My Home Hospital Start-up Co-Design

Report

November 2020

democracyCo

Contents

“When you go into a hospital, by default you accept the rules of the hospital. When you come into my home, the practitioner needs to accept the norms and rules of my home.”

Participant, CALD Workshop

Introduction / Background

In 2017/18 the State Government made a commitment to rebalance the health system by increasing and enhancing existing out-of-hospital and community-based hospital alternatives as a key strategy in supporting the sustainability of the system into the future.

With this aim in mind, SA Health through Wellbeing SA is looking to industrialise and scale HITH services through the implementation of *My Home Hospital* in late 2020.

As a new SA Health HITH service, *My Home Hospital* is an opportunity to build upon and expand the way HITH services are delivered in South Australia. Providing HITH services is not a new concept – care has been provided safely and effectively in HITH models in South Australia and around the country for over 30 years.
My Home Hospital aspires to scale the model in South Australia to provide for more South Australians to choose this way of receiving their acute hospital care.

Following an open tender process, Calvary andMedibank were selected as the providers of *My Home Hospital*. The Calvary-Medibank joint venture will deliver My Home Hospital services on behalf of Wellbeing SA and bring local medical, nursing and allied health experience; and in partnership with Wellbeing SA have committed to a collaborative and inclusive design of *My Home Hospital* services. This has been envisaged from the beginning of the design and implementation process. Partnership and collaboration is essential to the sustainability and success of *My Home Hospital* services and will continue as the service model is refined to meet the needs of the South Australian community and achieve integration into the existing SA healthcare landscape.

My Home Hospital Co-design

"Co-design is the active involvement of a diverse range of participants in exploring, developing, and testing responses to shared challenges together. Bringing together people with different perspectives and experiences enables the development of innovative ideas and assists government in responding to community and or stakeholder needs.[1]"

ANZSOG (Australia New Zealand School of Government)

My Home Hospital co-design has included:

1. A *My Home Hospital* Advisory Committee including SA Health and Local Health Network (LHN) representatives;
2. Appreciative inquiry discussions with an extensive range of stakeholders, including residential aged care facilities, Local Health Network (LHN) clinicians, Aboriginal health professionals, advocacy groups and General Practitioners (GPs);
3. Collaborative work with clinical champions, appointed and funded in each of the metropolitan LHN and the Barossa Hills Fleurieu LHN;
4. Workshops with community members with lived experience of hospitals and hospital in the home, everyday South Australians and priority care groups to develop a series of Co-design Principles;
5. A series of three workshops & testing – which are the focus of this report.

democracyCo has worked with WellbeingSA to support the co-design process with the last two of these processes.

The purposes of the start-up co-design have been threefold:

To build relationships & partnerships

- Introduction of the Calvary-Medibank team to LHN Clinicians and other stakeholders, provide an opportunity for them to showcase their model and begin building longer term trusting relationships.
- Building a shared understanding and personal networks between the Calvary-Medibank team, community and LHN clinicians, aged care and disability services, and other relevant stakeholders.

To design the Patient Journey

- Authentic co-design of key elements of the patient journey, and explanation of elements that were already determined by Commonwealth and State legislation and SA Health commissioning processes.
- Identification of barriers and enablers that might impact clinical safety and/or service uptake.

To undertake authentic engagement

- Provide opportunities for the views of people with lived experience to be heard and built into service design.
- Establishment of preferred methods for Wellbeing SA to engage with stakeholder groups on an ongoing basis.

[1] https://www.anzsog.edu.au/resource-library/research/the-promise-of-co-design-for-public-policy

It is intended that this work (and the content of this report) will only be the start of the Co-Design experience for this project. Both Wellbeing SA and Calvary-Medibank have repeatedly said that the program will only succeed if it incorporates and values the input of stakeholders – to design, implement and continually improve the service through ongoing review and evaluation.

How to read this report

This report is the third in a suite of reports – also prepared by democracyCo – which reflect on the process and outcomes of community engagement about My Home Hospital to date. The previous reports are:

1. *My Home Hospital* – Outcomes of Community Consultation Report – August 2020
2. *My Home Hospital* – Priority Care Group Report – August 2020

This report focusses on the three co-design days and the testing phase and details the process and outcomes of this part of the start-up co-design workshops. This report also references the previous processes, in particular the sustained involvement of community members.

Executive Summary

My Home Hospital will provide acute hospital care to patients in their own home, including residential aged care facilities and disability-supported accommodation. A joint venture between Calvary and Medibank will deliver this important service on behalf of Wellbeing SA.

To facilitate the development of a sustainable service that meets the needs and expectations of community members and interfaces effectively with other elements of the health system, Wellbeing SA held a series of co-design workshops throughout October 2020**.** Workshop attendees included community members, Local Health Network (LHN) and community clinicians, LHN Clinical Champions, General Practitioners (GPs), aged care and disability providers, advocacy groups and the new *My Home Hospital* provider Calvary-Medibank, working together to ensure a more seamless and innovative patient experience.

The co-design explored the key elements of the patient journey including suitability, referral, service responsiveness, collaborative care, discharge, transfer of the deteriorating patient and concurrent service interface. The process commenced with an initial 'briefing' day which set out the known information about the service, and commenced the divergent 'brainstorming' element of the co-design. This was followed by a full day 'deep dive' into each of the previously described patient journey elements.

This report sets out the start-up co-design process, including the design and intent of the process, and describes the key themes and input provided by the participants, unchanged and in their own words. Wellbeing SA and Calvary-Medibank have committed to an authentic, ongoing process. They reported back to the group during the final workshop session on how their feedback was being incorporated into design and development of *My Home Hospital*.

Key outcomes desired by participants for each section of the patient journey were:

Assessing Suitability

- Consent to or willing to consider *My Home Hospital* (patient choice);
- Ready to embark on it – suitable home environment, ability to manage at home, comfortable that it's the right choice for them;
- Confident that the right processes and protocols are in place/ have been met.

Referrals

- Effective and efficient – people would know what was to happen next and the system would 'kick into gear';
- All 'players' would be confident and certain;
- Nothing would get missed – no important information would be lost, missed or duplicated;
- It would be timely and matched to the circumstances for the patient.

Collaborative Care

- It would start with a question to the patient: *'what is important to you? Who is important to you?* Patient-centred, holistic, respectful and culturally appropriate;
- It would be seamless – people would tell their story once;
- It would allow everyone to contribute to the goals for care;
- It would be comprehensive and high quality, safe care.

Discharge

- The patient's health would be improved – better than admission;
- Everyone would know what was going to happen next – roles and responsibility, transfer, when regular services restart;
- Information would be shared and accessible – plan and summary;
- There would be an opportunity to understand how the experience of *My Home Hospital* was – a feedback mechanism.

Transfer of a Deteriorating Patient

- Transfers and the decision to transfer needs to happen in a timely way – just in time. There should be rapid assessment and good handovers;
- A physical bed needs to be available at the hospital;
- Everyone needs to be informed and understand what is going on;
- People need to be supported – the patient, the loved ones, the carer, the medical practitioners making the decision;
- There needs to be sound stewardship of resources.

