be further stated here. By justifying different methods of data capture, this section primarily focuses on exploring formats for holding conversations during a co-design session, examining Erik Olin Wright's conceptual theory of 'Emancipatory Social Science' (Wright, 2010).

Furthermore, ethical considerations will be taken into account in preparation for the fieldwork. Informed by Aristotle's Nicomachean Ethics (2001) and Steen's (2012, 2014) practical application of virtue ethics in PD, the researcher will apply an ethical code to aid engagement and analyse the effectiveness of their engagement methods. The virtue of reflection can also help the individual researcher explore and strengthen their agency. This serves as an aid to the practice of engagement, enabling meaningful conversations and fostering a safe environment for sharing lived experiences.

Lastly, the analytical approach to the data captured from engagement will be described. The data corpus will undergo Thematic Analysis (Braun & Clarke, 2006). Informed by the project's objectives and valuing qualitative data, the data will be extracted semantically, and the understanding of the context will be built inductively to prioritise participants' lived experiences.

The chapter will conclude with a reflective exercise on the researcher's positionality. This is to highlight the role of background, values, and assumptions in shaping the trajectory of this project. It also practices principles such as transparency and trust, which are important to cultivate prior to engagement.

Epistemology

A social constructivist epistemology underpins this project. Constructivism is the formation of a single understanding through the synthesis of multiple theories (Amineh & Asl, 2015). This stance believes that "learning is a process of constructing meaning; it is how people make sense of their experience" (Merriam and Caffarella, 1999). Social Constructivism emphasises the relationship between the individual and others in the process of gaining knowledge. This ideology assumes that individual rationality is informed through their understanding of the world as a system of functions and emphasises the use of language to communicate and construct their own reality (2015). As members of society, reality is mutually shaped through the invention of the world's properties through human interaction, and reality cannot be perceived before social interactions (Kim, 2001).

Put simply, the epistemological stance can be declared 'X socially constructs Y' (Mallon, 2024). The belief that knowledge is produced through causal effects. However, what socially constructs what? The agents of construction have been split into two camps: 'impersonal' and 'personal' (2024). Culture and social structures are examples of impersonal constructs, while people and social groups are defined as personal constructs (2024). Furthermore, the factors being constructed are divided into two categories: 'representations' and 'non-representations' (2024). Representations consist of ideas, theories, and other concepts, while non-representations are composed of facts about human traits, such as biology and nature.

When comparing the two categories of construction agents, a clear imbalance is identified. Personal constructs are also directly shaped by impersonal constructs. Furthermore, representations are more prevalent when analysing engagement than non-representations, as this project focuses on social research. Therefore, this project will focus on the declaration that Impersonal constructs socially construct representations. This can be given further clarity: Social structures socially construct ideas.

Social constructivism recognises that knowledge is not objective or universal but instead defined through cultural or social factors (2024). This has a significant interpretive value for this project when engaging with stakeholders. Stakeholders' lived experiences inform their understandings of situations. Therefore, the narrative co-constructed through engagement is context-bound. It is also crucial to critically analyse their knowledge by reflecting on why the participants believe what they believe.

This epistemology operates for both participants and the researcher, as it begins to establish a reflective perspective on understanding the meaning behind the research for the individual researcher and also enables conscious decision-making by considering positionality.

Social constructivism is beneficial for gathering a deeper understanding of the research context and the participants. As a learning process, it highlights that "Meaningful learning occurs when individuals are engaged in social activities" (Kim, 2001). This aligns with the creative engagement element of design research.

From a design background, it is not expected that the researcher should be well-versed in technical and medical information. The value of design research lies in abstract thinking and skills that enable individuals to approach a situation differently from those living within a specific context. Social constructivism values facilitating interactions with stakeholders, enabling mutual learning. Through these interactions, stakeholders equip the researcher with knowledge that can only be attained through years of experience, and in return, the stakeholders gain design expertise.

This epistemology values the interpretation of stakeholder experiences, which the researcher will then further interpret; it is limited in that the project's outcome will not be generalisable but will be highly subjective. Therefore, the project's conclusion will be particular to the complexities of North Ayrshire.

Theoretical Perspective

In the pursuit of a research project, it is important to frame knowledge as an active process (Magee, 2001). When evaluating and analysing a research context, the aim can be interpreted as rectifying issues by identifying what is missing or incorrect (2001). Traditional research was considered inherently scientific as knowledge was perceived as "impersonal fact" (2001). When enquiring through that understanding, researchers embodied a "spectator view" (2001). This lens attempted to view the world as if the researcher were not a part of it. In response to this perspective, Peirce said, "we acquire our knowledge as participants, not as spectators" (2001). George Herbert Mead stated that the mind, self and the interpretation of meaning are acquired through social interaction, which reinforces the argument that knowledge is socially constructed (Mead, 1934).

The second generation of Pragmatists further developed this philosophy to be practically applied to social issues such as politics and education (Legg & Hookway, 2024). Mead's contribution is relevant to the perspective being utilised with this research for engagement with stakeholders, as he focused on prioritising and reflecting on the development of the relationship with the community and of the self (2024) through the internalisation of others' perspectives (1934):

> *"As social, to the degree that the self has taken the attitudes of others into itself through the language process, it has become the others, the values of the others are its own; to the degree that the self assumes the role of the generalized other, its values are the values of the social process itself."* (Mead, 1934)

Here, Mead discusses how individuals are shaped by social interaction. By communicating with others, a person begins to internalise other people's beliefs. At this stage, the individual and society they inhabit merge; their belief systems, ambitions and values resemble those of their social interactions. Mead's concept of the 'generalised other' can be utilised by the design practitioner during engagement as the practitioner adopts the role of a generalised other by viewing themselves objectively and reflecting from a broader perspective, allowing the practitioner to act in alignment with the collective, social values of their participants.

> *"The genuine implication of democracy is that each should realize himself through moral participation in a co-operative process."* (Mead, 1934)

Through Pragmatist principles, Mead strived for a moral society built on democracy. Prioritising and utilising a democratic process during engagement is a practical and ethical way to create new knowledge, as participants develop a shared narrative through interaction. Dewey's principles further expand democratic ambitions, which Dixon et al. (2021) adapt for utilisation in the PD process to assist policy-making, as Dewey believed people needed to congregate to discuss issues and further the democratic process.

Dewey's pragmatist perspective focuses on the community as the core of democracy. To enable this democratic prospect, key concepts must be implemented. To achieve 'Creative Democracy', which is defined as "community-based understanding of democratic discourse" (2021), 'Positive Freedom' must be enabled. This form of freedom refers to understanding and enacting one's rights. Dewey aspired for an educated population with the initiative to evaluate courses of action and with the foresight to strive towards intended outcomes. Through sustaining this cycle of positive freedom enabled by a creative, democratic community, social intelligence would be achieved, solidifying an adaptive culture that understands and meets new needs.

Through consideration of these values, this research aims to bring together healthcare staff, community care professionals, and third-sector workers with experience caring for individuals with LD to discuss how to strengthen community-based support, consider the different needs of the sectors and explore models of care for the future of services in North Ayrshire, as well as its relationship with the community.

Methodology

For the practical application of a Pragmatist perspective, informed by Social Constructivism, engagement should embrace values such as mutual learning and collaboration between public sector members and the community through social interaction. Based on the development so far and the practice-led inquiry of this project, the methodology can focus on the engagement strategy of Participatory Design (PD).

A definition of PD can be provided through its historical context. Originating in Norway, the need for workers' opinions to influence managerial decisions was a necessity, as these decisions would directly affect the workers. The practice of PD was introduced to analyse the lived experience of these stakeholders to tailor the design solution to their requirements. Therefore, the PD approach aims to engage with participants creatively to mobilise towards change (Teal & French, 2020).

PD aligns with Pragmatist principles, fostering the creation of new knowledge through a democratic process (Dixon et al., 2021). It encourages creative thought and emphasises the involvement of all participants in the design process, ensuring that each voice is heard and valued (McKercher, 2020).

To mitigate the risk of surface-level participation, the researcher must consider the power dynamics among participants, which are prevalent in top-down public-sector models (Broadley et al., 2025). To mitigate the imbalance, the research aims to recruit participants at the same hierarchical level within their profession when facilitating social interaction and observe their professional relationships, while accommodating activities that promote equal inclusion. During the first phase of engagement, when participation is singular, the research afforded the opportunity to consolidate perspectives from different hierarchical positions, such as management, which offered diverse insight for data collection.

One example of supporting equal inclusion is to utilise breakout groups with equal representation from each sector (Figure 6). Ideally, the number of participants would be divisible by three and four. Therefore, there can be four groups of three. In a group of three, a topic would be prompted for discussion. After that interaction, the four groups merge with another group to form two groups of six, allowing them to compare and combine their answers. Finally, the groups would merge as a whole to discuss and reflect on their answers, creating a shared narrative. The process of iteration and idea synthesis could be achieved through the merging of smaller groups, which allows for more comfortable discussion and fosters a sense of ownership over ideas. However, this engagement concept was too ambitious for this project, as facilitating a group co-design session on this scale proved to be difficult, because each participant needed to be interviewed before this phase of engagement and accommodating professionals' busy schedules would have made it hard to find a suitable time, considering the project's timescale.

Engagement can also facilitate a speculative dimension. Framing participation around thinking and conversations about the future will allow stakeholders and even the design to break free of some of the complex constraints acting upon them in the present (Dunne & Raby, 2013). Although PD outcomes focus on design solutions specific to the research context, by freeing design solutions from constraints, the values stakeholders find important will be more identifiable and easier to extrapolate for generalisable application (2013). A design proposal could already be speculative if nothing of it is taken further. Why not conceptualise it as a goal to work towards rather than an immediate intervention? Let proposals act as "compasses not maps" (2013).

The methodology to be employed during fieldwork is Participatory Design. Utilising design methods, such as speculative framing, will aid participants in channelling their imagination to shape alternative services and systems, and then reflect on what informs their current situation. Through the PD process, engagement aims to achieve mutual learning and creative collaboration across sectors.

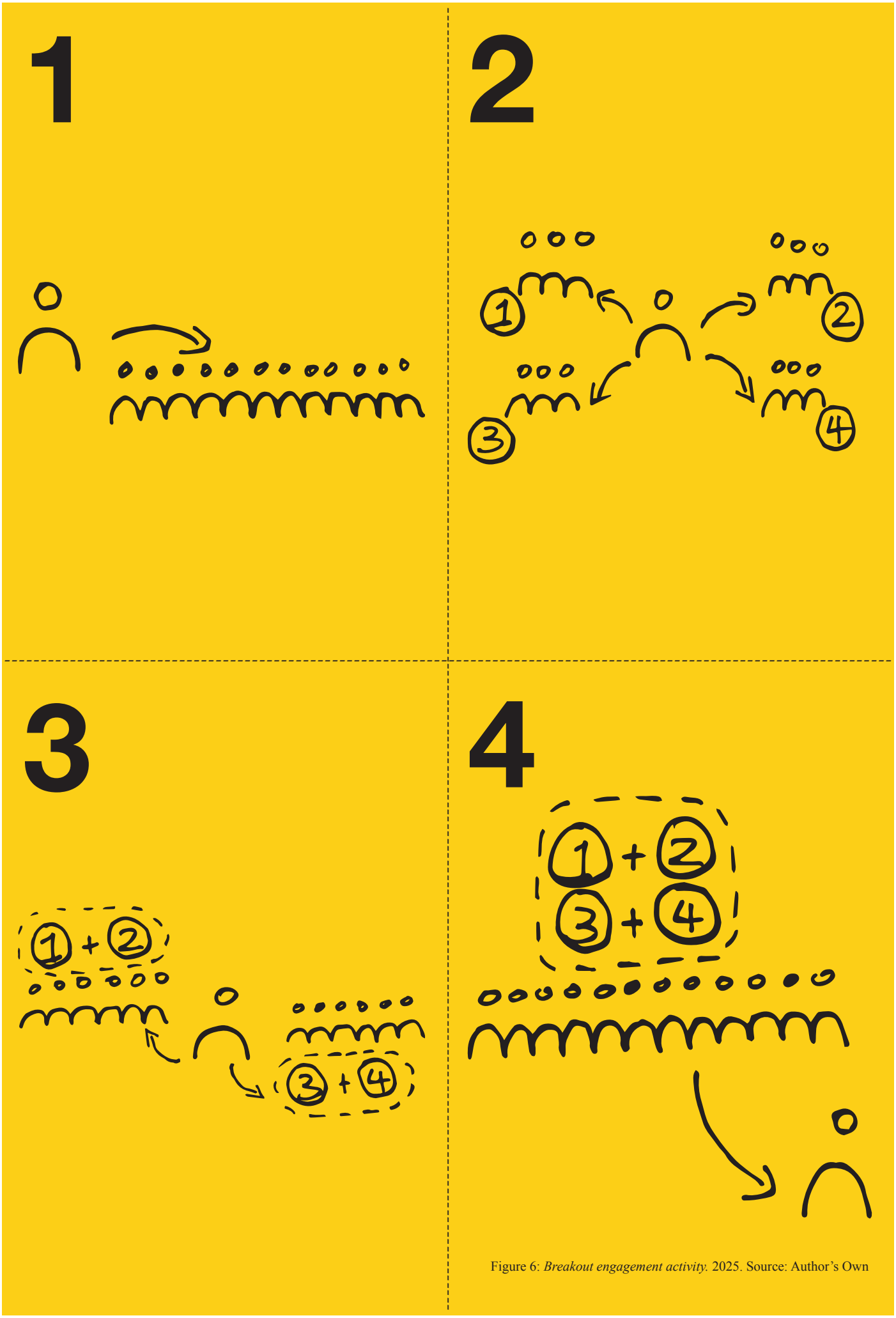


Figure 6: *Breakout engagement activity.* 2025. Source: Author's Own

Methods

The engagement process commenced with semi-structured interviews, involving an equal mix of NHS, social care, and third-sector professionals, conducted one participant at a time. Through utilising open-ended and closed questions, this engagement format aimed to navigate the current landscape of care for individuals with LD in North Ayrshire and inform the practical design of the co-design workshop. Through the data collected from interviews, the analysis aimed to identify design opportunities to prompt collaborative discussions and ideation during co-design. By tailoring the questions to the participant's comfort level and adapting the language of the questions, interviews felt more natural and conversational. This enabled greater rapport-building and fostered an inclusive environment, allowing participants to discuss the experiences that matter most to them. By following a line of questioning that was more specific to their answers, the interviews uncovered unexpected insights and enables the researcher's assumptions to be challenged (Newcomer et al., 2015). With a focus on dialogue rather than the interview structure, the engagement allowed for deeper consideration of sensitive topics that may have arose during the exploration of care for individuals with LD (2015).

Informed by the interviews, the co-design workshops aimed to foster meaningful engagement through creative discussion of an elected design opportunity, while keeping values such as inclusivity in mind. The co-design sessions were intended to facilitate social interaction among equal numbers of NHS staff, social workers, and third-sector representatives, enabling participants to synthesise their lived experiences into a unified narrative. However, due to scheduling conflicts, each sector was engaged with individually, but they were given the chance to see other participant outcomes during the latter phase of engagement. The first workshop activity elicited individual responses from stakeholders, considering three time frames, then prompted breakout discussions to begin forming a consolidated narrative. The speculative narrative comes with its own set of challenges, as participants may not have immediately seen the benefits of dedicating their time to this engagement when prompted to develop a speculative mindset. Therefore, the final activity outcomes needed to give participants a sense of ownership over the concepts they ideated. For this purpose, the final activity of the co-design workshop facilitated conversations to create a timeline and a storyboard for an ideated concept, informed by their discussion of prompts. As a co-design method, storyboarding is a valuable technique for enabling participants to empathise with the user experience and visualise the pathway when designing a proposal (Young et al., 2022). It is also a useful method for creating design artefacts and for showcasing the depth of participants' knowledge and specialisation (2022).

The engagement structure drew on Erik Olin Wright's conceptual theory of 'Emancipatory Social Science' (Wright, 2010; Dunne & Raby, 2013). Wright's idea discusses solutions through three framed conversations (Figure 7). The first conversation is 'Diagnosis', which critiques the present situation, identifying what is currently being done right and what is being done wrong. The second part is the 'Theory of Alternatives', which examines possible alternative models in contrast to the current one. This prompts speculative thinking free from the constraints currently acting upon what was diagnosed. The final part is the 'Theory of Transformations', which facilitates conversations about how one could get from the present to the alternative (2013). By categorising conversation prompts using Wright's three definitions, each section prompted three discussion frames, each intended to investigate a topic from a different angle to help shape a proposal in response to a design opportunity.