Interface of Services

- Everyone would have peace of mind, and be empowered – and they would know what was going on, and who was who;
- There would be tolerance for deviation of care – an ability to flex and move as needed;
- There would be greater outcomes of care as everyone is working for the same end;
- Information would be available as needed.

Further rich discussion provided by with regard to key considerations in *My Home Hospital* design, innovations which should be explored and outstanding questions are detailed below.

The process

This co-design approach is the final in a series of processes to inform the initial development of the *My Home Hospital* program. This is best shown in the following diagram:

This report (and the co-design) focussed on the orange sections in the diagram above. Co-design involved a commitment of three key sessions for participants.

Principles underpinning the process

democracyCo drew on the below facilitation principles to support our design and implementation of the Co-Design process.

1. **Form follows function** – supporting participants to **agree** what they are trying to achieve both in an overarching sense (i.e. what they are trying to achieve from the co-design process) but also what outcomes they want from each stage of the *My Home Hospital* service. This approach (going slow at the start to go fast at the end) resulted in a very clear, deep and robust understanding of the objectives for the process. This approach is central / critical to co-design processes.
2. **Diversity**
    - Diversity of community inputs – it is not possible to represent all the different community views needed around the table – there are too many. In lieu of this, participants around the co-design table were diverse in the following respects – gender, age, and experience with the hospital system, household type, cultural background and 'socio-economic' status.
    - Community testing - testing the thinking with a broader group of experts and a broader cross section of the community was conducted to ensure broad applicability of principles, and identify groups with specific needs.
3. **Equity amongst participants** – ensuring that community members were comprehensively 'heard' throughout the process
4. **Building understanding and knowledge** - Community members were supported in their participation to ensure that they did not feel out of depth or overwhelmed working with experts. democracyCo helped to build the knowledge of the community members before the process started and all relevant project information was provided to participants to support their equitable participation in the co-design workshops.
5. **Time** – democracyCo used the time available to support the group to reach agreement with each other and to consider the breadth of the issues appropriately.
6. **Commitment** – that Wellbeing SA and Calvary-Medibank model a commitment to genuine co-design.

Co-Design

The Launch event and first co-design workshop was held in Adelaide on the 14th and 15th October 2020, facilitated by the democracyCo team. Approximately 140 participants attended on Day 1, with approximately 80 carrying over to Day 2. Both days included 16 community members who had been recruited to work through the process of co-design.

Wellbeing SA actively sought the engagement of a broad selection of stakeholders; which included a range of community and hospital clinicians; advocacy and special interest groups; and other government stakeholders. Invitations to submit expressions of interest were distributed through professional and peak bodies in general practice, aged care, disability services, and the Adelaide and Country Primary Health Networks, in addition to nominations from Local Health Networks and other key government contacts.

"... nearly 3,000 years of expertise was in the room today designing My Home Hospital!"
Jeanette Walters, Wellbeing SA in summary remarks from the co-design

The conscious intent of co-design was to uncover a diversity of perspectives, facilitate intelligent, sustainable service design and minimise unintended consequences. Although conscious of venue restrictions on numbers of participants due to COVID-19, Wellbeing SA sought to maximise the range and diversity of stakeholder individuals and organisations represented during co-design. Prioritising the viewpoint of the community and people with lived experience of hospital care (who represented almost 20% of the smaller working groups during Day 2 of intensive co-design) was also central to the selection process.

ACH Group	ACIA	Adelaide PHN	Aged Rights Advocacy Service
Arkaba Medical Centre	Australian Family Care	Better Medical	Barossa Hills Fleurieu LHN
Boandik	Central Adelaide LHN	Calvary-Medibank	Carers SA
Citizens of South Australia (16)	Cystic Fibrosis SA	Commonwealth Department of Health	Department of Human Services
East Adelaide Healthcare	Eldercare	Glenunga Medical Centre	Health Grants and Network
Helping Hand	LASA	Lifecare	Mawson Lakes Healthcare
Mental Health & Wellbeing Directorate	Metropolitan Referral Unit	Multicultural Communities Council of SA	Murray Mallee Aged Care Group
Northern Adelaide LHN	National Disability Insurance Agency	Oakden Medical Centre	Office for Ageing Well
Relationships Australia	Resthaven	SA Ambulance Service	Southern Adelaide Local Health Network
Sonder	Southern Cross Care	Summit Health	Women's & Children's Health Network

Community as part of the Co-Design

A key focus of the co-design process was to involve community members – everyday South Australians in the process.

Given that this Co-Design followed on from a significant initial 'lived experience' engagement process[2] (also conducted by democracyCo), it was considered appropriate to extend the opportunity for all people who had been involved so far, to attend the workshop. As a result, democracyCo extended invitations to all of the participants who had been involved in the previous process to express an interest in the Co-Design. Invitations were extended to 69 people – with 33 people expressing an interest in attending.

democracyCo identified 20 people from this group – across key priority care groups (Disability, Carers, CALD, Cystic Fibrosis, Mental Health Carers, Mental Health, LGBTIQ+, Hospital in the Home Lived Experience and general community members – from democracyCo's citizen database). From this group, 16 were confirmed. Participants who attended were from:

- General community – adults
- General community – youth
- Lived experience
- LGBTIQ+
- Mental Health carers
- Cystic Fibrosis
- CALD
- Carers SA

The selected disability community member had to withdraw from the process due to personal factors.

Getting community members ready

Being one of 16 community members in a room of over one hundred health professionals is a potentially daunting experience! As a result, democracyCo and Wellbeing SA wanted to ensure that the community members succeeded in their participation.

We wanted to ensure that they had the opportunity to:

- be included meaningfully
- share their views
- learn and further their understanding
- to deliberate on an even keel with the other people in the room.

[2] This process is explained in the democracyCo Report: *My Home Hospital – Outcomes of Community Consultation Report*, August 2020

To support this, democracyCo ran a briefing workshop two days before the Co-Design process for the 16 community members , including staff from Wellbeing SA to make sure community members had 'friendly faces' they knew, and had a chance to ask questions in a more informal environment. The briefing session went for 90 minutes and included:

- Background and context of what *My Home Hospital* is, and the development process to date
- Introduction to the process of co-design – what they can expect, and exploring together what they felt their role was – allowing them the opportunity to think about what value they brought to the process – and how to bring that to the fore
- Some discussion about language / health jargon – so they understood it before they were in the room.

The group also had quite an open discussion – exploring their reactions and opinions about *My Home Hospital* service. This relaxed and open style briefing session helped to set participants at ease before the workshop, and they commented during the Co-design workshops that this assisted them to fully participate at every step of the process, community members were paid an honorarium in recognition of the substantial amount of time they were investing in the process.

"I was 'anti' My Home Hospital when I first heard about it – but after spending a day with these amazing people, hearing about this incredible program I have totally shifted. This is so exciting… thank you so much for the opportunity"

Gareth, Community Participant

Co-design Agenda

Below, is an overview of the process for both days:

Day 1: Launch (14 October 2020)

- Welcome to Country
- Formal Welcome from The Hon. Stephen Wade MLC, Minister for Health & Wellbeing, and Lyn Dean, Chief Executive of Wellbeing SA)
- Meet and greet – workshop session on how participants were feeling about
- The process so far: briefing session on the lived experience / clinical design to date
- Intro to My HH – Wellbeing SA
- Introduction to the *MyHome Hospital* Model – by service providers Calvary-MediBank
- Workshop: a moment in the patient's shoes
  Workshop: patient journey and exploring desired outcomes for seven key elements of the patient journey: assessing suitability, the referral process, service responsiveness, collaborative care, discharge, transfer of a deteriorating patient, and interface with concurrent services

Day 2: Co-Design (15 October 2020)

- Re-entry and introduction to co-design
- Three rounds of mixed groups working on the key patient journey topics: assessing suitability, the referral process, service responsiveness, collaborative care, discharge, transfer of a deteriorating patient, and interface with concurrent services.
- Participants discussed key focus areas during each round and recorded their work in a google doc.
- Separate area created for innovative ideas and open exploration of these.
- The process moved from divergent / exploratory to convergent / refinement throughout the day and during the final workshop once groups had received the additional feedback from 'testing' groups.
- Participants identified key outstanding issues / questions requiring further testing and design.

Topics explored

There were seven topics explored in the two days of Co-Design. These were identified by Wellbeing SA, and developed further with democracyCo and the Calvary-Medibank team.

The topics were:

- **Suitability** - We know who is eligible, but who is suitable for *My Home Hospital*?
- **Referral** - How do we make referrals work well?
- **Service responsiveness** - How does the service provider prioritise urgency for first home visit?
- **Collaborative Care** - Partnering with consumers, carers, loved ones and clinicians who have an existing relationship with the patient
- **Transfer of a deteriorating patient** - If a patient requires the resources of a physical hospital
- **Concurrent Services Interface** - If a person is receiving concurrent services including aged care or disability support, how will those services and *My Home Hospital* work together?
- **Discharge** - How do we ensure the discharge process works well?

A separate open space was created for participants to explore any wild ideas and **innovations** they might have for the service. Participants who rotated into this innovation space did not have a worksheet / defined process, but instead were encouraged to explore 2 questions: ***What if…?*** and ***How might we…?***

Workshop Flow

The below image provides an overview of the flow of the workshop, and the content of the worksheets participants were provided.

Facilitated deliverables: MHH Co-Design

Topics and a one-line description		**Suitability** *"we know who is eligible, but who is suitable for MHH"*	**Referral** *"how do we make referrals work well"*	**Service responsiveness** *How does the service provider prioritise urgency for first home visit?*	**Collaborative Care** *"partnering with consumers, carers, loved ones and clinicians who have an existing relationship with the patient"*	**Transfer of a deteriorating patient** *"if a patient needs to be admitted to hospital"*	**Interface** *How do the people providing care work together? If a person is receiving aged care or disability care how will those services and MHH work together?*	**Discharge** *"how do we ensure the discharge process works well"*	**Innovation** "what amazing ideas do you have that we could apply to this program?"
Co-design Goal	**PURPOSE**	**Perspectives** on factors impacting whether someone is suitable or not for MyHH.	Clearly identify elements required for an effective referral	Recommendations in response to the key question - *How does the service provider prioritise urgency for first home visit?*	Understand how regular care providers can stay involved - 'how can I maintain an involvement in the care of my patient'? Understand what partners in care means for a patient / loved ones - "how am I looked after – not clinically, but as a human"	What do we need to consider about the transfer & management of a deteriorating patient in MyHH?	Develop an understanding of the best way for all parties to work collaboratively to ensure safe, high quality and continuous care	With a focus on collaborative and seamless care, what elements are required for an effective/efficient discharge?	To enable participants to freely co-design anything they want about the program
Participation outcome	**For each of the 7 topics we will have a sense of where the group agrees (what they can live with) – and also a sense of where they don't agree or what issues still to be worked through.**								**New ideas, new thinking**
Round 1 – Note: Day 1 **Thinking with the end in the mind about the big picture outcomes**	**DIVERGE**	Desired end In terms of suitability, what outcome is best for: - The patient - Their loved one/s - The clinician	Desired end In terms of referrals, what outcome is best for: - The patient - Their loved one/s - The clinician	Desired end In terms of service responsiveness on entering MHH, what outcome is best for: - The patient - Their loved one/s - The clinician	Desired end In terms of collaborative care: - What outcome/s are clinicians looking for in the ongoing care of their patient? - What outcomes do patients expect – what does being a partner in care look like?	Desired end In terms of managing a deteriorating patient (and transferring them out of MHH), what outcome is best for: - The patient - Their loved ones/s - The clinician	Desired end In terms of communications & working together, what outcome is desirable for: - The patient - Their loved one/s - The clinician (Or what pitfalls do we need to avoid)	Desired end When discharging, what outcome is best for: - The patient - Their loved one/s - The clinician	How could we do this project in a new/better and different way?
Round 2 – workhorse round – doing lots of the grunt work.	**DIVERGE**	What types of patients are you most worried about receiving MHH? Who is not suited. (what would make them clinically unsuitable?) Innovation – how do we do this innovatively?	What makes referrals work well? What can go wrong with referrals – what do we need to watch out for (patient / clinician / SP) What would stop you from referring?	In terms of responsiveness – what sorts of considerations are deemed urgent / what is not? What should trigger the service provider to prioritise urgency – upon being admitted to MHH?	What does a partnership look and feel like? What is meant by the patient being a 'partner in care'? What can we do across the system to make sure patients	What is important to consider as/when a patient deteriorates? What needs to occur as a patient transits from hospital to MHH Innovation – how do we do this innovatively?	What sorts of things enable integrated services (help multiple organisations work together)? How can delivery of care be communicated effectively between all parties?	What makes discharges work well / effectively? What can go wrong with discharges – what do we need to watch out for? Innovation – how do we do this innovatively?	How could we do this project in a new/better and different way?
				How does this look during hours or after hours. Innovation – how do we do this innovatively?	and carers are involved to the full extent they choose.				
Round 3 – starting to theme up thinking into coherent ideas / themes	**CONVERGE**	What would help clinicians make a decision about suitability? Innovation – how do we do this innovatively?	What would give clinicians confidence to refer to MHH – what do you need in place? Innovation – how do we do this innovatively?	What additional services may be required to support acute care provision in the home? What do you recommend in relation to service responsiveness? Innovation – how do we do this innovatively?	What would assist service provider to work in an integrated way with specialist medical services? Innovation – how do we do this innovatively?	What do we still need to talk about / resolve in regards to managing a deteriorating patient? Innovation – how do we do this innovatively?	What principles can assist in integrating – and ensuring high quality services? Innovation – how do we do this innovatively?	What elements are required for effective / efficient discharge? - Information sharing - Sub-acute - Post-acute - Specialist teams - Community svcs Innovation – how do we do this innovatively?	How could we do this project in a new/better and different way?
Round 4 – making sure we are clear	**CONVERGE**	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained?	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained?	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained? (esp social, activities of daily living, transport home, mental health consideration, care responsibilities) Are there carer burden aspects that need to be considered?	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained? Are there carer burden aspects that need to be considered?	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained? Are there carer burden aspects that need to be considered?	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained?	**Check / Improve** How does this align with the principles? How do we ensure safety and quality is maintained? Are there carer burden aspects that need to be considered?	How could we do this project in a new/better and different way?