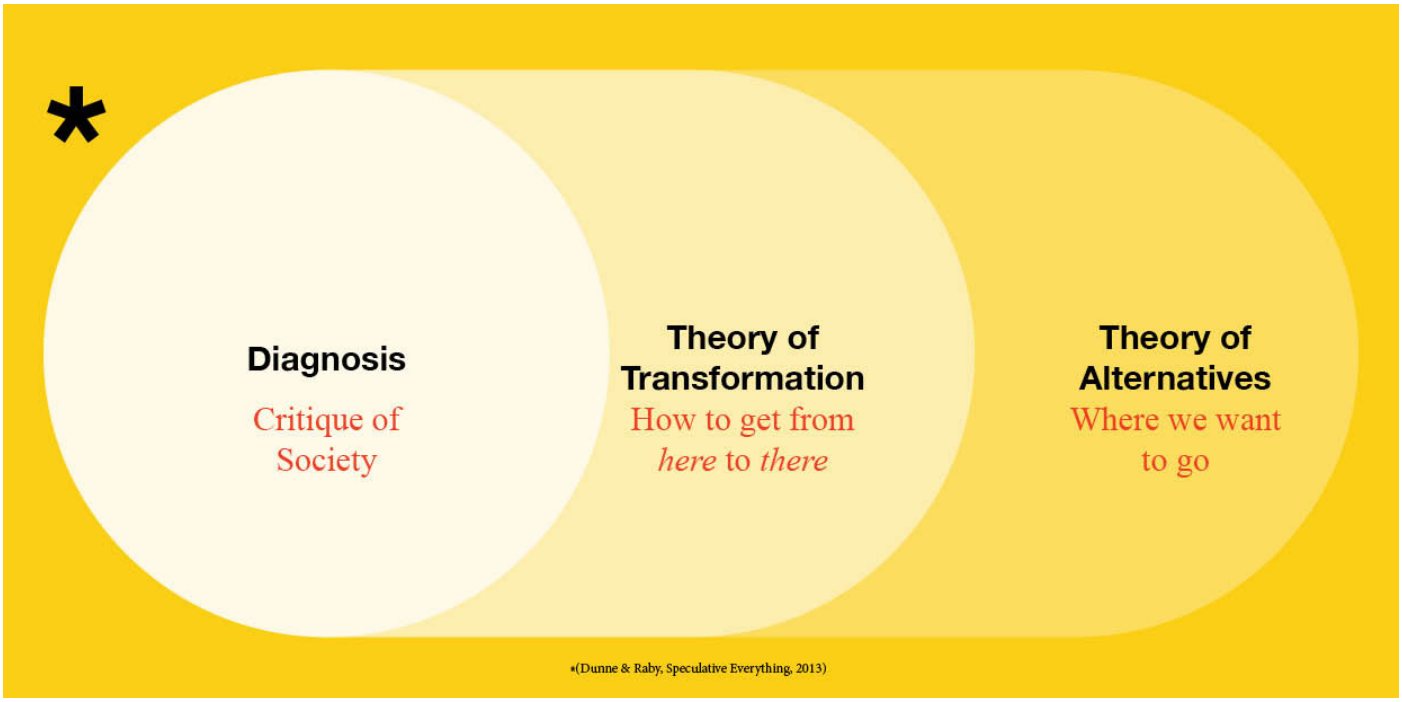


Figure 7: *Erik Olin Wright's conceptual theory of 'Emancipatory Social Science'.* 2013. Source: Dunne & Raby

The final method used during the fieldwork stage was group evaluation sessions with the stakeholders who helped design the co-design outcomes. This approach aimed to generate an overall consensus to refine the proposals created during the co-design session. While individual evaluation might provide more in-depth, reflective feedback, conducting multiple individual sessions would have been time-consuming, and the one-on-one format could have also discouraged stakeholders from expressing their honest opinions. Although a group session still needs to account for power dynamics between stakeholders, it was more time-efficient. It also facilitated group discussion and offered the chance to develop a unified narrative across workshops, which was informative for the discourse generated by the proposals. The storyboards from the co-design sessions were a useful discussion tool, as they facilitated communication of other participants' ideas, motivated participants, and informed future research (Newcomer et al., 2015). In alignment with Newcomer et al.'s (2015) third strategy for using stories in evaluation, by assembling the storyboard outcomes from each co-design session, participants helped to identifu patterns and themes that signify the future direction of care provision in North Ayrshire.

Analysis

Once the data was collected using PD methods, it underwent thematic analysis (Braun & Clarke, 2006). Informed by a constructivist epistemological stance, the analysis of data was conducted through an inductive approach. Therefore, no thematic framework was prepared before engagement, allowing the narrative to be built from the ground up. From the interviews, data was extracted and themes identified semantically to shape and prioritise the participants' lived experiences, informing the understanding of the current care landscape. To position themes more closely in relation to each other, a further analysis using a latent approach was utilised to identify and examine the underlying ideas participants implicitly articulated. By grouping themes and insights, opportunities were identified to inform the next phase of engagement.

Ethics

When undergoing fieldwork, the processes utilised and the activities designed for engagement adhered to GSA ethics policy and further upheld NHS ethical guidelines, as some stakeholders were professionals working within the NHS organisation.

With the shift in priority from a political perspective towards an ethical mindset when developing PD activities, 'virtue ethics' offers a moral framework for practitioners to engage with stakeholders (Steen, 2014). Through making the implicit explicit, Steen expects that, by considering virtues, practitioners can enable stakeholders to participate more actively and critically within the PD process (2014). The framework that virtue ethics presents complements the epistemology and theoretical perspective well. Through seeking Eudaimonia (Aristotle, 2004), the state of human flourishing, virtue ethics serves as a guide towards PD engagement and the researcher's reflection and assessment, including positionality.

In a previous paper, Steen (2012) highlights reflexivity as an active virtue to cultivate above all others, allowing the practitioner to assess the prioritised values they identified during engagement. Reflexivity can help PD practitioners design how they can work towards their ethical virtues. Steen (2012) believed it was important to reflect on his tendencies and traits to enable more meaningful engagement by being aware of these inclinations and to actively "lean toward the opposite extreme" (2012). Therefore, reflection is an important and consistent exercise to partake in before fieldwork and during analysis and synthesis.

Positionality

As a designer with prior experience collaborating within the healthcare environment and with individuals with LD, it is acknowledged that the perception in which this project is framed was established through the study of Product Design and previous projects. This project builds on the trajectory of designing for an inpatient unit to designing transitions to the community. However, this narrative comes with its inherent bias, as the knowledge is being broadened from the initial involvement with Ward 7A. The choice in undergraduate studies also potentially forms a narrative that solutions reside in tangible objects or conceptual services.

Although previous experience within this topic offers valuable context, which has been utilised to propose this project, a previous lens has been established. This lens needed to be revised to accommodate new knowledge and diverse perspectives for consideration. Steps were taken to remain reflexive throughout the study by engaging stakeholders in co-design processes, iteratively reviewing findings with participants, and maintaining transparency in the decision-making process during analysis.

Figure 8: *Adaptation of 'The Foundation of Social Research'.* 2025. Source: Author's Own

Conclusion

To conclude, this chapter set out to inform the knowledge and assumptions that have shaped the project, which further shaped analysis and findings in the following chapter. By exploring abstract philosophical schools of thought, this chapter justified a course of practical action aimed at acquiring meaningful knowledge.

The epistemological stance chosen to underpin this project was Social Constructivism, as it is believed that impersonal constructs, such as social structures and culture, inform how individuals perceive and understand experiences. This stance emphasises stakeholder engagement to produce meaningful research findings. It also provides a critical angle for analysing people's lived experiences, as it assumes that individual rationality is built on a foundation of socially acquired knowledge.

Informed by the theory of knowledge, the Theoretical Perspective was defined by Pragmatist thought because it holds that knowledge is an active process adapted to the situation in which it is applied. Mead's exploration of the self in relation to community, complements Social Constructivism and further justified the engagement strategy planned for use during fieldwork. By adapting Dewey's principles to PD, engagement emphasised a democratic process in which the design practitioner strived for equal participation and knowledge exchange.

The Methodology adopted for fieldwork was Participatory Design. PD offers participants the opportunity to inform the project through their expertise and lived experiences, thereby aligning the outcome with the needs of stakeholders and people with LD. PD, when considering societal factors, aims to facilitate mutual learning between the design practitioner and participants.

The methods utilised during fieldwork were semi-structured interviews, group co-design sessions and evaluation sessions. These methods facilitated data gathering, leading to the development of concepts through discussion and iterative refinement of co-designed storyboards. The co-design sessions were framed through a speculative lens, allowing solutions to manifest free from complex constraints currently affecting the care landscape. From the iterative development of co-design outcomes, recommendations were extrapolated to conclude the research by considering how services can be transformed into a preferred alternative. This also offered more generalisable insight for further research.

The data collected from fieldwork was justified to be analysed thematically. Identifying themes semantically and building an understanding of the context inductively helped prioritise stakeholders' expertise and knowledge.

By aligning PD and practical engagement with an ethical process, the design of activities and the practical actions required during engagement enabled more inclusive participation. Virtue ethics served as a guide for the PD practitioner.

The chapter ended with a reflective exercise on positionality that highlights the subconscious limitations one imposes on oneself through past experiences.

Fieldwork

Introduction

The following chapter presents a narrative of the three stages of engagement undertaken to ground the research in the lived experiences of people who care for individuals with LD, drawing on key findings and emerging insights. As previously discussed in the methodology chapter, the fieldwork phases are structured using Wright's Emancipatory Social Science framework (Wright, 2010), with data being collated under the headings of diagnosis, alternatives, and transformation. However, based on scoping conversations, these headings have been modified to be more accessible to participants, as a term such as 'diagnosis' carries different connotations within a medical discipline. Therefore, the headings were changed to "Understanding and Critiquing the Present", "Imagining What Could be" and "Moving from Now to the Future".

Three phases of engagement were utilised over the course of fieldwork, with each phase informing the next. Fieldwork began with interviews, during which all three frames of conversation were discussed, and 'understanding and critiquing the present' was finalised as a line of inquiry for the remainder of this project. A co-design workshop followed the interviews, which involved the previously engaged participants who were available at the time. This workshop focused on 'imagining what could be', with activities designed and facilitated based upon the interview findings. Finally, an evaluation phase was conducted, which involved participants from the co-design workshops to review each other's work and evolve their concepts, while also serving as a final iteration cycle for the workshop outcomes. This phase focused on 'moving from now to the future', as conversations emphasised moments that participants believed were achievable and reflected on how this preferred future could be attained (Candy, 2009).

This chapter begins by describing the connection with the gatekeeper and our conversations, which have helped shape the project, as well as their support with the initial immersion and the fieldwork recruitment process. The justification for the recruitment criteria follows, which was circulated among health, social, and third-sector care providers to advertise the project and provide people with the opportunity to engage.

The interview process is then clarified before discussing the interview findings. The interview questions were designed to critique the current landscape of services within North Ayrshire, discuss idealised care solutions that offer viable alternatives to the current situation, and identify the values that practitioners believe are important to their discipline when transforming services for individuals with LD. The interviews aimed to surface themes, insights and opportunities that could be taken into later engagement phases and inform prompts for participants to answer.

Findings from the present care landscape were finalised after the interview phase. This informed design opportunities that were taken into the co-design phase of the fieldwork to be further discussed and translated into proposals for design outcomes.

Discussion of the co-design workshop follows. Informed by interviews, this section examines the workshop design, execution, and outcomes. It also discloses certain limitations that emerged during this phase of fieldwork, as participants' schedules and time constraints led to compromises in the workshop's ambitions.

Following the co-design workshop, the outcomes and findings were shared with other co-design participants to complete a final iterative development cycle, which this chapter concludes with.

Scoping Conversations

From the project's inception, North Ayrshire Learning Disability services have participated as a partner, with one dedicated Development Manager acting as a gatekeeper for participant recruitment and providing access to services across the region. Monthly catch-up meetings were held during the early stages of the research to review findings from desk research, discuss complex topics for which reading material could be recommended to further expand on these points, and outline further actions in preparation for fieldwork. The meetings became more frequent as the project progressed. These conversations were extremely valuable in keeping the research grounded within the context, especially when undertaking ethics approval.

These early conversations also allowed me to attend local events, including an NAHSCP event centred on transitions, in partnership with Advancing Real Change (ARC) Scotland. At this time, ARC Scotland was hosting a workshop to unveil their app 'Compass' to support individuals with LD in transitioning through services. I also had the opportunity to join a meeting with service designers in England who were doing ongoing development work in Scotland for the 'Digital Front Door', an app that held personal health data and helped navigate health services. Multiple complex topics were discussed, including data governance for service users.

I had other opportunities to visit services on-site and attend meetings to promote the project. This proved useful as rapport began to develop with people who eventually became engaged in the project through online meetings exploring digital inclusion. I attended an LD management team meeting, which granted me access to circulate information about the project to services across NAHSCP.

The gatekeeper also arranged meetings with other stakeholders to explore digital inclusion in this context. These conversations informed case studies and potential solutions, which were discussed during fieldwork. However, due to the ongoing ethics review process, these conversations could not be recorded, and handwritten notes were taken to capture emerging themes that informed the discussions. However, experiences like these allowed me to immerse myself further in North Ayrshire and within Health and Social Care services before officially engaging in fieldwork.

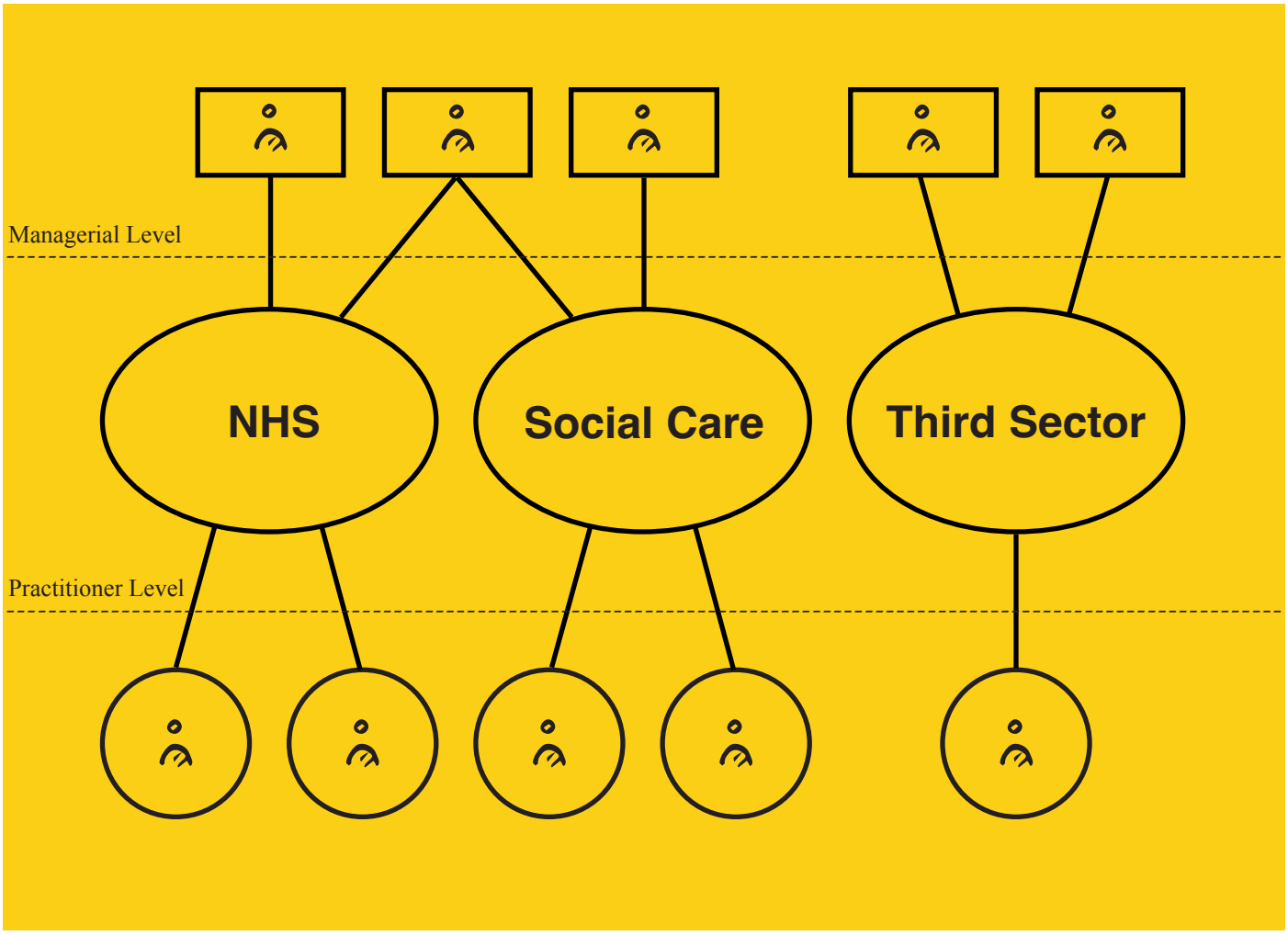


Figure 9: *Mapping Participant Criteria.* 2025. Source: Author's Own

Recruitment

Following ethics approval, the recruitment process commenced. I identified stakeholders from each sector - NHS, social care and third sector - who met the recruitment criteria, aiming to achieve an equal split across all three to ensure each received representational input (Figure 9). For this phase, I opened participation to the managerial level, as their perspectives are unique given their overview of the service and their greater opportunities to interact with other sectors through partnerships and events.

An email containing the participant information sheet and consent form was sent to the LD management team for distribution to practitioners. If practitioners expressed interest, my contact details were shared to initiate correspondence and set up an interview. A relatively small number of people came forward from the initial round of circulation. However, after discussions with my gatekeeper, we identified potential participants, some of whom I contacted directly, and the gatekeeper contacted others to gauge their interest. The participants that I contacted directly were individuals with whom I had worked during previous projects.