"There was a lot of sincere passion in the room. Hoping this develops well and its inclusive of CALD, Aboriginal communities and other minority groups eg disability and carers… Some people carry with them many layers… and makes them more challenging but I do hope they too can become recipients of this program." Community Participant

Ensuring maximum participation and diversity

Key to a co-design process is the function of mixing and diversity – to avoid group think and work through core design aspects in a robust way. democracyCo used the following co-design methods and techniques:

- **Table mixing** – participants were intentionally seated at different tables, with different people working on different topics a total of four times throughout the first two days. The table mixing was conducted in a way that would ensure that a diverse mix of community members, health and service professionals and key staff from Calvary-Medibank were included in every topic, in every round of discussion. In many instances most tables consisted of strangers which further supported respectful and genuine exploration of topics from multiple vantage points. Mixing the tables this way also assisted in complying with distancing requirements at the venue.
  'it was good to be seated with a variety of people…it helped to really open up conversation'
- **Movements** - democracyCo designed the first two days using a diverge / converge methodology. This meant that at different stages of the two days, groups were working on different types of design – they may have been diverging (coming up with ideas, learning new things, exploring different experiences) or they may have been converging (coming to agreement, finding common ground, identifying what's next). Knowing where they were at (and the type of work they were expected to do at any one time) helped them to work through the process in a logical way.
- **Use of time** – supporting the movements, democracyCo also used time differently throughout the sessions. When divergent work was happening, there was less time allowed encouraging participants to move quickly through the work, brainstorm or get to the point with minimal discussion. When the group moved into convergent work, democracyCo slowed the process down, gave them unhurried time and allowed them to use it how they wished.
- **Clarity and focus** – democracyCo designed and used electronic worksheets for the group (via Google docs). These worksheets enabled the group to 'know what they were doing' at any time through the workshops, reducing the need for heavy handed facilitation. A simple system of 2-3 questions for each table at each 'movement' allowed the group to focus in on the key outstanding areas of design which were needed for *My Home Hospital*. The ***'workshop flow'*** image previously in this document gives a sense of what these worksheets contained and the work participants were asked to do.
- **Framing and evidence based** – Fundamental to the process of co-design, is that the designers have access to all of the information they need. In preparation for the process, Wellbeing SA produced a participant workbook. This workbook was a 'framing' tool for each of the seven topics explored through the process. Each topic was explained simply and easily – and then supplementary information was provided (i.e. example referral forms) to support the dialogue and discussion.
- **Agency** – democracyCo's facilitated approach to the Co-design was designed in a way to empower the group and give them agency over their own work. By using the Google doc worksheets as the core place for capturing information, democracyCo also empowered the group. democracyCo were upfront with the group that they were expected to 'write their own notes, be their own memory' – and that if they didn't write anything down it would not be captured. As a result, groups held the pen – literally and figuratively.

"I felt everyone was given a 'fair go' if they wanted to say something."
Community Participant

COVID Safe Co-design

Facilitating large processes like this in the era of COVID-19 requires creativity and an open mind. Some of the things we put in place to be COVID safe during the process included:

- Table mixing – intentional and planned in advance – so everyone knew where to go
- Working lunches and morning teas – long breaks which allowed food to be served and also promoted the unhurried approach to facilitation
- Comfort breaks – people taking them as and when they needed
- Participant bags – containing water bottles, pens, workbooks – and promoted mobility simply and quickly
- Walk around the block – at lunch, to enable the venue to change table cloths at key mixing intervals
- Creating a shared sense of responsibility

How the co-design principles were used

Prior to the co-design workshop process, a set of principles had been developed by community members and people with lived experience of hospitals and hospital in the home – as recorded in the democracyCo report entitled *My Home Hospital Outcomes of Community Consultations Report, August 2020*.. The principles were actively used by the co-design participants throughout each session – primarily during the first two days – to ensure that the ideas, recommendations, and advice they were putting together was consistent with community expectations for *My Home Hospital* service development.

Outcomes from co-design

General reflections

Overall, participants seemed hopeful and encouraging about the *My Home Hospital* service, particularly after being introduced to the service model by Calvary-MediBank.

"I wonder how we can ensure the stickability of this and wonder how far we can push the boundaries into the future?"

There were some concerns and challenges expressed during the process, and many questions unanswered throughout the two days – but in the main, participants seemed able to sit with those questions and that discomfort.

"I wish that everything I've ever worked on had this amount of people working and contributing to it."

In addition, participants relished the opportunity to be part of the co-design process – which was evidenced by the full involvement of participants' right through to end of each day. Throughout the process democracyCo received 'bouquets' from participants which were largely focussed on their genuine gratefulness to have a say in the design of such a ground breaking service.

"I like the fact that people have felt enabled to put their view forward and it has been respected. I appreciate that patients were given a voice today"

Reflections from Calvary-MediBank and Wellbeing SA included:

"There was a real fearlessness in how people have put forward their views. The courage to do that has been really appreciated, it's important that we hear those perspectives. Also we saw an inordinate amount of resources, effort and energy invested... We are committed to listening."

"Thanks for your willingness to be curious and creative. Such a privilege to be involved in these types of journeys"

"I like how we kept the design principles and the people at the centre of what we have done today."
Participant

Patient Journey Outcomes

The group dived deeply into each of the seven elements of the patient journey, and thought creatively about the service at large through the use of an innovations corner. The following provides a one page snapshot of key points from each topic.

Suitability

Assessing a patient's suitability can be difficult, but it comes down to two things:

- Consent and choice
- Home environment

Eligibility is pre-determined; suitability is a decision which is made by a collective of people – patients, their loved ones, their medical practitioner and the service provider.

If suitability decisions were made well, what would it look like for everyone involved?	• Consent to or willing to consider *My Home Hospital* • Ready to embark on it – suitable home environment, ability to manage at home, comfortable that it's the right choice for them • Confident that the right processes and protocols are in place/ have been met.
Key considerations for the service	There are some who won't be suitable for *My Home Hospital* and these include: • People who need intensive monitoring – acuity / unstable • New onset of cognitive impairment / confusion / delirium • Specialised care not currently available in *My Home Hospital* • Those with an insufficient support system at home • Where care is unable to be provided safely for all in the household Inclusion and exclusion criteria need to be developed and finessed – with an end goal to develop a traffic light system making it easier at referral to determine suitability. Care pathways and diagnostic certainty need to be developed / achieved with detailed descriptions of the service / level of care being provided. This will be supported through a clear workflow process –a simple interface for GP's / referrers. A simple to use (but highly effective) risk assessment tool to be developed to support the suitability decision making process. This should include input from the patient / career / loved one.
Innovations which should be explored	• Minimise data entry / duplication – interface which is linked to and able to extract information from to simplify the data entry exercise • Instant messaging to patient – patient portal which allows them to see progress towards suitability, prompters for them to provide extra information, and decisions made (and why)
Unfinished business – questions which remain	• How will we ensure that all risks are explored? Flags that might point out any clinical / risk issues. • Reporting / KPI's and accreditation

Referrals

Referrals captured a lot of attention from the group – this appears to be a topic requiring high levels of clarity and certainty, for medical practitioners and community members alike.

If referrals were done well in *My Home Hospital*, what would it look like for everyone involved?

- Effective and efficient – people would know what was to happen next and the system would 'kick into gear'.
- All 'players' would be confident and certain
- Nothing would get missed – no important information would be lost, missed or duplicated
- It would be timely and matched to the circumstances for the patient.

Key considerations for the service

Duplication appears to be a major issue when it comes to referrals – for patients (telling their story multiple times) and for medical practitioners. Ideally the referral process for *My Home Hospital* is simple, electronic, real time and clarifying for all involved.

In addition, the referral needs to support everyone understanding 'what happens next' so that nobody falls through the cracks and contain enough detail to kick start the care plan.

Participants saw referrals as an opportunity for the patient to begin ownership of their *My Home Hospital* stay – an opportunity for active engagement and patient choice. One of the best ways to ensure this is for referrals to be verbal/conversation based – not written. The process should allow for state of the art record keeping practices.

Innovations which should be explored

- Conversation based referrals
- Liaison officer to support – a concierge.
- Using avatars to explain the program.

Unfinished business – questions which remain

- How to use referrals as a way of assessing the whole patient – not just one diagnosis (complexity and comorbidity)
- Who can make referrals, and who can't?
- How do we make the form / process a 'goldilocks' process – just right!

Service responsiveness

If the service was responsive, what would it look like for everyone involved?	• Everything would happen at the right time – referrals, treatment, communication, discharge. • The service would be efficient with sound protocols in place • Consumer expectations would be met

Key considerations for the service

In some cases, service commencement should be expedited. These sorts of cases would include:

- Severity of diagnosis
- Available supervision at home – living alone
- Home responsibilities – if they are lacking in a support network
- If there are communication difficulties (for whatever reason)
- If comorbidities exist – which make the care more complex
- If the patient is anxious or their carers / loved ones are anxious about the service
- If referral occurs after hours – when it may be hard to access supports.

After hours care needs further thought. Is it OK to phone a patient in the middle of the night, what if they need meds from a pharmacy? What clinicians are available at this time (locums or normal *My Home Hospital* doctors).

Daily visits – you should have someone there every day. The service should provide the same level of care as a hospital.

Innovations which should be explored

- Monitoring / observations done using Bluetooth / VCC
- Ways to get equipment and medication to patients quickly (i.e. 'Uber meds')
- Personal alarms for high risks groups (falls) and a system to link to SAAS
- Capacity dashboard – enable medical practitioners to quickly see capacity of the service
- POC testing – real time labs

Unfinished business – questions which remain

How can the service be sure it doesn't 'scope creep' – independent case audits every 10 patients to see how the process worked, and if they indeed required admission.

Review of DRG's at six and 12 months – with audit and stakeholder engagement.

Workforce KPI's – time to be seen / referral & assessment / patient satisfaction & complaints

Collaborative care

If care was being provided genuinely collaboratively, what would it look like for everyone involved?	• It would start with a question to the patient: *'what is important to you? Who is important to you?* Patient centred, holistic, respectful and culturally appropriate. • It would be seamless – people would tell their story once. • It would allow everyone to contribute to the goals for care. • It would be comprehensive and high quality, safe care.
Key considerations for the service	The program needs to allow all parties to understand each other, and develop a respectful and trusting relationship throughout the episode of care. This will require timely structure and frequent communications – between humans not between systems. Partner in care also means have agreed, documented and measurable goals – which are individualised to the patient and take into account householders and carers. The care needs to be values based – adhering to the principles and living up to safety and quality standards. The program must be established around clear communication and information sharing principles – with multiple beneficiaries – GP's, virtual telehealth staff, regular service providers, family members/loved ones. A multidimensional team!
Innovations which should be explored	• Having everyone 'present' at key junctures – admission, care planning, assessments and discharges • Tailoring care for what the patient needs – what language do they need it in, what other supports do they need, how do they navigate discomfort / complaints, how can the patient become more aware / knowledgeable about their condition and their care. • Electronic client records (with client consent) • Aboriginal cultural advisory role / linkage worker • Volunteer workers to enhance care – record client testimonials, advocacy, doing shopping etc. • Spiritual support if required and requested
Unfinished business – questions which remain	How will *My Home Hospital* interface with RACF / Aged Care Providers and GP's – the details!

Discharge

If discharge was done well, what would it look like for everyone involved?

- The patient's health would be improved – better than admission
- Everyone would know what was going to happen next – roles and responsibility, transfer, when regular services restart
- Information would be shared and accessible – plan and summary
- There would be an opportunity to understand how the experience of *My Home Hospital* was – feedback mechanism.

Key considerations for the service

Discharges work well when:

- Communication is done well / thoroughly
- Details are provided – this is not the time for shortcuts
- Patients are empowered and take charge
- Linkages are made – to follow-up services, allied health, support, education

At admission, the planning for discharge should be happening.

Consider establishing discharge reviews – 3-5 days post. This would help check-in on the patient (duty of care) and source valuable feedback on how to improve the experience. Technology and record keeping is vital – especially for OPD reviews / GP review. Needs to be accessible to all.

Innovations which should be explored

Consider calling discharges 'referral to ongoing care' – so it helps everyone know that the journey to health is not yet complete.

Communication of estimated discharge date with patient – through electronic means.

Unfinished business – questions which remain

Need to think about how to manage discharge information under complex situations – guardian / child protection / other nominated agency.

Process where the MDT comes together to make a decision regarding the best discharge pathway.

Processes and discharge pathways should be developed in more detail with carers, consumers, and clinicians.

Transfer of a deteriorating patient

When transferring a deteriorating patient, what outcomes should be pursued for everyone involved?

- Transfers and the decision to transfer, needs to happen in a timely way – just in time. There should be rapid assessment and good handovers.
- A physical bed needs to be available at the hospital
- Everyone needs to be informed – and understand what is going on.
- People need to be supported – the patient, the loved ones, the carer, the medical practitioners making the decision.
- There needs to be sound stewardship of resources.

Key considerations for the service

It may not always be the goal to prevent patients dying in *My Home Hospital*. For some, end of life might occur in *My Home Hospital*. This is not a 'death avoidance' program.

If it's not warranted to transfer patients back to a hospital, it shouldn't be done. Defining deterioration / pre-escalation planning needs to be done well and thoroughly as part of the care plan. Clinical governance is key.

When transferring, *My Home Hospital* needs to be able to release information that is critical for a patient's health and ongoing care.

The program needs to consider when SA Ambulance Service is required, and when a different mode of transfer can be used. Ideally if transfer happens earlier, it can avoid use of ambulances. Also, carers should be able to accompany patients as much as possible during the transfer.

Need to consider the protocols for transferring patients in the terminal phase.