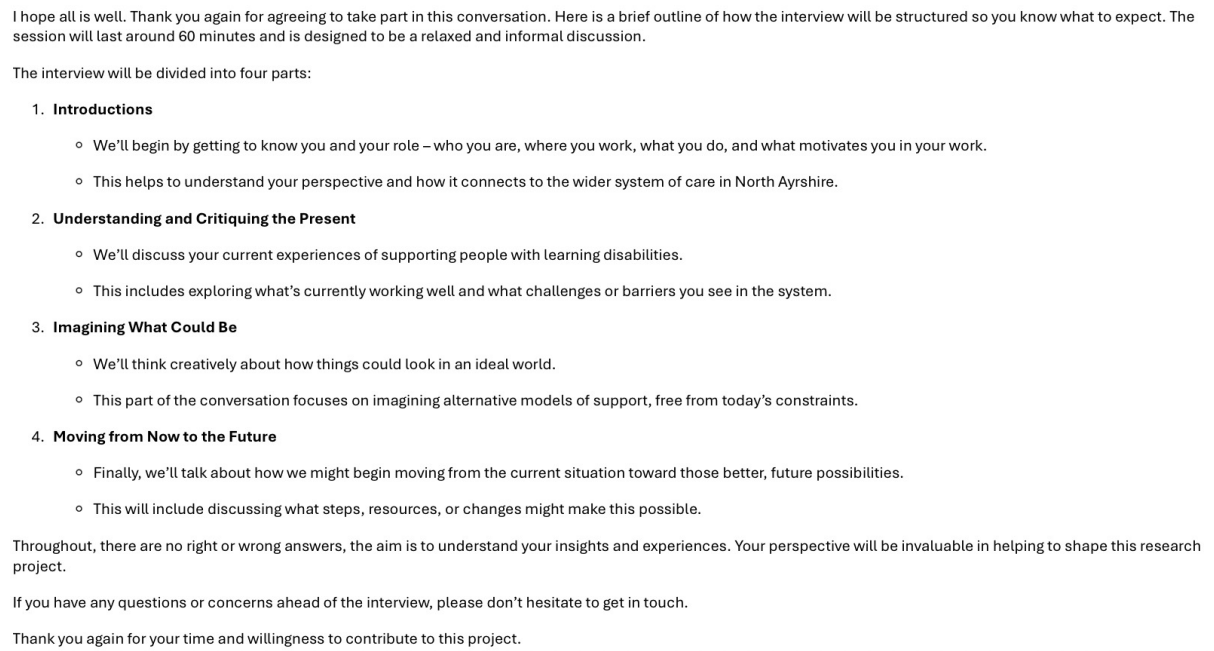
Interviews

Participants received information about the interview structure in advance to allow for appropriate reflection and preparation (Figure 10). There were four groups of questions, including introductory questions, understanding and critiquing the present, imagining what could be, and moving from now to the future, with the questions after the introductory phase in relation to Wright's Emancipatory Social Science framework (2010). The introductory questions included a mapping exercise, planned to evaluate their position and awareness in relation to other services in North Ayrshire.

Before each interview, I obtained consent from the participants, which enabled me to audio-record the interview. This was helpful because it allowed me to be present during the session instead of taking notes and, following the interview, to listen back and extract quotes during analysis.

For this phase of fieldwork, 10 interviews were conducted, each lasting approximately an hour. I had prepared follow-up questions to reframe the questions in case of misunderstanding, for instance, when participants had little to say on an issue. However, these questions were rarely utilised.

During interviews, I actively listened to how participants answered questions to adapt the wording of the prewritten questions and to ask follow-up questions based on answers I did not anticipate. Along with open body language that demonstrates my listening through both verbal and non-verbal cues, the interviews took on a more conversational, semi-structured dynamic.



I hope all is well. Thank you again for agreeing to take part in this conversation. Here is a brief outline of how the interview will be structured so you know what to expect. The session will last around 60 minutes and is designed to be a relaxed and informal discussion.

The interview will be divided into four parts:

1. **Introductions**
    - We'll begin by getting to know you and your role – who you are, where you work, what you do, and what motivates you in your work.
    - This helps to understand your perspective and how it connects to the wider system of care in North Ayrshire.
2. **Understanding and Critiquing the Present**
    - We'll discuss your current experiences of supporting people with learning disabilities.
    - This includes exploring what's currently working well and what challenges or barriers you see in the system.
3. **Imagining What Could Be**
    - We'll think creatively about how things could look in an ideal world.
    - This part of the conversation focuses on imagining alternative models of support, free from today's constraints.
4. **Moving from Now to the Future**
    - Finally, we'll talk about how we might begin moving from the current situation toward those better, future possibilities.
    - This will include discussing what steps, resources, or changes might make this possible.

Throughout, there are no right or wrong answers, the aim is to understand your insights and experiences. Your perspective will be invaluable in helping to shape this research project.

If you have any questions or concerns ahead of the interview, please don't hesitate to get in touch.

Thank you again for your time and willingness to contribute to this project.

Figure 10: *Email Sent to Participants in Advance of the Interview.* 2025. Source: Author's Own

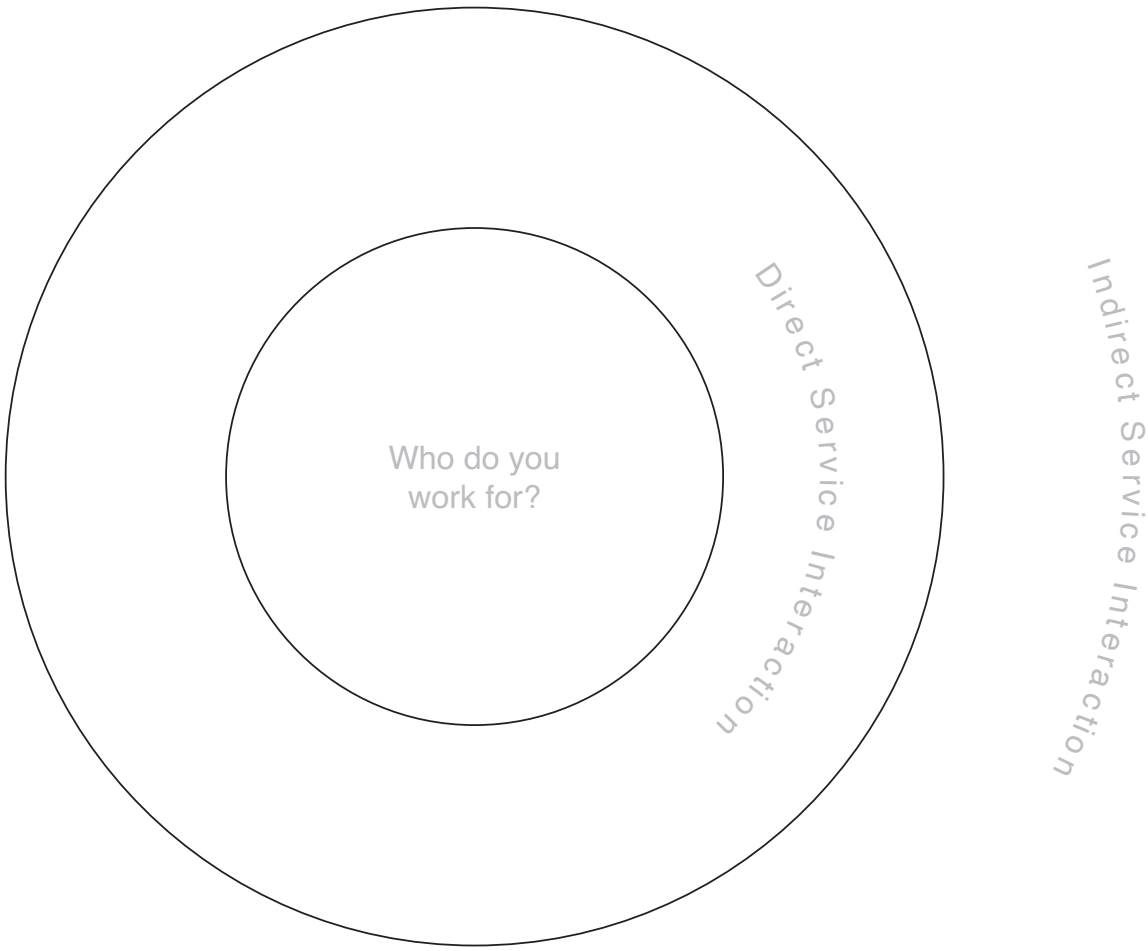


Figure 11: *Mapping Exercise Template.* 2025. Source: Author's Own

Mapping Exercise Within Interviews

In the introductory section of my interview questions, I designed an initial engagement activity that asked participants to list some of the services outside of their own that they had communicated with. This was to gain perspective on their perceived position across North Ayrshire and to understand the services that they thought were most impactful for someone with LD.

During scoping conversations with practitioners, I was disoriented by the quantity of acronyms and abbreviations for services that were casually used in conversations to describe positions and roles. Therefore, I wanted to capture this information during interviews to build my knowledge of services and to scope which services were aware of each other.

I had formatted this contextual information as three concentric circles: the central circle is the service they work for, the second represents the services they have contact with, and the outer circle represents the services they are aware of but don't have a relationship with.

Figure 12: *Collection of themes from interview.* 2025. Source: Author's Own

Interview Analysis & Synthesis

I undertook thematic analysis (Braun & Clarke, 2006), which began after four interviews were complete. This was because I had gathered data from at least one participant in each sector. I listened to and transcribed all four interviews, extracting quotes and organising them under relevant themes while keeping each interview separate (Figure 12). I took an inductive approach, identifying themes which were strongly linked to the data gathered. The aim was to build a narrative from the bottom up to highlight participants' lived experiences rather than extracting quotes and themes to meet a predetermined criterion. After each interview, I began to shape the narrative of each participant in these 'tree branch' like structures (Figure 13), with each quote positioned with other thematically aligned quotes. Overall, this helped form connections, for example, by highlighting how the lack of resources creates inconsistencies across services, which in turn leads to poor communication.

After completing this phase of analysis for the first four interviews, I began synthesising by compiling quotes across the interviews under collective themes (Figure 14). I then reordered them by theme, keeping related topics in the same vicinity, and began 'tree branching' a collective narrative (Figure 15), a consolidation of barriers and concerns around the current care landscape. Similar opinions emerged across different sectors, such as the lack of funding affecting how services communicate with one another. After completing the first phase of analysis, quotes from interviews five and six were added to validate and expand the emerging insights and were also reviewed for any new themes.

After conducting six interviews, I compiled and cross-referenced the mapping exercise results to determine whether there was significant overlap. Interestingly, there were no similarities across their respective sectors, highlighting a key weakness in the network's service signposting. I also began to identify insights that solidified connections between different themes, which were extrapolated into potential opportunities for design solutions. Through clustering the collective narrative, I recognised that the left side offered more design opportunities, while the themes on the right side acted as barriers to change (Figure 16).

Figure 13: *'Tree Branch' Narrative.* 2025. Source: Author's Own

Figure 14: *Compling of Themes.* 2025. Source: Author's Own

Figure 15: *'Tree Branch' Collective Narrative.* 2025. Source: Author's Own

Figure 16: *Added Insights.* 2025. Source: Author's Own

Co-Design

Preparations for the Co-Design Workshop: Survey

To begin preparing for the co-design workshop, I emailed each participant individually to determine their availability. Knowing the inevitable constraints of each person's schedule meant that I was prepared for fewer participants in the workshop than in the interview phase. After gathering the participants' availability, a provisional date was set. This date was the only one that worked for the largest number of people and had the most diverse participant configuration, as each sector was represented.

Following the analysis and synthesis of interviews, the opportunities identified through insights, quotes, and themes were presented to the gatekeeper. Participants were sent a survey presenting the opportunities to enable a democratic decision on which opportunity area to discuss further during the co-design workshop, as required due to the limited participation time. This meant that people who were unavailable to participate in the workshop still had a role to play in the co-design. Given the limited time of one hour, this allowed for greater depth in exploring one topic. However, this presented a limitation, since other areas of interest would not be discussed further. The survey consisted of three short questions to minimise inconvenience for participants' schedules. First, a multiple-choice question asked which sector they resided in. The second question asked them to vote on their preferred opportunity, and the final question offered them the chance to write their own opportunity if they believed an alternative should be represented.

Preparations for the Co-Design Workshop: Schedule Limitations

Between the survey and the co-design session, three of the four participants dropped out of the workshop due to scheduling conflicts, leaving neither the NHS nor the Third Sector with a representative. Therefore, I decided to split the co-design sessions into three workshops. Each was intended to target a different sector, while allowing availability to open to more participants. I was able to schedule the first workshop with two social care workers from Trindlemoss Day Opportunities and the second workshop with two NHS representatives in Ayrshire Central Hospital. For the final workshop, I was able to include someone who represented the third sector; however, due to scheduling conflicts, I was unable to include another. Therefore, I invited another participant from social care who was available to join, aiming to foster interesting discussions based on their different perspectives.

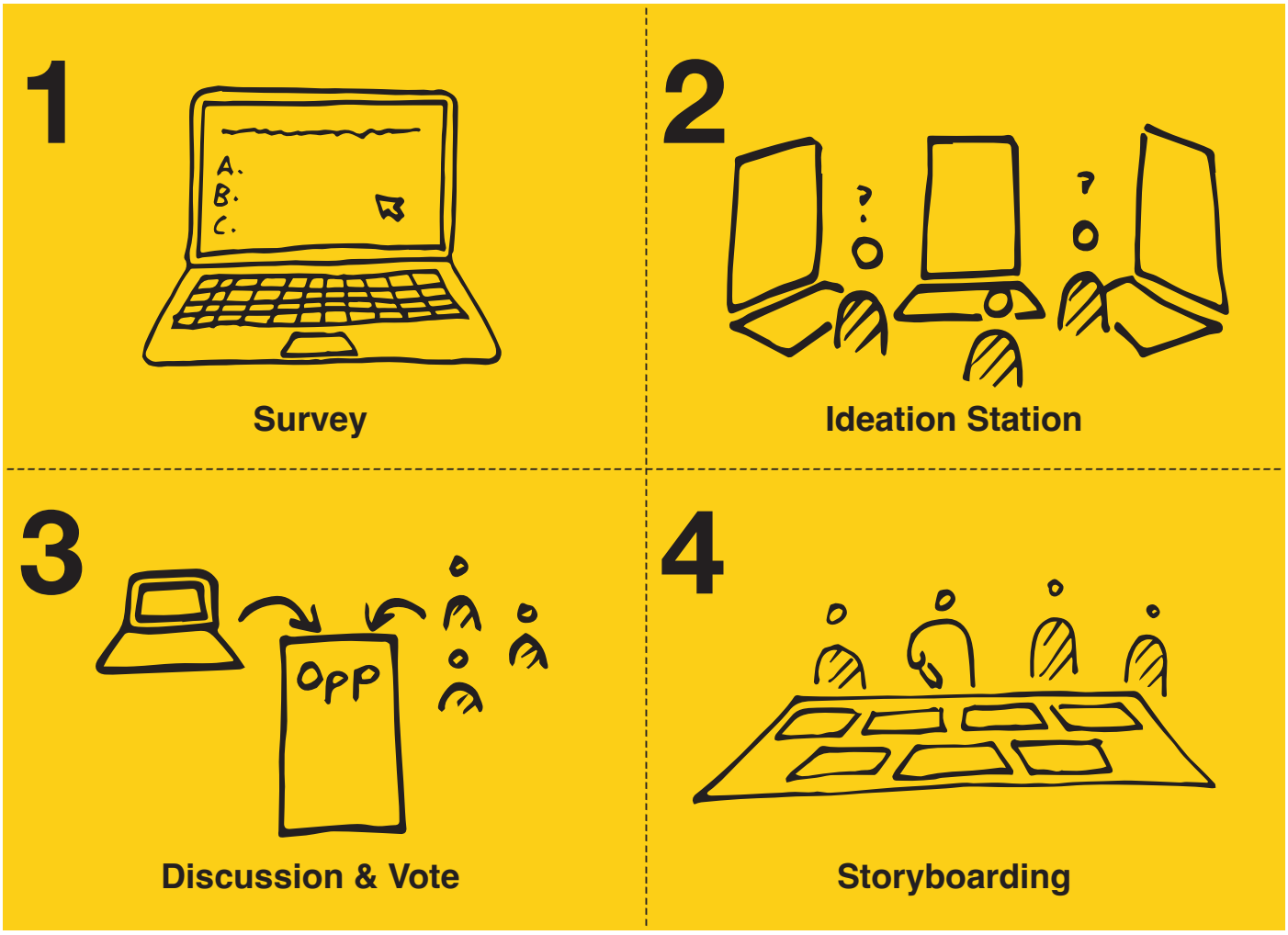


Figure 17: *Co-Design Workshop Timeline.* 2025. Source: Author's Own

Preparations for the Co-Design Workshop: Designed Activities

The workshop aimed to envisage a preferred future (Candy, 2009) to provide a narrative of the potential impact of a design concept. The workshop timeline was as follows: the 'ideation station' phase, lasting 15 minutes (Figure 17). During this phase, each participant was given five minutes to read and engage with the three identified opportunities (Figure 18). Then, a 10-minute discussion of the answers sparked by the ideation stations and further conversations around the opportunities identified in the survey. One opportunity was then selected to prioritise and discuss further during a storyboarding activity, while also making reference to the survey's voting outcomes. The storyboarding began with a timeline, using sticky notes to represent practical steps toward the desired outcome in response to the opportunity. Participants were then prompted to reiterate their timeline using an 8-panel storyboard template, which encouraged them to brainstorm and prioritise moments within this outcome.

Figure 18: *Ideation Station.* 2025. Source: Author's Own

Preparations: Evaluation Sessions

For the second and third co-design workshops, there was a further evaluation stage that enabled participants to critique and build on previous participants' work. A separate evaluation session was facilitated following the co-design workshops, for participants from the first session to share their feedback on the outcomes from the sessions that followed . The evaluation sessions focused on the storyboards produced during the co-design sessions, as this was a consistently formatted outcome that could be compared and evolved.

Figure 19: *Participants engaging in the Ideation Station Activity.* 2025. Source: Author's Own

Ideation Station

Four posters were created detailing the three opportunities identified, and the suggested opportunities from the survey. The three opportunity posters utilised quotes from interviews, with each poster featuring four distinct quotes from different participants, which helped to evidence the insights that informed the opportunities. The opportunity followed the quotes, which allowed participants to understand the justification for the opportunity. I had originally planned to present the posters on the walls of the workshop spaces and invite participants to walk between them. However, after reflecting on the spaces utilised during interviews, there was commonly a table in the middle of the room and relatively little unoccupied wall space. Therefore, the posters were assembled into a square pillar that stood on the table in the centre of the engagement spaces, to elevate their importance and encourage interaction (Figure 19).