Innovations which should be explored

- Four way communication – patient / carer / referring and receiving teams
- Concierge process – for in and out of physical hospital
- Rapid response team (mobile treatment) who can also provide a transfer to hospital if required.
- Clinical champions to be a point of liaison to improve trust and debrief around transfers

Unfinished business – questions which remain

What if a patient takes transfer into their own hands? Rings 000 without informing the *My Home Hospital* team?

Unclear governance. There is a need to ensure that anyone who is taking clinical responsibility for a patient is properly qualified.

Interface of services

If services were interfacing together concurrently, what would it look like for everyone involved?	• Everyone would have peace of mind, and be empowered – and they would know what was going on, and who was who. • There would be tolerance for deviation of care – an ability to flex and move as needed. • There would be greater outcomes of care – as everyone is working for the same end. • Information would be available – there as needed.
Key considerations for the service	Clear and transparent communication about expectations, roles and responsibilities is the centrepiece for this to work. This includes: • Clear expectation on the referrer to collect information. • A GP consult needs to be included in the DRG's to ensure all relevant information is captured around patient care and other services. • Clarity around continuity of services and responsibilities of all parties servicing the patient. • Coordination of all the information collected about the patient and services at the point of referral and ongoing during the admission. • Continuity of the program under pandemic outbreak conditions should be clear. Medication management will be important. Continuity of care – ensure the same clinicians are caring for patients throughout an episode. Clinicians with specific skill sets are needed for the identified patient cohorts. Scheduling and visiting times are clear / no surprises. Make sure it's respectful and not disruptive.
Innovations which should be explored	• Cloud based electronic medical records.
Unfinished business – questions which remain	How does *My Home Hospital* fit into broader health pathways – including ongoing chronic disease management? What's the role and regularity of visits from allied health practitioners during care episodes? Where there are services already being delivered in a person's home, need clarity on care arrangements during *My Home Hospital* admission.

Testing

democracyCo was engaged to conduct two testing workshops, with Culturally and Linguistically Diverse (CALD) communities and Carers. Both workshops were held on Tuesday 27th October 2020. Wellbeing SA conducted testing with a range of stakeholders between the Co-Design workshops (without the involvement of democracyCo) – and those notes are provided for completeness at the back of this section.

Wellbeing SA conducted testing separately with a range of stakeholders between the co-design workshops and will continue to test some of the thinking from co-design over the next few months. Some of these stakeholders include the Commonwealth Department of Health and the Aged Care Quality and Safety Commission in regards to the interface with aged care; the National Disability Insurance Scheme in regards to the interface with the disability sector; South Australian Ambulance Service; people from priority care needs groups and GPs and other clinicians. Engagement and continued testing will be a crucial part of the implementation and continuous improvement of the service.

Culturally & Linguistically Diverse (CALD)

CALD workshop process

The CALD workshop was held at the Relationships Australia office in Hindmarsh, with participants being recruited by Relationships Australia using their extensive contact database.

A total of 15 participants attended spanning 12 cultural perspectives. The group was asked to consider what a 'gold standard in multicultural practice' would look like for them – and also how / if they wanted to be engaged going forward.

Key Outcomes: CALD

The key issues and ideas identified by the CALD group are captured below.

Theme	Specific comments / Inputs
Willingness to adopt	Overall, *My Home Hospital* appears to be a very attractive option for many cultural groups. There was general support for the program – particularly as people viewed it as a way to overcome the fear of hospitals that exists in their communities (driven by a fear in 'institutions') as well as practical challenges faced by people who speak a language other than English. Many people also felt the program would be well suited to aged and elderly CALD community members.
Cultural competency	The group discussed cultural competency at length, as they felt this was a key aspect of the success (or not) of the *My Home Hospital* program. They told us "you cannot expect anyone to be an expert on any culture', but instead what you need to put in place are the following processes / mindsets: • Ask questions genuinely and authentically – be curious and 'human' if you

	don't know. • Focus on relationship building – and ensuring that you build a sound, trusting and open relationship with the client and their loved ones in the home. • It would be beneficial to support consistency of cultural knowledge. Their advice was to assign *My Home Hospital* staff to certain cultures – so that they can build their 'muscle' about those cultures and deepen their understanding – don't take a 'vegemite' approach! • Do some basic background work on the culture you are walking in to. Suggested to link the *My Home Hospital* technology platform to the **SBS Cultural Atlas** and **Nations Online** – which both provide basic knowledge about cultures. This will minimise the risk of making cultural errors around gender issues / taboos / religious and cultural protocols / respectful behaviours.
Empowering patients	The group shared with democracyCo that most cultures are traditionally reluctant to question professionals and those in authority – out of respect and tradition for health professionals. They saw an opportunity to help build the 'empowerment muscle' of patients – helping them to be confident to ask questions and seek the information they need – therefore supporting the successful delivery of the program.
Language / Translation	The group discussed the need to use translation services that don't breach privacy of patients. For small cultural communities, it is highly likely that translators may know the patient – and this is an undesirable / unethical position for a patient to be placed into. Also the group advised against using family members (including children) in translation for the same reasons. ***"you wouldn't ask a child of any other patient to take on this responsibility, so why should you ask that for multicultural communities?"*** The group recommended the use of interstate translators for this work.
Health literacy	Overall, health literacy is low in multicultural communities – probably lower than that of the general South Australian population. It was deemed important for the program to seek to improve health literacy – and also to not assume patients and their loved ones would understand basic health concepts. This was seen as a huge barrier to success of the program.
Workforce development	The group also recommended that *My Home Hospital* draw on the immense resource of multicultural health professionals – both practicing and those who may not yet be approved to practice in Australia. Regardless of their medical 'status' in Australia, these people can help their cultural communities to understand and embrace the program – and also build cultural competency of the *My Home Hospital* workforce.

Communications	***"everyone should know the plan…"*** The CALD group felt that if *My Home Hospital* was leading the way in integrating with multicultural communities, it would have a leading edge communications approach. They were comfortable with different people coming to their home, ***"as long as I don't have to keep telling my story".***
Cultural astuteness	Particular cultural groups (i.e. Uyghur Community) highlighted the ongoing stress and anxiety that their community here in South Australia are experiencing as a result of political conflict / dislocation in their home countries. This is a very real-time experience for them – and service providers need to understand the particular fragility and sensitivity for these individuals and family groups – who in many cases have relatives suffering overseas. This will require a level of sensitivity and awareness that the system cannot provide – but the people in the system need to.
Volunteers	The group noted that there were multicultural community volunteers all throughout the SA Health network – who help people settle into hospital and navigate the system. The group saw a valuable use for these volunteers in doing the same in a *My Home Hospital* context – specifically assisting them to navigate the technology.
Technology adoption	In the main, participants felt that most CALD community members are comfortable with technology – as it is a way in which they connect with their families back home on a regular basis. Elderly patients were seen to need specific support – and the group suggested the use of symbols to help older people navigate the technology. They also shared their preference for animations / infographics as well as voice based technology.
Ongoing engagement with multicultural communities	The group explored this issue and democracyCo were advised of a new approach of cultural consultancy being offered through Relationships Australia. This was deemed as a good way to continue exploring issues and designing with CALD communities – as well as through Multi Cultural Communities SA.

Carers

Carers Workshop Process

The Carer workshop was held online using Zoom and participants were invited through Carers SA.

A total of five participants attended the workshop – with three of them from regional communities. The group was asked to share their thoughts about what a 'partner in care' looks like, and also share their ideas for how to minimise the burden on carers through the service.

Background and context for Carers

democracyCo observed that carers were feeling disengaged / disempowered and unheard. This was evident in the workshop – and carers themselves expressed this in the workshop. They expressed frustration in being set aside when it comes to health issues – particularly in their role as a carer. These sentiments were confirmed by Carers SA – who shared with the group that they had recently undertaken a significant survey of carers across the state – and had uncovered the same feelings and views.

"We are not engaged across the health system sufficiently. Why would they listen to us now if they don't already?"

Carer

For *My Home Hospital*, this is critically important to be aware of. The scars left by either a lack of involvement, or bad engagement experiences (by others who have come before you), will impact on the program. It will take time for carers to learn that there has been a change in intent – and it will take sensitivity and care, using relational approaches, to bring carers along on the process, to inform and improve the service.

The carers who participated in the workshop, spoke about their value add – and what they can bring to the broader health picture of the person / people they care for. Their knowledge is immense. This presents a very significant opportunity for *My Home Hospital* to shift the dial on how carers are included at each step of the way, as authentic partners in care.

Key Outcomes: Carers

The key issues and ideas identified by the Carers group are captured below.

Theme	Specific comments / Inputs
Partners in Care	Carers absolutely want to be true and real partners in care. For them this includes: • Not being dismissed as a provider of care; • Integrating with the professionals to evaluate the care and inform the scope of care; • Be understood – even when carers might not be across the technical vernacular and can't speak the language of medical professionals • A clear and written care plan – which is understood by carers, and they are supported to understand it; • Respect for all members of the household – including children. • The ability for the carer to end the stay of care – if it's not working for them (as well as for the patient); • Ability to obtain a second opinion – if they want to • Access to the patients notes – so they can be 'in the loop' of care as a provider. Carers experience in a hospital environment is that they don't matter, they don't have a meaningful role – and this will be unacceptable in a *My Home Hospital* environment which is occurring in their home.
A service in my home	A range of concerns were raised about the service being in a home. These concerns included: • How is medication stored safely? • What happens at midnight when someone gets worse • What if someone gets attacked in the home – a patient or a provider? • What about someone with a disability? Are they eligible? • Whose insurance pays for accidents in the home? Work / health and safety • What if the kids get hold of the iPad and break it? • How will infection control be managed? • What about carers or patients who are non-verbal? • How do we guarantee the home is as clean as a hospital? • Security – will they have a key to my home? • Privacy – how do I know they won't invade my privacy? • If COVID continues, will staff all wear PPE? **"Are they going to come in, turn my home into chaos and turn my life upside down…?"** Carer
Service delivery	Carers raised real concerns about how the program could be run viably and

	professionally. Despite reassurances that the program could be delivered, carers were sceptical. They were concerned about workforce issues – especially in a health system which is currently understaffed. They expressed a lack of trust in institutions – which appears to be influencing their views on the program. Carers also recommended that a good complaints process was put in place – allowing carers to provide feedback on the standard of care / professionalism and any breaches of privacy. Carers see the *My Home Hospital* program as a great benefit, especially for older people – reducing the travel to and from appointments (and the logistics that goes along with that).
Admission and Care Planning	When admission and care planning is happening, there should be an agreement with the carer on what they are willing to do / not willing to do during the *My Home Hospital* stay. A process to empower the carer to make the decision.
Carers advocacy and support	Carers also requested a system of advocacy and support. They said themselves that ***"carers are not great at saying 'I'm overwhelmed'...."*** They said there is a need for someone who can see if things are not working and who can support them - not related to the hospital / medical care. Suggestions included a Counsellor / advocate independent / 24/7 support network that they can call. Peer support could also work. For a process like this to work, it would need to place no judgement on the carer.

Final workshop

The final workshop was an opportunity for Wellbeing SA and Calvary-MediBank to address a range of issues raised in the first co-design sessions – with a focus on highlighting what was being done to consider / incorporate the feedback given. The workshop also enabled participants to spend time on issues of importance to them – and provide their final pieces of advice (for this early stage of the program development) to the *My Home Hospital* team.

Final workshop Agenda

The final co-design workshop was held in Adelaide on the 28th October 2020 for a half day. It included:

Day 3: Final Co-Design Workshop
28th October 2020

- Welcome to Country / Re-entry
- Participants were asked to identify the single powerful insight they had about *My Home Hospital*
- Presentation from Wellbeing SA & Calvary-MediBank – response to co-design
- Presentation from Telstra Health – demonstration of interface
- Participants workshopped their outstanding issues
- Presentation / handover by participants of their advice
- Close and thanks

The workshop was facilitated by democracyCo – and 140 participants attended the workshop – approximately the same participants as highlighted earlier in this report.

Outcomes of Final Co-Design Workshop

The below provides a snapshot summary of the outputs from the session.

Themes (as raised by participants)

The following key issues and themes were raised by the group – and worked on throughout the workshop session.

Patient centred Care

- always include family members loved ones or carers;
- both patients and carers need to be central. They are concerned about being lost in the system. They need to understand the process and the clear pathways and the ways in which they might access different options. They need clear contact numbers not just online platforms - multi form methods of information, pamphlets, online, community presentations;
- the care has to be relevant to the patient and family and carer regardless of the DRG;
- Can carers be individually interviewed – separate to the patient?
- can we inform carers through carer groups and when they register at Centrelink?
- the program needs to be easy and have clear benefits to the patient;
- *My Home Hospital* has to be user friendly.

Engagement of clinicians

- need to sort rate limiting steps to engage clinicians - who can be referred, what capabilities does the service provide;
- being patient centred is great but how do we make it clinician centred too
- will GP's be consulted appropriately?
- engage sub-acute services;
- demonstrate the sufficient skills that are available within the service, but also that it won't impact on service care within a hospital setting - because you still need it;
- *My Home Hospital* has to work closely with the patient's usual GP ;
- Calvary-Medibank needs some local medical professionals involved who understand the South Australian context at the leadership level;
- targeted GP education program run during lunch times in practises or in practise meetings - we can't expect them to build their own knowledge about the program.

Engagement of broad community / SA Public

- need to engage consumers and carers to drive the models of care;
- we need to sell the message authentically - stick to the facts , no blame game;
- build on the support in the room during codesign to create the desire to deal with resistance to change.

Communications about the benefits of the program

- use the media – positive messaging;
- effective public awareness campaign is needed because there will be confusion;
- need to also build awareness about the technology capability because there will be concerns;
- ensure the message that this is a public health care initiative is very clear;
- establish communication platforms for specific groups (cystic fibrosis).

Local Health Networks Involvement / Inclusion

- clear delivery to LHN's and community of the results of the service - accountability and transparency;
- partnerships are critical;
- clear delineation of services is required.