Figure 20: *Answers and Question Prompts from Ideation Station Activity.* 2025. Source: Author's Own

For 5 minutes at each station, prompts were displayed on A3 paper for participants to answer in relation to the opportunity. The prompts were colour-coded, with yellow representing the present, orange representing moving from now to the future, and red prompting participants to think about what could be possible in the future (Figure 20). The prompts were not mandatory; participants were asked to state their overall opinions on the opportunities; however, all participants chose to engage with them.

Through this activity, participants began to naturally talk to each other about what they were writing and the answers they had read from the others. Hence, the activity became conversational. This was not the case for the NHS staff workshop, which focused on writing answers as their time was more limited than in the other sessions. The participants found this activity useful to begin the sessions, as the short, intense brainstorming enabled them to adopt a creative mindset from which to consider preferred models of care.

Group Discussion and Vote

The discussion section of the co-design commonly ran over the intended time, as participants' answers sparked further conversation, all of which was useful in shaping the narrative that informed the vote on a particular opportunity. Participants were informed of the most popular opportunity identified in the survey: 'developing a signposting platform'. However, two of the workshop groups opted to explore an alternative opportunity: the 'soft care' approach. They did, however, both identify a link between creating a signposting platform through firstly establishing a 'soft care' approach. The outlier was the first set of participants who decided to develop the opportunity that aligned with the survey vote. This decision was primarily shaped through the group discussion.

Storyboard Timeline

To begin the storyboarding exercise, the timeline was presented on A3 paper. I wrote the agreed-upon steps on sticky notes to implicitly indicate that their answers were not permanent, so participants could move them around if they wanted to amend or change their answers or change their minds (Figure 21).

As I captured notes, I guided the conversations with prompts that emerged from their responses. I believe that, in my role as the design researcher, it was important to mediate during this stage of the workshop, as participant responses were being consolidated into a single outcome. This also helped turn responses into actionable steps. This meant that by the end of the activity, an informed outcome was co-designed to conclude the discussions. Narratives from the beginning of the workshop, along with their answers, informed by lived experiences during the interview phase, were incorporated.

8-Panel Storyboard

Now with an articulated outcome in mind, the A3 sheet was flipped to reveal the 8-panel template, which prompted participants to consider moments of impact that their solution may create. This activity enabled participants to imagine their proposal from the user's perspective, which further shaped the outcome by identifying points of interaction and moments that needed further exploration (Figure 22).

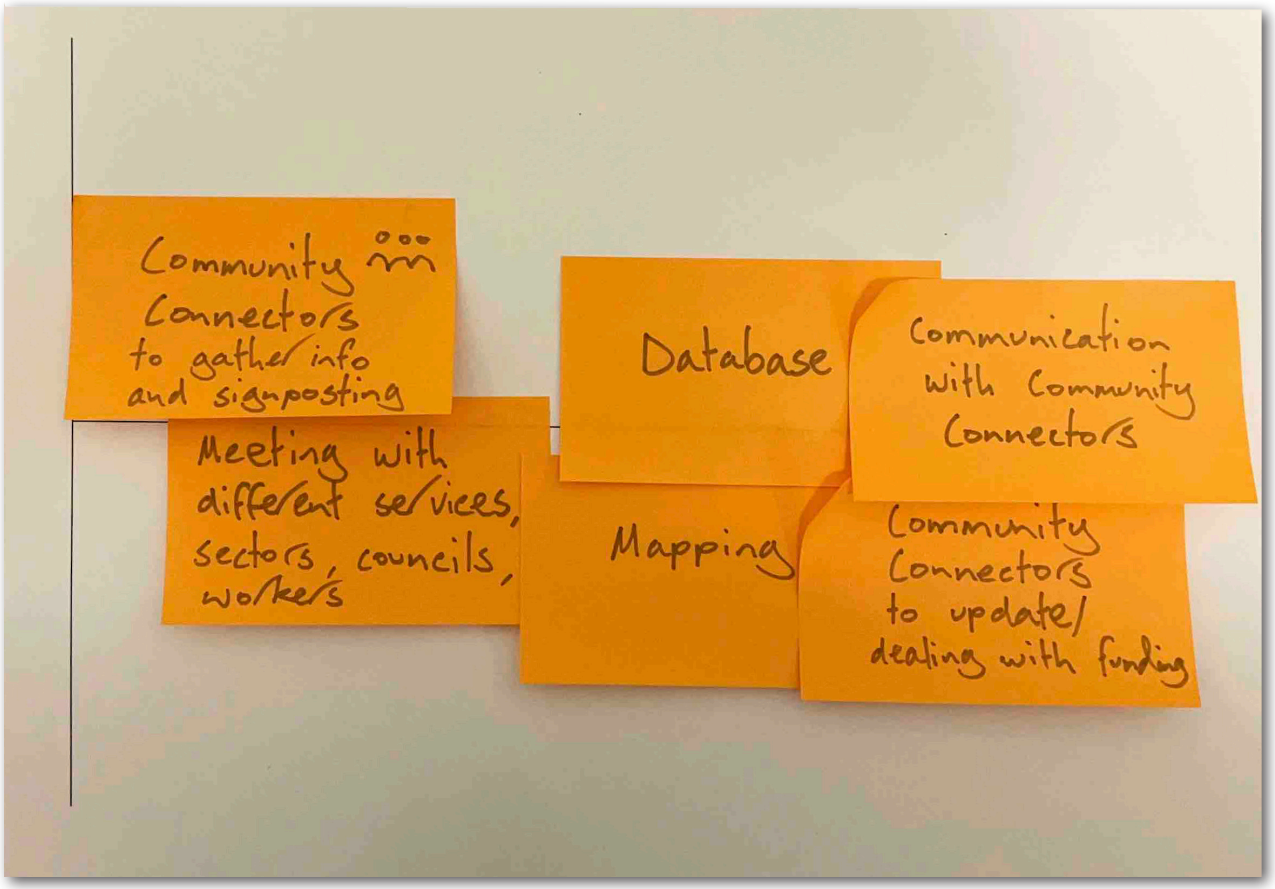


Figure 21: *Sticky Notes from Timeline Discussion.* 2025. Source: Author's Own

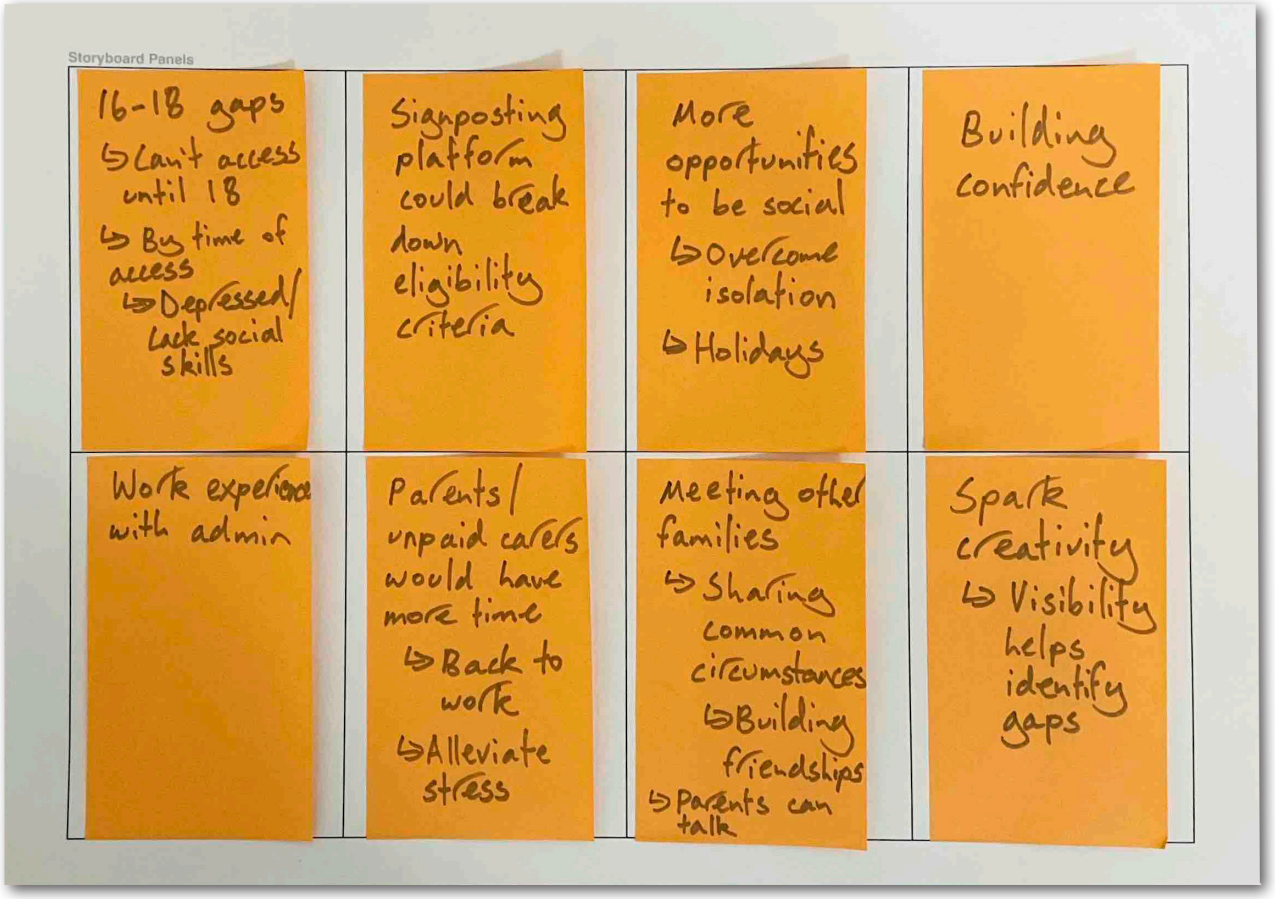


Figure 22: *Sticky Notes from Storyboard Activity.* 2025. Source: Author's Own

Workshop Summary

Following the workshop, I synthesised the participants' responses into a consolidated timeline and the storyboard, which would then be used to articulate their outcome during the evaluation sessions with other participants. It was rewarding to create and explore something more tangible, which had no shape or direction prior to the workshops. All participants actively engaged with the activities, and conversations naturally occurred without the need for further prompts, which contributed to a more inclusive environment.

Evaluation Sessions

Due to individual participants' schedules, time was set aside at the end of the co-design workshops to evaluate the outcomes from previous participants. This followed the wrap-up of the co-design, directly after they had created their own storyboard. For participants in the second and third sessions, this allowed them to see outcome examples from previous sessions . Given that they had just finished the activity themselves, this enabled empathetic responses, as participants from different sectors could see things differently and develop solutions based on their own experiences.

After the third evaluation session, held separately with the participants of the first co-design workshop, and after a conversation with the gatekeeper, I began to identify relationships between the storyboards and timelines. A nice moment I achieved during the final evaluation session was allowing those participants to see their own outcome, along with the others. Therefore, I concluded fieldwork by sending digital scans of the storyboards back to their respective participants.

Fieldwork Summary

Fieldwork took place from the end of September to the middle of November 2025 and followed three phases of engagement. The first phase gathered and developed an initial understanding of the current care landscape for individuals with LD in North Ayrshire through service mapping and the identification of constraints. This phase also began shaping and framing preferred alternatives to the current care model by positioning parts of our interview conversations in the future. The second phase developed solutions in response to opportunities identified through thematic analysis of interview data. This began the process of merging individual narratives into collective actionable steps and recommendations for a preferred future. The final phase of engagement critiqued, built upon and linked the outcomes of the separate co-design workshops. The findings and outcomes are discussed further in the analysis and discussion chapter.

Findings

Introduction

This research aimed to explore the value of PD through engagement with diverse stakeholders within the NHS, social care and third-sector organisations to identify viable care alternatives and facilitate conversations around potential design proposals. Through participatory engagement with stakeholders who care for individuals with LD across sectors, the research sought to understand and navigate the current care landscape for individuals with LD, enable mutual learning and collective action, and extrapolate values to develop recommendations that alter the trajectory of care services toward a preferred future.

From the interview phase of the engagement, data was gathered and analysed to identify themes, insights, and opportunities. Those opportunities enabled further conversation and shaped solutions grounded in shared narratives among sets of participants. Finally, evaluative critiques across participants' workshop outcomes acted as a final iteration of ideas to extrapolate further values and recommendations for the NAHSCP to consider.

NHS:

*The number refers to which interview participant gave these answers.

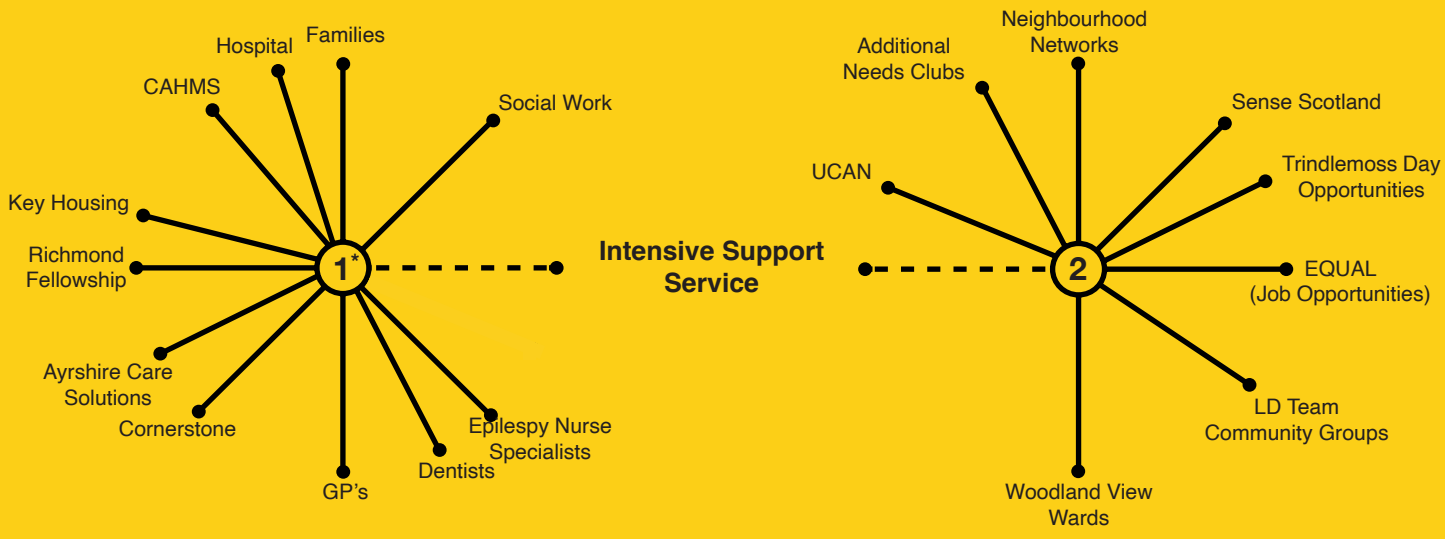


Figure 23: *NHS Participant Answers to Mapping Activity.* 2025. Source: Author's Own

Service Mapping

To capture the variety of services across sectors within North Ayrshire, I designed a mapping exercise as part of the introductory questions to collect lists of services participants have corresponded with.

To analyse the maps, I began by comparing the maps made by participants within each sector (Figure 23-25). However, to my surprise, there was no overlap in the named services. Part of this was perhaps due to the open interpretation of the activity, with two participants naming specific stakeholders, such as Dentists and Families. In contrast, others named whole sectors, such as social work.

Leaving the structure of the activity open to interpretation was partly to gain a deeper understanding of the participants themselves during the introductory phase of the interviews, by seeing which services they prioritised and named as providers of care. With the in-person interviews, this activity also provided insight into how participants preferred to engage in creative activities, which helped to inform the design of the co-design sessions. I offered them the pen and paper to fill in the template themselves, but also offered to fill it in for them if they did not feel comfortable doing so.

NHS participants positioned their understanding of care by naming numerous social care services, along with a few NHS departments such as 'Woodland View wards' and 'General Practitioners', with minimal Third-Sector providers being identified.

Social Care:

Figure 24: *Social Care Participant Answers to Mapping Activity.* 2025. Source: Author's Own

Social care participants focus more within their own sector, but with greater acknowledgement of third-sector providers.

Third Sector:

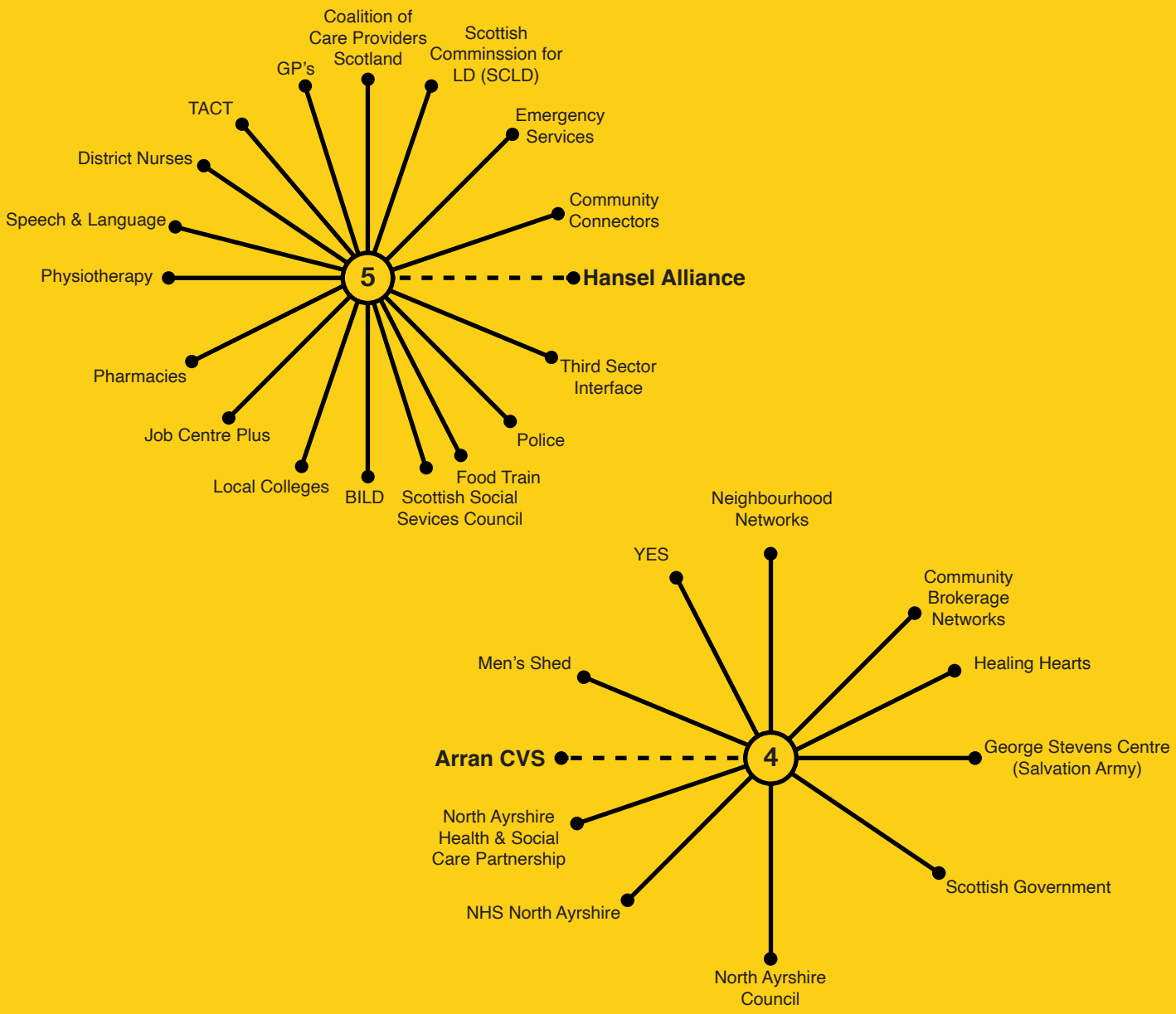


Figure 25: *Third Sector Participant Answers to Mapping Activity.* 2025. Source: Author's Own

Finally, third-sector participants provided the most named services. However, most of these were not specific to individuals with LD. The content of their lists ranged from small community initiatives to large-scale institutions themselves, such as the NHS and the Scottish Government. This set of data may reflect third-sector participants' holistic understanding of the different impacts that effect an individual's quality of life. One participant, for example, described their experience of informing people working in the emergency services and police to be more understanding of challenging behaviour if they were required to support someone with LD.

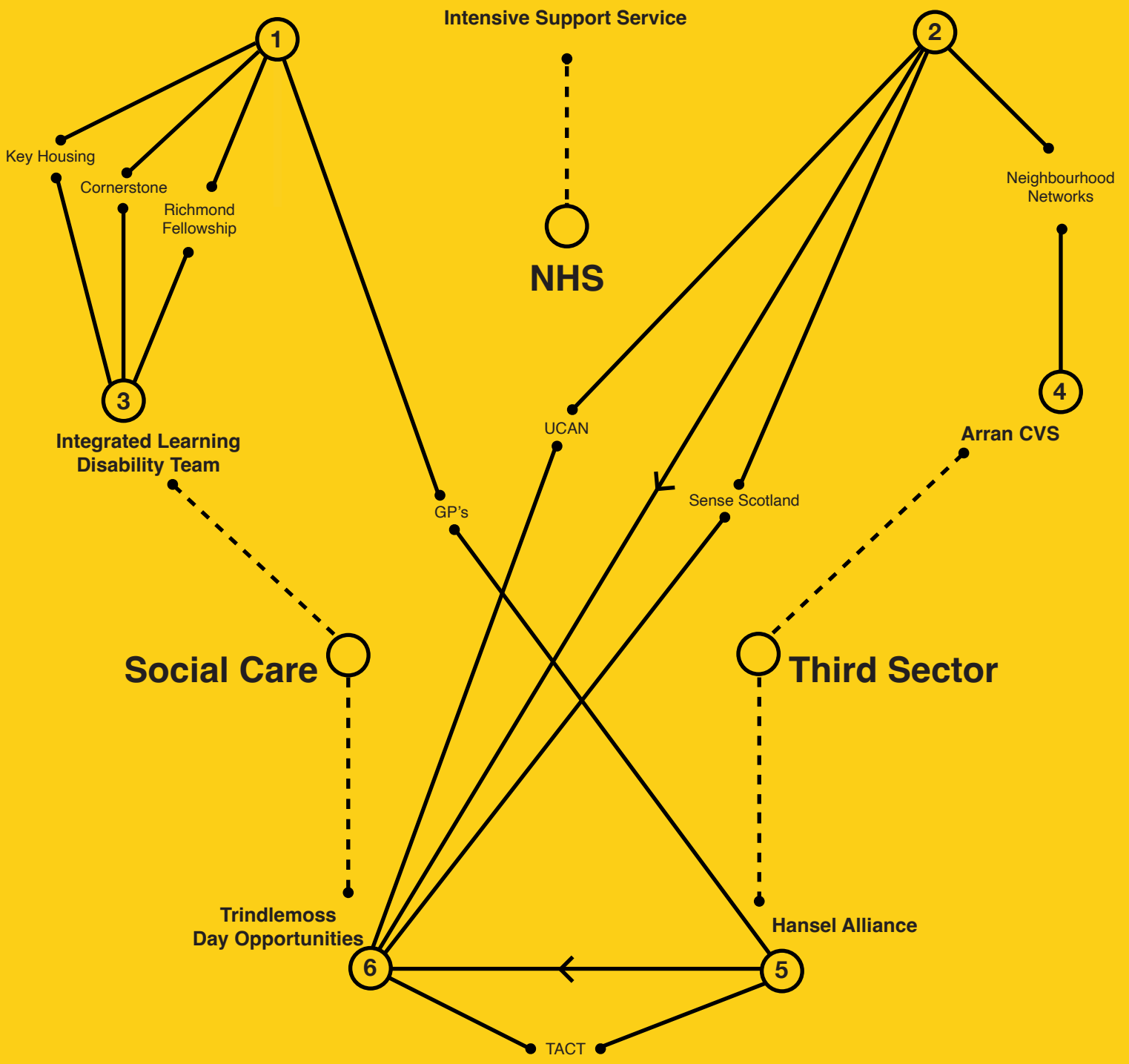


Figure 26: *Crossover Map Between Sectors.* 2025. Source: Author's Own

After comparing within sectors, I examined the data set as a whole to identify overlap across sectors (Figure 26). The most significant occurred between individual representatives of the NHS and Social Care. I believe this comes from a strengthened communication channel between these sectors, with the formation of the NAHSCP, which was referenced by multiple participants later in the interview:

> *"Quite a lot of cohesion within teams. Health and Social Care teams and people work well together."*
>
> - Participant 3, Social Care

Critiquing and Understanding the Present

This section covers the 'diagnosis' (Wright, 2010) of the present as perceived by stakeholders who care for individuals with LD. Using thematic analysis (Braun and Clarke, 2006), an overview of the barriers and themes identified through an inductive approach, grouping stakeholder insights recorded across all interviews, will be provided.

Barriers

These barriers identified through this research describe the context of care provision in North Ayrshire, recognising the trends identified across interviews and their collective impact on services. However, for the purposes of furthering conversations centred on preferred futures, these topics are not pursued further once made explicit.

Lack of Funding

Throughout the interviews, participants from each sector acknowledged that the lack of funding in the public sector was the main constraint impacting the effectiveness of services in providing care.

> *"Lack of money, not enough funding there for people to have the packages that they probably need... that's when we find those problems creeping in because people don't have that support that they actually need."*
>
> - Participant 1, NHS

> *"The third sector is reliant on funding... You've got groups who've had to change their direction, because maybe their funding changed. So they maybe used to do x, y, z, now their funding is changing, they can only do Z. And people might still be coming to them saying, I thought you did this, but they don't anymore... they're having to jump through hoops to keep their funding"*
>
> - Participant 4, Third Sector

> *"We don't get any money from the council... any money we need for activities or anything now, we need fundraise... we used to have buses sitting outside here, and then it would be like today, it's a lovely day, everybody jump on the bus, we're going to Largs. Can't do that, you now need to hire the buses, so then it means all the individuals need to pay towards the buses... so it's about now trying to think of activities to minimise money."*
>
> - Participant 6, Social Care

This perceived barrier was believed to be the root of many of the more specific constraints across care provision, as mounting pressure from budget cuts has led services to prioritise inwards maintenance and focusing on the effectiveness and responsibility of their own care provision to justify funding for themselves.

Eligibility Criteria

Participants across social care and the third sector mentioned eligibility criteria as a barrier. NAHSCP have requirements to refine its caseload due to service's capacity to provide support, which results in individuals being categorised to meet specific standards for receiving care. This also means that individuals may not be receiving the proper support they deserve.

> *"The amount of time it takes people waiting to be assessed to find out if they can get any help, and then they go through the process, and then it's potentially not enough help. So it's obviously a financial thing and a capacity thing, that people are on the long waiting list, then they're not really getting a huge amount of help."*
>
> - Participant 4, Third Sector

> *"The way services are commissioned just now are quite rigid."*
>
> - Participant 5, Third Sector

> *"It feels sometimes like everybody's protecting themselves."*
>
> - Participant 3, Social Care

This, in turn, has created an isolated culture across public-sector services that provide care. Overall, it makes navigating care systems more complex for individuals with LD and care providers alike, as accessibility is inflexible.

Lack of Respite

Individuals representing the NHS and the third sector recognised the importance of respite for families and carers in delivering effective care for individuals with LD. Respite is a resource used by families and carers to provide them with breaks from their care responsibilities. This allows the responsibility of care to be more manageable and enables individuals to remain residing in their own home and have less interaction with statutory services, as this form of care can be sustained with appropriate rest. However, if respite resources are unavailable, there is a risk of a care breakdown. Furthermore, given the current trend across the public sector, these resources are lacking, resulting in individuals with LD needing more traditional forms of care that are already struggling, as a lot of effort is required from unpaid carers, which can become overpowering.

> *"If we had more respite, I think that would help… a lot of families don't have access to any respite. There's nowhere for people to go when they're really struggling."*
>
> - Participant 1, NHS

> *"If unpaid carers recognise themselves as unpaid carers and do actually get some support, some respite... unpaid carers are really propping up a failing system in many ways... There's so many people that wouldn't even recognise themselves as being an unpaid carer. But if you're able to imagine them disappearing, you suddenly see, whoa, like, how much they are doing that if they disappeared, this person could end up institutionalised or needing more support."*
>
> - Participant 4, Third Sector

Themes

Theme 1: Communication, Interdisciplinary, and Consistency

To improve communication across sectors, participants advocated for more in-person collaborative interaction to be facilitated. Hosting events such as training opportunities offers knowledge exchange and connection building, which would enable alignment between sector standards through role clarification and sustained consistency. These interactions could soften the rigidity of accessing care, as teams become more blended and communication becomes more open. Cross-sector collaboration is improving; however, due to incompatible information recording and varying practices, the sectors remain fragmented. Therefore, it was further recommended that the way information is recorded be unified. This could be a long-term aim for the collaborative interaction events.

> *"Some joint training. I think if they had the ability to all get together for different training events... would probably help, and share knowledge."*
>
> - Participant 1, NHS

> *"We all have different ways of recording information… I can't access social work care plans… It would be good if we could see each other's assessments… if we were all on the same kind of data platform."*
>
> - Participant 2, NHS

> *"Having regular meetings together. So we all know where we are, what everybody's thinking, because everybody does work differently."*
>
> - Participant 6, Social Care

However, one individual from Social Care rightly pointed out the limitations when it comes to building relationships and creating a new collaborative culture between sectors:

> *"The biggie is around consistency. We've got a high turnover of staff, so those relationships have to keep being rebuilt."*
>
> - Participant 3, Social Care

Theme 2: Signposting and Connection

A number of participants felt that the third sector was more disconnected in comparison to the communication and connection between the NHS and Social Care. Individuals receiving care are encouraged to socialise with peers and explore interests outside their comfort zone to improve their social skills and quality of life. Third-sector organisations are more closely linked to community initiatives and clubs, which could facilitate increased socialisation. Therefore, keeping the third sector more closely connected to other care provisions could open avenues for greater community integration. This could be of mutual benefit for the other sectors, as NHS and social care providers would be able to recommend groups and activities that suit the individual's needs:

> *"With NHS and social work, there's clear communication pathways. Third sector's a bit harder because you have to go looking for them."*
>
> - Participant 1, NHS

> *"I find that one of the barriers for my role, because there's wee niche things, but actually a lot of the time, it's the niche things that the person wants to do."*
>
> - Participant 2, NHS

> *"The services that are out there, they're not well known."*
>
> - Participant 6, Social Care

The third sector is less centrally structured in comparison to the other sectors, as it is composed of independent organisations. Third-sector organisations are constantly changing, which makes it hard for them to maintain communication with one another:

> *"Third sector organisations are generally small. They're only operating in the area that they're in. They don't necessarily have that overview... they might not feel like they have that oversight and overview to understand 'How do I access everyone?', 'How do I let people know about my group?' So I do think there's some work to do there in terms of connecting the community groups"*
>
> - Participant 4, Third Sector

Therefore, many stakeholders believed they would benefit from readily available information highlighting initiatives that would enable individuals to explore their interests and integrate more fully into the local community. This would, in turn, improve organisation and identity within the third sector.

> *"People having access when they want it, where they want it... not having to jump through hoops to get to the service that they need, and being able to find it easier. I think it's still a little bit of a maze for people to navigate..."*
>
> - Participant 3, Social Care

Theme 3: Accessibility, Earlier Intervention, Stigma and a Softer Approach

> *"We need to be much more softer in how we start things off... So therefore, that shared interest should be the seeds that you could maybe take forward in a relationship with your peers... immediately breaking down barriers"*
>
> - Participant 5, Third Sector

The final theme identified from the interview analysis was to improve the quality of life for individuals by making community initiatives more accessible and by equipping community members to host individuals with LD within their groups and clubs. This could include learning life skills to help people live more independent and fulfilling lives.

> *"Community Resources in general... could be a bit more welcoming of people with learning disabilities"*
>
> - Participant 3, Social Care

Education is a valuable resource that is already being utilised in North Ayrshire to reduce discrimination, for example, by providing information in schools. With community members being more informed, earlier intervention can take place to prevent care breakdowns before reaching crisis point through knowing who to contact:

> *"To feel prepared, ready and capable of having everyone in the community come in... they're not dramatically going to stop a breakdown of care, but they might be 10 steps back before a breakdown of care is even on the horizon."*
>
> - Participant 4, Third Sector

Many discussions from interviews focused on inclusivity, not necessarily designing outcomes exclusively for the needs of someone with LD, but on breaking down stigma and viewing people as no different from ourselves. One participant used the word 'soft' to describe how we should approach care, which sparked a meaningful discussion about the values that inform care provision. Therefore, following that interview, I prompted participants to describe what the term 'soft care' means to them:

> *"Embedded in the community, something which is accessible and available to other members of the community, not just because you've got a learning disability, it provides you with a natural connection to your community and the more local that is, the better."*
>
> - Participant 9, NHS

> *"A lower level of care that perhaps is desired rather than required... So it's not about keeping that individual safe, etc. Probably more social care and dealing with somebody's social needs rather than their care needs."*
>
> - Participant 10, NHS

The latter participant's description is noteworthy, as it articulates soft care in relation to the prevailing care approach. Their experience with the NHS influences their perspective on the nature of care. As previously discussed, care is primarily experienced through a transactional approach, particularly in clinical environments, and eligibility criteria reinforce this principle. The phrase "desired rather than required" emphasises the current attitude towards care, prioritising efficiency and urgency over building long-term relationships outside clinical settings to make care accessible and inclusive.

Through a softer approach, individuals are positioned more as active community members rather than as recipients of care. This theme emphasises participants' critiques of transactional forms of care and highlights their support for a more person-centred, relational model of care. Although participants from each sector made comments in support of this alternative care approach, it was most strongly emphasised by third-sector representatives.

Imagining What Could Be

Drawing on Wright's (2010) theory, this section explores alternative outcomes to the present care provision.

Opportunities

From identifying and collating themes, three opportunities were defined to refine the direction of the next engagement phase and to facilitate discussions to expand the themes:

Opportunity 1: Co-create universal documentation that reflects shared values and practices by fostering collaboration and knowledge exchange between all sectors supporting individuals with learning disabilities.

Opportunity 2: Develop a signposting platform that makes community opportunities more visible and accessible by mapping available services, enabling care providers to share information and connect with relevant community resources and support.

Opportunity 3: Collaboratively define 'soft care' and explore effective approaches for integrating its principles into current community initiatives and support models.