Confidence & trusting relationships

- be clear about what success looks like - is it more people cared for at home vs no increase in activity?
- communications with clinicians and community can be an early win;
- timely information provision;
- provision of the right information;
- ongoing transparency - repeat updates to the participants who have contributed so far in a face to face context every six months;
- don't have a 'too hard basket' - make a plan to address difficult issues;
- partner with residential care, and the established health care team.

Collaborative care

- collaborative and personalised care needs to be firmly embedded in the process.

Mental health support needs to be a key focus

Service delivery

- timeliness and responsiveness will be everything;
- test the programme with early adopters and frequent Flyers until you get it right. Could also test with aged care, start small;
- Test everything prior to implementation;
- importance of short and stay and early supported DC as a referral source;
- Be adaptable to need and to opportunity;
- need for continuous assessment and monitoring of patience including psychosocial parameters and potential anxiety about stuff;
- start small in peri urban areas - potentially start in the Emergency Department and then move into other areas
- fill the void with a South Australian medical workforce;
- medical leadership - separate from the clinical governance team;
- recognise the value of Primary Health sector and how it can support the program;
- capacity dashboard - how many beds are available, how timely is the delivery of service , KPI's.

Technology

- undertake contingency planning for technology failures. make sure that the technology works and gives a good patient experience;
- keep it simple to minimise failure and complexity;
- in principle the technology sounds good and we features are added overtime;
- video options for loved ones and cares made the opportunity to ask questions in a video context, needs its own protocol.

General themes and insights

Participants also left some general comments throughout the session, which included:

- home is more than a house;
- Calvary-MediBank are committed and capable of delivering this service;
- all things are possible if we get the relationships right, and focus on the outcomes;
- How many different problems *My Home Hospital* can help with for different groups?
- Great concept – the sooner the better;
- How few people realise this isn't additional services, but is a shift from public to private;
- It might be possible for some or many patients to avoid the hospital experience, as it has existed thus far;
- *My Home Hospital* will keep families together;
- I have hope!

Engagement Recommendations

Participants in all workshops provided advice and recommendations about how they would prefer to be engaged with going forward.

"I wish that everything I've ever worked on had this amount of people working and contributing to it"

Their summary recommendations include:

- Ongoing face to face engagement – COVID permitting, the strong preference of all participants is to continue to come together in ongoing co-design.
- Diverse groups – overwhelmingly, participants saw value in working with others, especially those with varying perspectives and insights to their own. This bodes well for the spirit and goodwill required for co-design to work effectively for the long term.
- Involvement in continuous improvement – participants want to be involved in design thinking – but also in improvement. They see their value in troubleshooting the project and looking with new eyes at problems.
- Working with the project – participants also highly valued the opportunity to work closely with Calvary-Medibank and Wellbeing SA – and want this continue going forward.

In general terms, democracyCo recommends that going forward the *My Home Hospital* program seeks to engage in a way which:

- Continues to involve a diversity of those affected by the program, as well as those who work in the system.
- Enables evidence based decision making – the sharing of evidence, facts, knowledge and data (even information deemed 'commercial' in nature) to continue to inform decision making / policy and program design.
- Continues to build on the collaboration created through the first stage. Don't be tempted to run engagement for people – adopt the principles of 'with' to everything that you do.
- Allowing sufficient time for good decisions to be made / good advice to be prepared. Allow people with the opportunity for reflection and to work things through in an unpressured and unhurried way.
- Is planned – invest in the development of an engagement strategy – which is shared broadly and widely with the community of interest in this project – so they know what to expect and can hold Wellbeing SA to account. This could be co-created with participants + Wellbeing SA + Calvary-Medibank.

Specifically, we recommend some methods and approaches – which are framed in suggested timeframes: immediate, medium and medium-to-long-term.

Immediate

1. **Immediately establishing a communications line with all 150 participants**
   We recommend that an immediate action following on from this start-up co-design is to open a line of communications which can be used to easily communicate with all participants at all parts of the process. This could be as simple as an email or as complex as an online portal. Whatever tool used, the critical thing will be that it enables two way sharing and ongoing communication.

2. **Immediately reporting back**

We recommend that Wellbeing SA / Calvary-Medibank prepare a "You said, we did" report upon receipt of this engagement report. We think it will indicate a true commitment to co-design if the government / joint venture partners commit in writing to what has changed as a result of the co-design work that has been done. This report should also provide an opportunity for people to provide more feedback – "did we get it right?". This will go a long way to prove that co-design was not a 'one-off' experience.

Medium Term

3. **Prepare a long term engagement strategy**

We recommend that Wellbeing SA and Calvary-Medibank develop a long term engagement strategy – that reflects the work to date and sets the tone and direction for engagement / involvement going forward. This should include a detailed stakeholder analysis and risk analysis – as well as identifying critical engagement methods tailored to specific groups and need. democracyCo also make the observation that the innovative nature of *My Home Hospital* means that it (and the process to design / develop it) could set a new standard across the health sector (in SA and beyond). This engagement strategy could be quite bold in its objectives.

4. **CoP (Community of Practice)**

We recommend that Wellbeing SA / Calvary-Medibank establish – using the 150 people as a starting list – a community of practice. A CoP is a group of people who are interested in the success of the work and are willing to provide input going forward. To formalise this, Wellbeing SA and the Joint Venture partners could ask participants to 'sign-up' and indicate the topics they are interested in contributing to. This allows people to opt-in and provides a ready-made database of people and their interests which can be tapped into as the need arises.

Further, we recommend that the CoP is used to recruit bespoke co-design groups – or if you like a 'pop-up' group – that meets for a certain period of time with a defined focus or topic. This will assist to ensure that a small among of people are not constantly used, preventing burnout of participants.

5. **Engagement of GP / LHN's**

We observed a deep interest in the program from both GP's and LHN's – and in fact would make the observation that their buy-in to the program is one of the key critical success factors. We know they have had a positive engagement experience – but it needs to be sustained – so that they are heard / cared for and their input included in the implementation / monitoring and continuous improvement process.

Medium to Long Term

6. **Gatherings**

We recommend, in line with what we heard, that the program considers a regular gathering of the scale of the co-design workshops once or twice a year. These gatherings are liked by participants, but importantly they are where culture is set – where people have the opportunity to share, network and learn from each other. This is an example of the types of initiatives which should be fleshed out in the long-term engagement strategy. We note that these should only be held if there is a strong, meaningful purpose for the gathering, as bringing people together without purpose could undo the relationships which have been built to date.

7. **Ongoing oversight**

As the project is implemented Wellbeing SA has indicated that they want to have a process of continual review involving the community. democracyCo have recommended this in previous reports. The intent of this will be to improve the transparency of the system as well as to enable improved quality control and refinement of service provision. For this stage we recommend an ongoing advisory group which involves community members as well as service providers and experts.

We would encourage Wellbeing SA and Calvary-Medibank to spend time considering what they want to achieve through the establishment of this group and carefully construct the groups terms of reference in line with this. Setting this group up for success will rely on getting the objectives of the group right (its terms of reference). Clear systems and processes will also be required and built into service providers' contracts to ensure that such an oversight group achieves its objectives. Again these are thing which should be explored in the long-term engagement strategy.