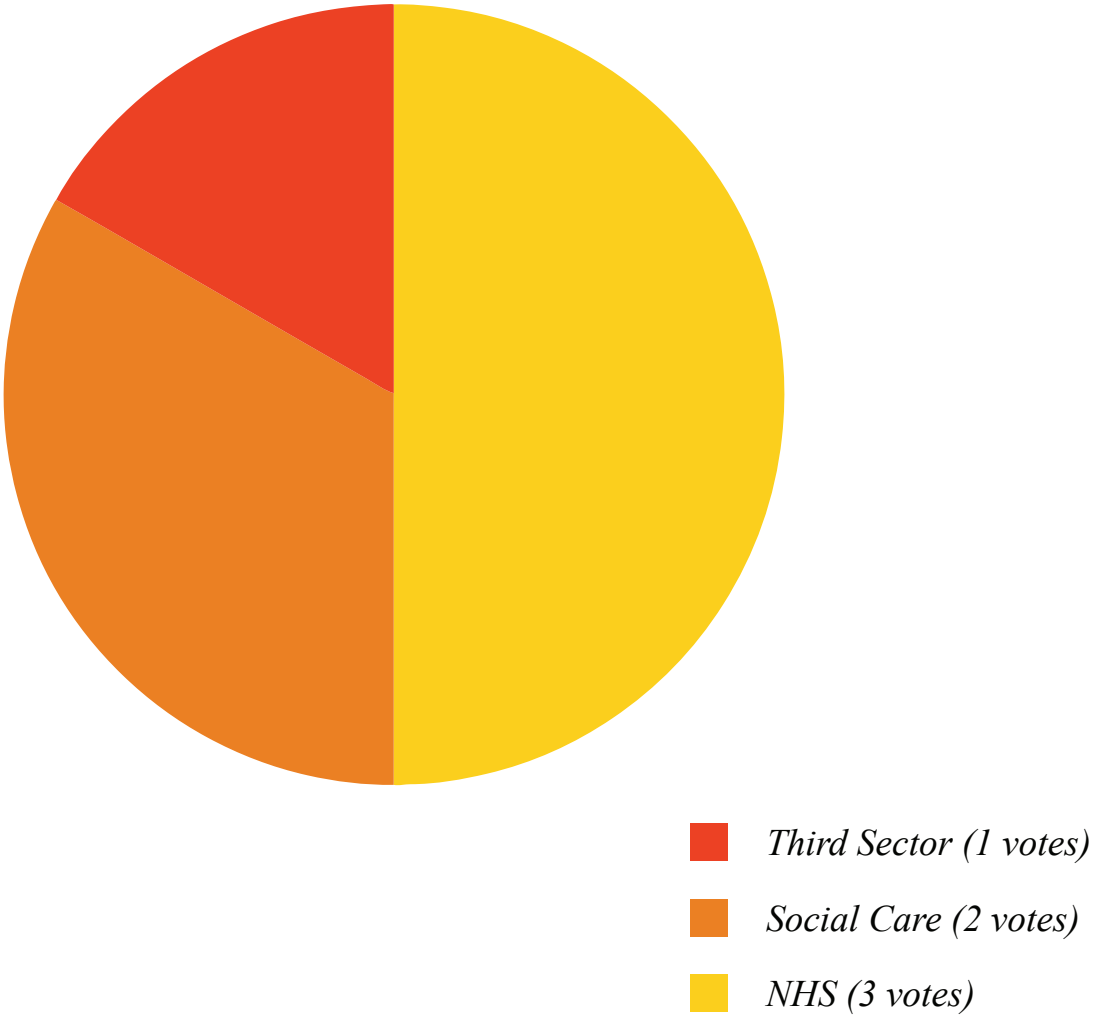


Figure 27: *Pie Chart of Sector Participation in the Survey.* 2025. Source: Author's Own

Survey Findings

The opportunities were presented to all participants from the interviews. Of the 10 participants invited to take part in the survey, six engaged (Figure 27). With the final question, they had the opportunity to voice their own opportunity, three participants suggested new opportunities:

> *"Develop a respite service collaboratively to support people perceived as more challenging"*
>
> - NHS Participant

> *"A day opportunities service that is more focused in supporting individuals with profound learning disabilities or complex/challenging behaviour."*
>
> - NHS Participant

> *"I believe that if there was an abundance of Changing Places Toilets within North Ayrshire communities, then this would allow much more involvement. This would enable people that require these facilities to get out and about and enjoy day-day activities that we take for granted. Instead of seagull proof bins and other silly wastes of money, all sectors that support people that require facilities should collaborate and sort this out. Then we can talk of good, positive collaboration."*
>
> - Social Care Participant

Opportunity 1: Co-create universal documentation *(1 votes)*

Opportunity 2: Develop a signposting platform *(3 votes)*

Opportunity 3: Collaboratively define 'soft care' *(2 votes)*

Figure 28: *Pie Chart of the Voting Tally for the Design Opportunities.* 2025. Source: Author's Own

The following is a breakdown of the voting tally from the participants who engaged with the survey (Figure 28). These results were taken forward into conversations with co-design participants to guide discussions and help them decide which opportunity to expand upon. It was anticipated that participants might find it hard to agree upon an opportunity. Therefore, whether they agreed or disagreed with the vote, it would prompt participants to make a decision.

Co-Design Workshops

Ideation Station

The ideation station aimed to spark individual thought by setting aside short periods to form opinions on the presented opportunities. This meant that opinions were captured without the influence of the other participant. This helped participants feel prepared for a group discussion, as it equipped them with material to discuss when given the platform. This alleviated aspects of power imbalance, as both participants were equally prepared for the discussion and had the chance to read each other's answers as they moved around the stations. Even if an opinion was not voiced during the discussion, I was able to read what they had written during transcription and analysis. One of the participants reflected on the value of this activity:

> *"Five minutes, focuses the mind. So maybe I'm not being as specific in what I've written down, and the conversation, hopefully, will allow me to expand that."*
>
> - Participant B, Co-Design 3

Co-Design Outcomes

From group discussions and voting on an opportunity, storyboards were produced as outcomes from the co-design workshops. The first co-design workshop participants chose to discuss developing a signposting platform. While the latter workshop participants preferred to discuss defining and approaching 'soft care'.

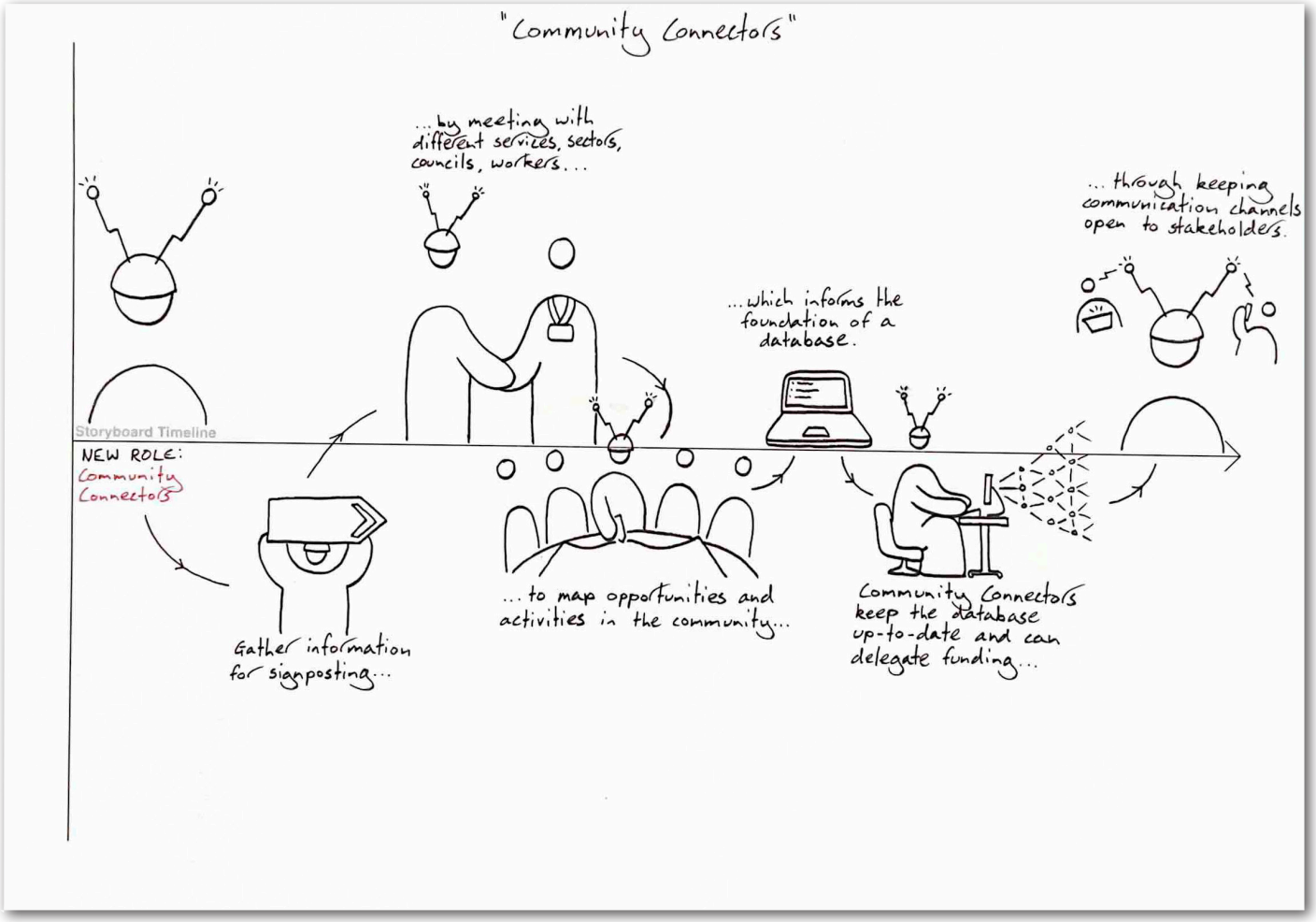


Figure 29: *Timeline from Social Care Participants.* 2025. Source: Author's Own

Participants from the first workshop came up with the idea of the "Community Connector": a person or group, independent of existing organisations, who gathers information for signposting by facilitating meetings with a range of stakeholders to map and visualise the opportunities and activities currently active within the community. This role intends to inform the foundation of a database network for community members to view and provide live information through communication channels with the 'Community Connector', who would also be responsible for maintaining the database and would also have the responsibility of delegating funding to different initiatives.

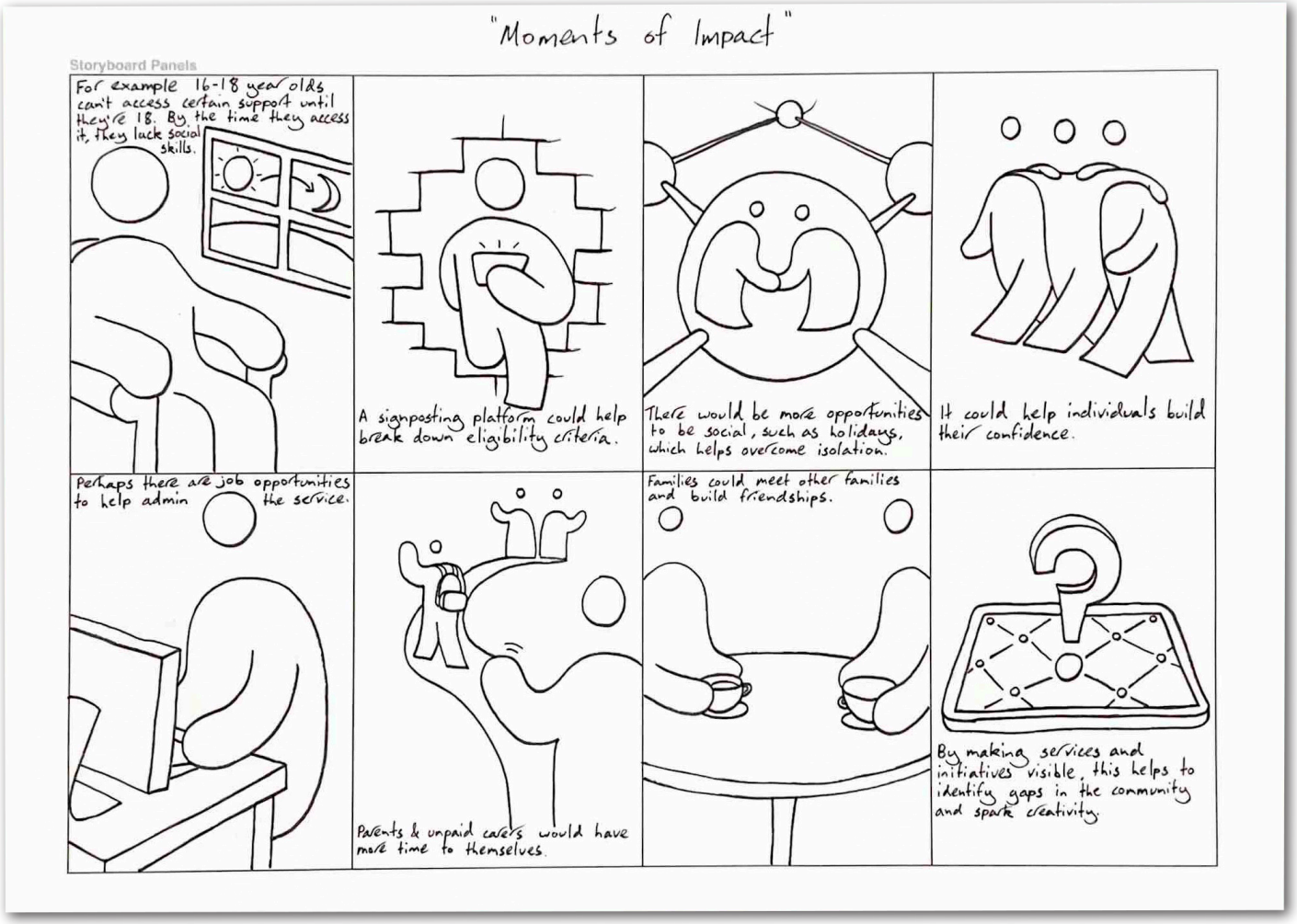


Figure 30: *Storyboard from Social Care Participants.* 2025. Source: Author's Own

When prompted to reiterate their concept using an 8-panel template, the participants focused on moments involving those who would interact with the database. They believed it would help individuals navigate and transition between care providers. They gave an example of individuals who had chosen to leave school but were unable to receive care from adult services due to age. Therefore, individuals in this predicament are unable to exercise their social skills. However, with a database that makes activities more visible and welcoming, there would be more opportunities to overcome isolation and grow their confidence. Confidence was a value the participants felt was crucial for living a more fulfilling life, as they believed individuals with LD would attend clubs and events only if they already knew someone there. A possibility with this concept would be the opportunity for work experience, as individuals could help administer the service . Participants also considered how this concept could benefit families and carers, whether that was through achieving respite or connecting with others with shared experiences. The final opportunity they identified was for community expansion, as making provisions and initiatives visible in the local area would make it easier to identify gaps where new organisations could flourish.

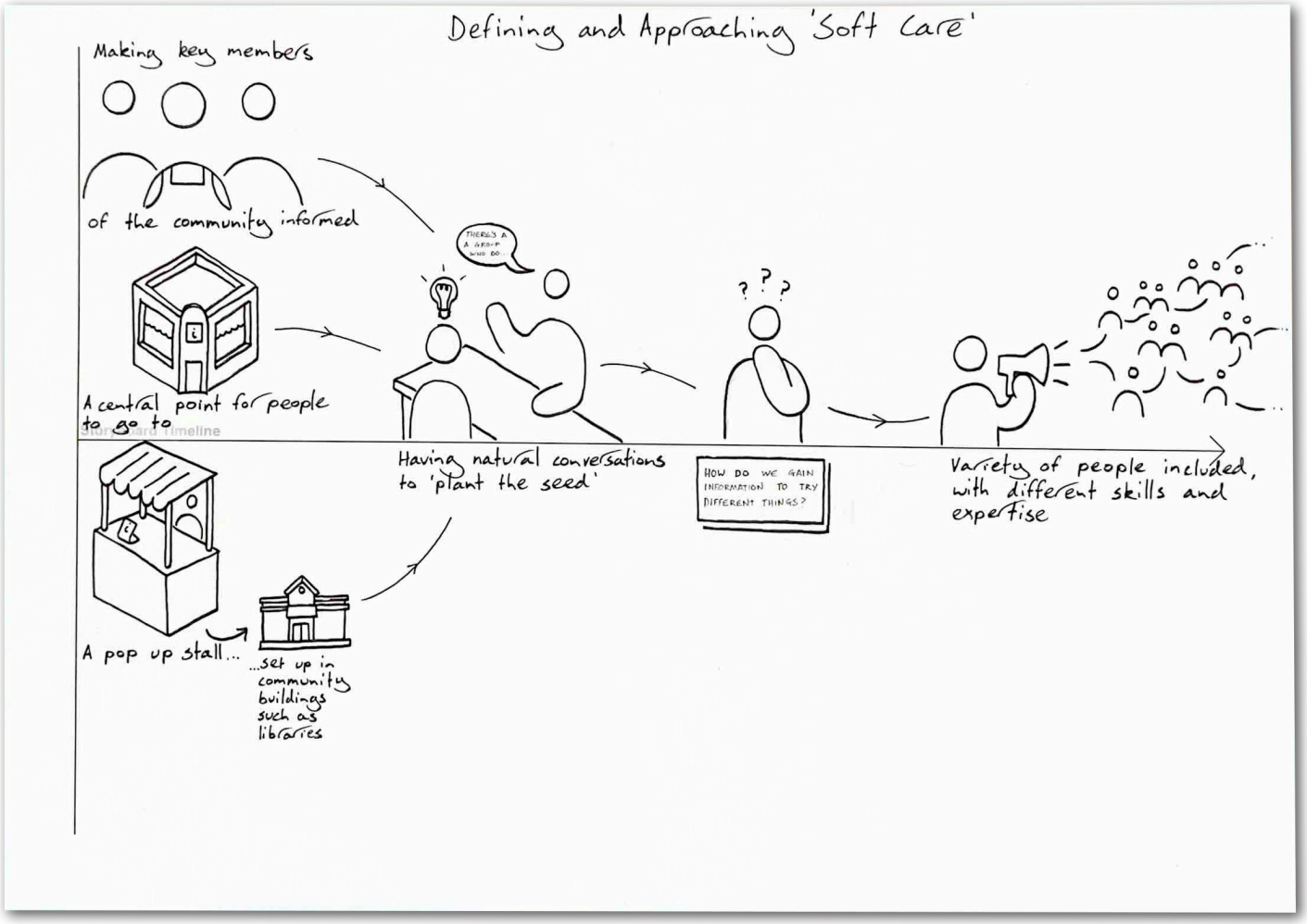


Figure 31: *Timeline from NHS Participants.* 2025. Source: Author's Own

The concept developed in the second workshop with NHS participants focused on access points for 'soft care', acknowledging that a shared definition is required. The access points that participants ideated were a hub, pop-up stalls in existing community facilities, enabled by equipping key community members with the information needed to include people with LD. Part of the 'soft care' approach was to have natural conversations about care and building connections. A key challenge that participants identified was the lack of ways for people to feel comfortable trying new things and exploring their community, which could be naturally addressed through building a 'soft care' culture within the community. This would rely on a large number of community members being informed.

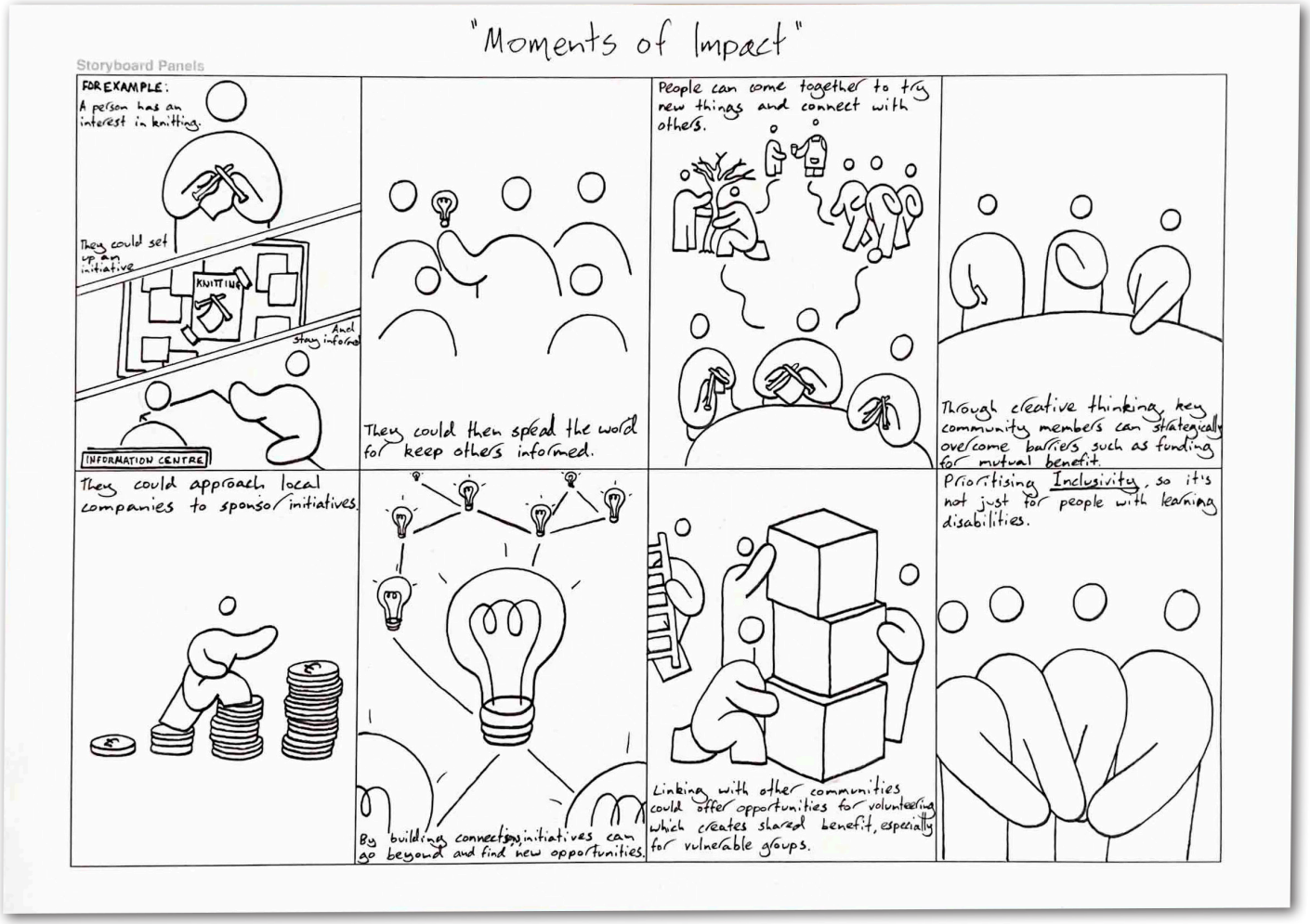


Figure 32: *Storyboard from NHS Participant.* 2025. Source: Author's Own

The moments that participants identified began with an example of someone with a passion for knitting who wanted to set up their own community initiative. Through engaging with an access point, they could be equipped with the information and guidance required to be as inclusive as possible. Then, as an informed member of the community, they could begin to inform others. This would establish a community culture with 'soft care' as its essential value. One barrier they thought to address was the financial aspect; the participants thought of approaching local businesses and tapping into the private sector. With this concept, the participants believed it had the potential to go beyond the local community by establishing networks with neighbouring communities for mutual benefit and creating new opportunities. The value they believed best describes 'soft care' is inclusivity.

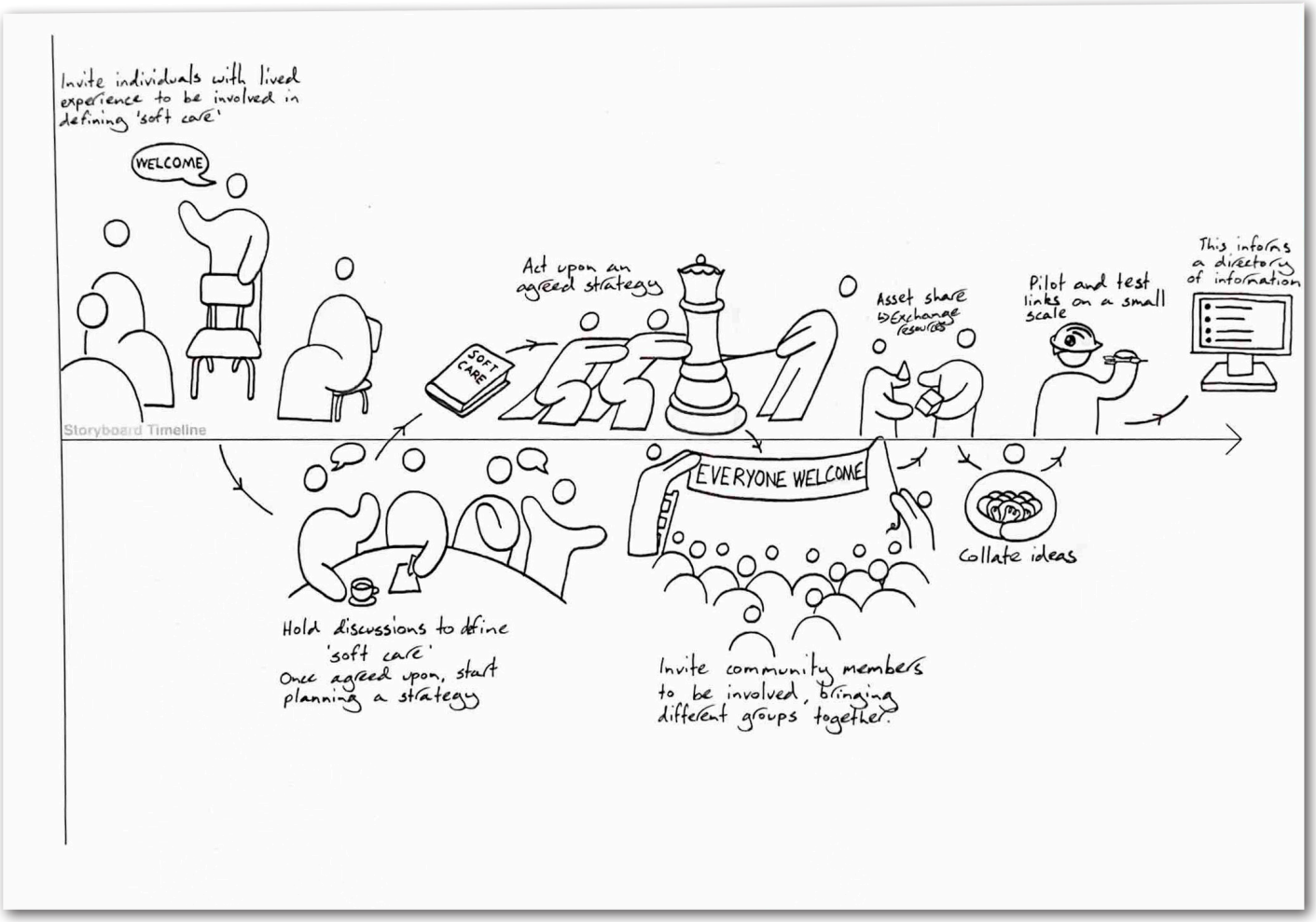


Figure 33: *Timeline from Participants in Social Care and Third Sector.* 2025. Source: Author's Own

The final workshop group thought it was most practical to define 'soft care' by involving individuals with LD. They would hold discussions to allow people to have a voice in defining the term and to refine it until they have a unified definition that everyone involved has agreed with. From defining 'soft care', the group would then move on to developing a strategy to integrate 'soft care' values into the community. The participants believed that this could be achieved by inviting the broader community into the process through facilitating an event to share assets in exchange for support in other areas that are lacking. From gathering examples of mutual aid, additional funding could be provided to encourage and test these exchanges of support. Their end goal for defining and implementing soft care in the community would be to make all local initiatives visible through an information directory.

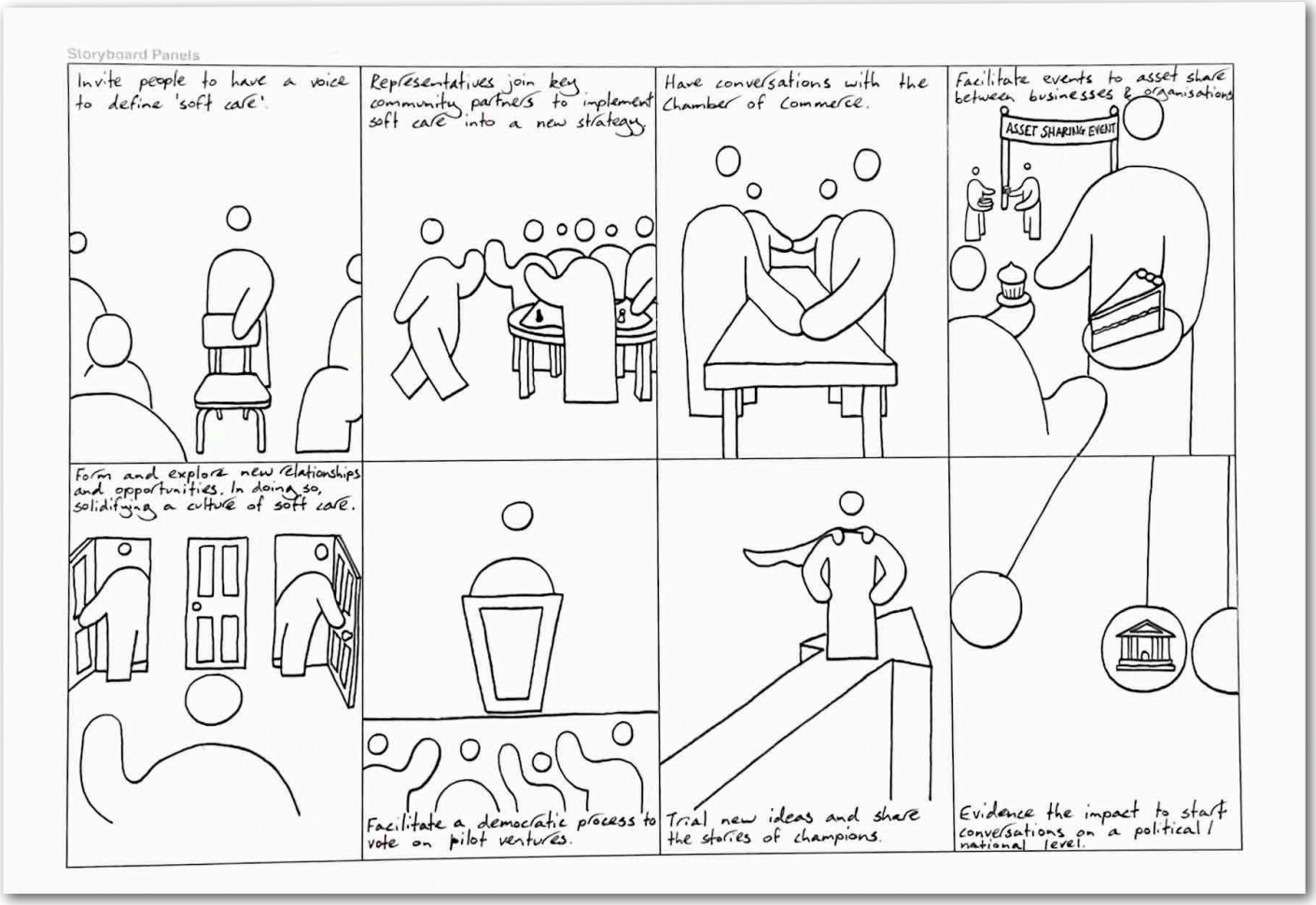


Figure 34: *Storyboard from Participants in Social Care and Third Sector.* 2025. Source: Author's Own

The moments that participants chose to iterate followed the timeline more closely than with the other co-design workshops. One moment of significance was the participants' proposal to identify the Chamber of Commerce as a potential collaborator to secure funding to expand opportunities. This insight led to the invitation being extended to businesses for the asset-sharing event. A milestone moment that they highlighted during the integration of their strategy for implementing 'soft care' was when the community culture would potentially shift to solidify soft care values. This sparked a conversation about influence and who could be involved to help shift community culture. Stakeholders, such as legislators and policymakers, were identified as potential culture shifters. The participants thought it would be useful to include a storytelling element in the piloted ventures, stemming from the 'soft care' approach, to help evidence its impact and begin conversations in the political realm.

Evaluation of the Storyboards

Due to time constraints on overall engagement, evaluation sessions were kept brief, with two sessions held immediately after the co-design workshops. Consequently, after guiding participants through the other storyboard outcomes, two questions were posed to encourage quick discussions: What parts are missing or unclear? And what parts resonate with you?

Storyboard 1

When presenting the storyboard from the first workshop, the participants from the other co-design workshops had similar responses to the concept of 'Community Connectors'. Both sets noted that something like this had already existed.

> Evaluation Session 1
> Participant A: *"We used to have that, though. So we had locally the coordinators years ago, and that was the foundation of their role. But then you have to look at, well, why didn't it work, and why wasn't it funded, and what were the barriers and things? So it might be good to go back and review that, because that's already happened."*
>
> Participant B: *"But then there's the third sector interface. So, like in North Ayrshire, it's TACT, like it's called TACT. So they, up to an extent, provide a bit of that, and then lots of other things. And when I worked in East Renfrewshire, they did something like that. Again, it was a third sector interface that led on it, and they actually helped us create a database with lots of stuff on it. But then somebody needs to keep up to date."*
>
> Evaluation Session 2
> Participant A: *"But there are community link workers who do all that signposting. They were the ones I was talking about that developed at Carena and everything, so they spent a lot of time initially finding out what was out in the community... social prescribing, almost. It was just that any kind of club or whatever that would be useful to somebody. The GP's, if it wasn't medical, they could send it to the community link workers... There may be a gap around what's available for people with learning disabilities... so I don't know whether it's a lack of knowledge that it's there, or that they maybe feel that it doesn't work for their client group."*

Further investigation revealed that the service Carena shut down due to required upkeep, misalignment with accessibility regulations, and no longer serving the community's needs. It should also be noted that TACT is a part of the TSI, not the whole TSI; TACT and ArranCVS together make up the North Ayrshire TSI. Another digital platform, ALISS, was mentioned during engagement. However, participants felt the range of services was too broad, and not sufficiently specific to include individuals with LD. However, the need for a service like this is evidently still there, as a data store, whether digital or a physical hub, was mentioned across all three workshop outcomes.

Another aspect of the first storyboard that participants supported from the other workshops was the idea that a digital platform would allow unpaid carers in similar circumstances to connect and support each other:

Evaluation Session 1
Participant A: *"I think that natural support as well, because you think of traditionally, lots of parents didn't work if they had a child with a disability, but now, as you say, they have to work. So if you were able to share that informal care, that 'I work on Tuesday night, but your kid can come across, and we can do an activity together, and I'll reciprocate.' So it's not always about paid care supporting each other."*

Evaluation Session 2:
Participant A: *"...that parents group, which I think is really important. Like, there's kind of a, I think, informally at Trindlemoss, a lot of the people who go to Trindlemoss, the parents know each other cause they've been to the same activities for years and I think they just find it so valuable to be able to speak to other people who are in a similar position and it gives them a bit of time to themselves because, I think, they've spent a lot of their life caring for them."*

Storyboard 2

When presenting the second storyboard to participants from the other co-design workshops, the moments that resonated most were those that were similar to their own storyboard outcomes. In the second evaluation session, participants focused on the innovative way in which a soft care community could secure funding, an aspect they also explored.

Evaluation Session 2
Participant A: *"That's good. And obviously looked at bringing in a little bit of funding into it."*

Participant B: *"Well, that's right, it's a new resource, because that's where the gap is, we have got finite resources, and we need to find a way to get the community (involved)."*

Participants from the final evaluation session, who participated in the first co-design workshop, related to the access points through which information could be distributed.

Evaluation Session 3
Participant A: *"Your sourcing information the same as there (points to own storyboard outcome)... And definitely it's all about sourcing information, and how do we act on that information, building clubs and friendships."*

Participant B: *"Just shows you if we worked together. It's actually the same ideas."*

The participants from the final session then explained their plans for an information hub similar to one of the access points described in the second storyboard outcome. What this showed was that innovative ideas and ambitions aligned across sectors and services. However, barriers have left them fragmented, as the communication of ongoing initiatives is frequently poor.

Storyboard 3

Due to engagement constraints, the storyboard from the third co-design was only presented to the participants of the final evaluation session. During the presentation of the storyboard, the participants observed the significant influence that a soft care community could have on the transition process for individuals with LD, as communication and relationships between services could become more fluid. This led the participants to discuss the value of enabling care providers to be more flexible in their roles for the benefit of individuals with LD:

> Participant A: *"...it's much better, rather than you're rigid... Opening up a community, creating opportunities. We changed to development workers. We were day centre assistants, and then they reestablished us as development workers, and so we're just running with this now. Which is brilliant, it's in early stages, but we need lots more places to do that."*

The participants resonated with the asset-sharing moment in the storyboard, as they were already looking into doing the same. However, they also believed it was important to incorporate the individual's voice within these interactions:

> Participant A: *"It's called corporate parenting... We're actually in the process of making our own pop up store... so we can go to these opening days and share what we have here, but also collect information on what's there for other places, and come back here and look at people and say, you know, there's something here that I think is better for you, and it's along there, and we can get you along there, and there'll be people there who'll get you to meet people."*

> Participant B: *"A big part is it's not just going to be about the staff going, we want to take our individuals with us, because it's their experience. It's there, they can talk, we had one at college the other week, and it was all about what they wanted out of support work, and what they thought."*

Their final remarks on the storyboards were insightful, as they identified a crossover between these proposals and how they could work together on a collective timeline:

> Participant A: *"There's not much difference in thought, is there? Just different approaches."*

> Participant B: *"And that's the way it should be."*

> Participant A: *"So you would have your database, you would have your parenting information days-"*

> Participant B: *"Yeah, there's your 1 2 3 steps."*

> Participant A: *"And that's your three different, you know, views... And you think today, technology and that, why is that missing?"*

Being able to see the different approaches and perspectives captured in these outcomes was motivating for this set of participants. It seemed to inspire them to think collectively, as they could see that they were not alone in their approach towards meaningful change for individuals with LD. They identified similarities in the other storyboards and empathised with the slight differences in approach.

Moving From Now to the Future

The following recommendations aim to support more meaningful change for individuals with LD in North Ayrshire. Derived from research engagement, interviews, and activity outcomes, these suggestions offer practical guidance for the future of services.

Shared Information and Visibility

There is a need to establish and integrate a live, central, and accessible platform in North Ayrshire for mapping support, activities, and contacts to assist individuals with LD. This platform should be regularly updated and maintained through accessible communication channels that enable organisations to modify their information. It should be accessible to families, the third sector, and statutory teams, helping them to discover niche activities and hobbies for better community integration and to share support needs.

Community-led, Relational Care

Participants expressed a need for relational care support that engages individuals by emphasising interests, community strengths, and natural conversations before assessments. This care model integrates softer forms of support within the community, reduces the workload on statutory services, and promotes independent living, as individuals are seen not merely as care recipients but as active community members.

Multi-Sector Collaboration and Regular Forums

The need for cross-sector meetings and steering groups was recognised to promote the sharing of values, ensure consistent use of accessible language, and enhance support co-ordination. This would enable sectors to access and contribute to shared information through unified documentation to minimise duplication and encourage a coordinated approach centred on a comprehensive view of the individual.

Transitions and Continuity

It was recommended that multiple interventions are required to support continuity of care. For example, early identification, comprehensive planning spanning from childhood through adulthood, a variety of flexible respite options to suit individual needs, and ongoing support that extends beyond traditional service boundaries to ensure continuous assistance throughout different stages of life.

Inclusive Access and Practical Barriers

It was advocated that costs and infrastructure issues should be addressed to promote inclusivity. Possible solutions include forming funding partnerships with the private sector, such as independent businesses, to encourage the sharing of assets, such as venues or provisions. These partnerships could fund the creation of small initiatives by utilising accessible venues and implementing safeguarding measures aligned with informal community roles. Most importantly, to overcome barriers such as funding, initiatives will become self-sustaining through policy and legislation changes to support them.

Findings Reflection

It was gratifying to attain a result derived entirely from others' ideas, made possible through their engagement with the research. From a latent analytical approach and a constructivist epistemological stance, throughout fieldwork, I engaged with participants who knew one another. From my observations of multiple sets of participants from the same sector, or more specifically, the same organisations, the answers at times bore similarities. For example, participants 1 and 2 both advocated for cross-sector collaboration through training. Although I cannot say for certain, discussions have taken place before, whether casual or more formal interactions, which have shaped their understanding of the reality of their lived experiences. It would have been useful to have more opportunities to engage with participants individually to build rapport and better understand the reasons behind their opinions, to inform the analysis process further.

I also observed that answers were filtered and articulated in a professional manner, particularly during interviews, so as not to be overly critical of the existing care serviced being provided. This form of individualism reiterates the current need for services to focus on their own responsibilities in order to survive in an underfunded public sector landscape. This ultimately makes collective action and collaboration harder to achieve, as services must prioritise self-preservation. This is further evident in my original plan for a cross-sector co-design, where I intended to foster collective collaboration, but it was then split into three fragmented workshops due to unforeseen circumstances that required rescheduling. If I had more time to account for delays and rescheduling, I would have liked to facilitate more cross-sector interaction and a larger number of participants per co-design session.

I would also have held all the evaluation sessions separate from the co-design sessions to produce their storyboards before evaluation, allowing participants to see their own storyboard included in the collected outcomes. Although I sent scans of the outcomes via email, seeing them in person proved to be rewarding for participants, as they could see their input on a larger collective scale.

From the third co-design workshop and the final evaluation session, I also saw the potential for a second, more actionable cycle of engagement to start envisaging and materialising practical steps towards reaching the preferred futures discussed. Given more time, I would have liked to expand upon this.

Ultimately, the barriers already affecting the care landscape of North Ayrshire would have significantly influenced some of the speculated outcomes from the co-design workshops, as seen in the evaluation sessions; similar initiatives were unable to be sustained due to the funding effort required to maintain them. Therefore, the outcome of the final co-design session had the greatest potential to be self-sustaining, as it aimed to scale up solutions within the soft care approach to the political realm through changes to legislation and policy.

Discussion & Conclusion

Discussion

Addressing the Research Question

The research question aimed to examine how PD can help create design recommendations through speculative proposals to strengthen community-based support for people with LD. Using PD during fieldwork enabled the research to operate in a dynamic and complex environment, allowing participants to contribute to and shape the project's understanding through their lived experiences.

Through co-design workshops, participants envisioned various concepts to enhance community support in response to opportunities identified through interviews. By framing these discussions speculatively, participants were able to think more freely and proactively about the opportunities, thereby avoiding the limitations presently impacting the care landscape in North Ayrshire. Therefore, the speculative framing made it easier to extrapolate design recommendations to strengthen community-based support.

Addressing Aims

The research aimed to explore the value of PD through engagement with diverse stakeholders within the NHS, social care and third-sector organisations to identify viable care alternatives and facilitate conversations around potential proposals. The identification of viable care alternatives intended to create distance and relieve outcomes of the current constraints affecting care services, to then further extrapolate directions for those preferred futures. Therefore, the findings acted as "compasses not maps" (Dunne & Raby, 2013).

I engaged in conversations with individuals who had much greater expertise on this subject, demonstrating the value of PD in emphasising lived experiences. PD also provided rich cross-sector insights across multiple phases of engagement, leading to collaborative sense-making and ultimately fostering participants' ownership of the co-design outcomes. Therefore, PD allowed discussions to evolve naturally as the narrative from interviews became more consolidated through conversations with participants in the co-design workshops. PD methods also supported creative activities, translating workshop dialogue into visual outputs that reflected shared values. Ultimately, by participating in activities within the PD process, participants can learn and incorporate aspects of this engagement into their own work.

By framing engagement through a speculative lens, it encouraged participants to think beyond current constraints and assumptions, and to reconsider systems and services. It also helped them to explore long-term possibilities without being restricted by immediate feasibility. Furthermore, it allowed participants to articulate aspirations that might otherwise be deemed unrealistic, thereby prompting them to generate transformative ideas. This framing was most effective during the co-design workshops as it promoted deeper conversations about "what could be" rather than describing the current reality, which was a productive and effective use of the limited engagement time. However, speculative thinking is a method of thinking "already contained in the present" (Lübker, 2025). Therefore, the concepts are not entirely free of current constraints, but this also means that the preferred futures articulated by participants are still rooted in the present.

Addressing Objectives

The objectives of the research were to generate an understanding of the current care landscape within North Ayrshire, enable mutual learning and collective action, and extrapolate recommendations for the future of services made by stakeholders. By framing the engagement phases through Wright's Emancipatory Social Science framework (2010), the interviews aimed to capture the understanding of the care landscape. Using a qualitative approach, the interviews captured the complex, nuanced narratives of diverse perspectives. Using thematic analysis (Braun & Clarke, 2006), common themes and barriers were identified through an inductive approach. This enabled the development of a highly contextual understanding from the bottom up, informed by stakeholders' lived experiences. The themes and barriers further informed the opportunities utilised in the following phase of engagement, which allowed for productive dialogue between the researcher and participants.

The findings indicated that the care landscape in North Ayrshire for people with LD is complex and challenging to navigate, due to the variety of support options available to individuals. However, there is a deficiency in visibility and communication among services, attributable to funding constraints affecting their capacity. Participants felt there was a lack of communication overall, but the connection between the NHS and social care was more substantial than with the third sector, as evident from the mapping activity conducted during interviews.

The PD process enabled mutual learning through facilitating an inclusive environment for participants to engage in. Mutual learning occurred through shared insights between participants and the researcher, as well as through prompts that encouraged reflection on the value of engagement activities, which facilitated brainstorming and productive discussions. To enable collective action and to further mutual learning, it was intended that participants from different sectors would be given space within a co-design workshop to discuss and develop a narrative in response to the opportunities. However, due to scheduling and participant capacity constraints, workshops were held separately. Therefore, collective action was inspired through evaluation sessions, where participants could see their individual contributions in comparison to other outcomes. In retrospect, achieving this objective would have been more feasible if the project had allocated additional time for fieldwork.

The extrapolation of recommendations was achieved by analysing data from co-design outcomes, offering directions rather than specific alternatives. From the evaluation sessions, prompting participants to identify which parts of other storyboards resonate with them further refined and shaped the recommendations.

In Alignment with the Literature

Through the PD process, these recommendations align with the literature, which suggests that preventing care breakdowns within community services is necessary to alleviate reliance on statutory services to take on additional responsibility. Building upon this, services should prioritise relational care values by defining and integrating softer forms of support to make the community more inclusive. Through co-design engagement, the storyboard outcomes responded to the Scottish Human Rights Commission (SHRC) definition of institutionalisation, as participants identified moments of impact to address isolation from the community, a lack of agency, and the same activities in the same place. Through discussion during the engagement phases, the findings also aimed to improve the Quality of life for individuals with LD, in line with Chowdhury and Benson (2011), by recommending more varied activities, greater leisure involvement, and enhanced social interactions. These overlaps validate the recommendation to integrate softer forms of support within the community.

The findings further extend the understanding developed from the literature, as previously highlighted, statutory services were unable to function as intended due to the lack of community provisions. The findings show that a lack of funding has impacted the capacity of individual services, resulting in services prioritising self-preservation as they focus on their own responsibilities, with no capacity to support other services mutually or to receive mutual aid. Participants recognised the fragmentation between sectors, yet also showed they have similar ambitions and advocated for better communication and cross-sector collaboration.

Constraints

Validity

To validate the research findings and outcomes, questions asked during the co-design workshops prompted reflective responses about the activities participants were engaged in. Further clarity on the research's validity was provided by reactions to the co-design outcomes facilitated during the evaluation sessions. Finally, a survey of closed questions centred around the research aim and objectives was provided to all participants of the co-design workshops to better understand their experience of engagement. Of the six participants invited to take the survey, four responded to the five questions.

All participants who responded believed that the opportunities identified through the thematic analysis of interviews were relevant for improving support for people with LD in North Ayrshire. They also felt a sense of ownership over the storyboard outcomes produced from their discussions during the co-design workshops.

Three of the four responders indicated they would consider using creative engagement methods, such as the activities they participated in during their interview and co-design workshop. It is unclear why one of the participants would not use similar techniques. However, it might be because they do not believe they possess the skills to facilitate engagement of this nature, which is a key insight I gained from a workshop with NHS staff:

> *"Blows my mind how people are so different, just that obviously artistic way of being able to turn what we're talking about into a graphic demonstration... My brain just doesn't work in that way. Well done."*
>
> - Participant B, Evaluation Session 1

All participants perceived that they experienced mutual learning through their involvement in the research, either by acquiring new insights from fellow participants or through discussions with the researcher. Ultimately, all participants felt recognised and heard during the engagement.

Limitations

Through undertaking this project, it is important to acknowledge the limitations that have hindered the research's direction and ambition. Firstly, the sample size of participants throughout the engagement was limited, and certain perspectives, such as the lived experiences of unpaid carers, were unfortunately unable to be captured. Due to the nature of third-sector organisations, it was challenging to recruit people at the ground level. Therefore, more managerial perspectives were taken into account within this realm. Given the direction of the opportunities to improve care for people with LD, these perspectives would have been valuable.

Another limitation was working to suit professionals' busy schedules, which was most evident in the adaptation of the original co-design plans and the numerous rescheduling, delays and cancellations of interviews. Although this impeded the engagement's ambition, the project outcomes weren't drastically affected.

The start of engagement was also heavily impacted by the extensive ethics approval process the project had to undergo by the university. As the research aimed to engage with professionals working within the NHS, additional applications had to be submitted, including lengthy discussions with the NHS research and development department.

Generalisability

By approaching the research from a social constructivist epistemological stance and utilising PD methods that value participants' lived experiences, the research is purposely contextual. Therefore, findings are not generalisable. However, through the description and discussion of the creative engagement process, the insights from my PD process are transferable to other researchers and practitioners.

Implications

The research findings gained through cross-sector collaboration will be valuable for the North Ayrshire Health and Social Care Partnership. It will also assist practitioners in designing ways to engage with complex, dynamic healthcare systems and services. The recommendations and co-design results could support both new and ongoing initiatives in North Ayrshire, as this research highlights the need for a signposting platform and the adoption of relational care principles.

Through undertaking this research project, I have found that the rigorous preparation towards employing methods like PD has been rewarding, as I had previously used such methods during my undergraduate studies. However, being informed by epistemology and a theoretical perspective has been beneficial to my experience with PD, as gathering an informed understanding of the methodology tacitly impacted the conduct of engagement.

To better understand the implications of this research, I met with the gatekeeper to present the co-design outcomes. It was important to me to hear someone else's interpretation of the value of the findings and outcomes, and whether they are of benefit to North Ayrshire's care services. The reaction was positive to the findings and outcomes, with the potential to develop practical steps based on the recommendations. Ultimately, the most significant value was the use of creative methods to engage people, which was advocated for further practice.

> *"Using those kind of playful approaches can kind of lead you to a different set of responses from people... And really dig into that kind of playful, creative, imaginative space where people can start to get a bit more daring in terms of their conceptualisation and their aspiration... As you know yourself, considering things which might be fanciful in their initial form, but they've got the germs of something really quite innovative, which actually can be realised in a practical sense."*
>
> - Gatekeeper

Further Research

This research examined ways to incorporate community-based care through engagement with professionals who support people with LD, for their benefit. Firstly, there is an opportunity to involve individuals with LD in the process of integrating community-based care, including their opinions and lived experiences. This could also expand to include unpaid carers and family members. Additionally, there is scope to explore whether a digital, analogue or hybrid approach is most inclusive and accessible for signposting and providing information to individuals with LD, carers and care professionals on community-based initiatives and support. There is also the opportunity to observe how mutual aid could bolster a poorly funded community and to explore upscaling actions to enable a self-sustaining, inclusive culture within the community. Finally, there is an opportunity to compare the effectiveness of storyboarding, speculative design, and other creative tools with more traditional methods for producing actionable service insights.

For my own practice, I want to explore how to facilitate greater collective action. In future research projects, I would prolong engagement with stakeholders to deepen rapport and enable actionable improvements to people's lived experiences.

Conclusion

The research aimed to facilitate participatory design conversations to strengthen community-based support for people with learning disabilities. The literature indicates that statutory care services don't function as designed due to insufficient community provisions, leading to reliance on them. Therefore, earlier intervention was identified as a key insight. Within the context of North Ayrshire, the closure of Ward 7A is reflective of broader and long standing challenges in relation to the support of people with LD and created the opportunity to envisage integrated support positioned in the community.

It sought to explore the value of PD through engagement with diverse stakeholders to create outcomes that proposed directions for current care provisions. Through thematic analysis, the research narrative was further informed by the lived experience of care professionals. PD enabled discussions to evolve and facilitated a speculative lens to generate preferred futures to work towards.

In doing so, the engagement intended to generate an understanding of North Ayrshire's current care landscape. This was achieved through a qualitative approach, especially during interviews, where inductive analysis was used to create a highly contextual narrative of the care landscape.

PD further aimed to enable mutual learning and collective action. Mutual learning was perceived as enabled during the co-design workshops through insights exchanged between the participants and the research practitioner. Collective action was a more challenging objective to achieve for this project due to the project's limitations and the constraints currently impacting care provision in North Ayrshire.

Finally, recommendations based on the outcomes of the co-design workshops were developed. These recommendations called for a live, central, and accessible platform to map support, activities, and contacts to assist individuals with LD; relational care support that engages individuals by emphasising interests, community strengths, and natural conversations before assessments; and cross-sector meetings to promote the sharing of values, ensure consistent use of accessible language, and improve support coordination.

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