From: Laureen Hines
Sent: Monday, 20 May 2019 12:24 PM
To: Laureen Hines
Subject: FW: Thank you!!!

From: Naomi Dwyer
Sent: Thursday, 22 March 2018 4:00 PM
To: Michael Zanco <Michael.Zanco@health.qld.gov.au>; Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: Thank you!!!

Hi MZ and Laureen

I just wanted to convey my sincere appreciation for your help with HITH review – we really need to get this model of care right, and I have great trust and confidence in the knowledge and expertise you and your team will bring! Thank you Michael for sharing Laureen with us ☺
Cheers
Naomi

Adj Prof Naomi Dwyer
Chief Executive
Sunshine Coast Hospital and Health Service
Adjunct Professor, School of Medicine, Griffith University

Contact:
Bianca Wilson
A/Executive Support Officer to Chief Executive
P: 07 5202 0035
E: SCHHS_Chief_Executive@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

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From: Laureen Hines
Sent: Monday, 20 May 2019 12:24 PM
To: Laureen Hines
Subject: FW: Thank you!!!

From: Michael Zanco
Sent: Thursday, 22 March 2018 8:50 PM
To: Naomi Dwyer <Naomi.Dwyer@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: Re: Thank you!!!

Hello Naomi
It's wonderful to be able to help and great to have you back in Queensland. Laureen is my favourite! She's a HITH rain maker!
Thanks Naomi ok mz

Sent from my iPhone

On 22 Mar 2018, at 4:00 pm, Naomi Dwyer <Naomi.Dwyer@health.qld.gov.au> wrote:

> Hi MZ and Laureen
>
> I just wanted to convey my sincere appreciation for your help with HITH review – we really need to get this model of care right, and I have great trust and confidence in the knowledge and expertise you and your team will bring!
> Thank you Michael for sharing Laureen with us ☺
> Cheers
> Naomi
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> Adj Prof Naomi Dwyer
> Chief Executive
> **Sunshine Coast Hospital and Health Service**
> *Adjunct Professor, School of Medicine, Griffith University*
>
> Contact:
> Bianca Wilson
> A/Executive Support Officer to Chief Executive
> P: 07 5202 0035
> E: SCHHS_Chief_Executive@health.qld.gov.au
> W: http://www.health.qld.gov.au/sunshinecoast
> <image001.png> <image002.png> <image003.png>
> *Sunshine Coast Hospital and Health Service acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.*

From: Laureen Hines
Sent: Monday, 20 May 2019 12:23 PM
To: Laureen Hines
Subject: FW: FOR REVIEW - Draft emails re SCHHS HITH REVIEW to Suzanne Metcalf

From: Laureen Hines
Sent: Wednesday, 4 April 2018 3:14 PM
To: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: Re: FOR REVIEW - Draft emails re SCHHS HITH REVIEW to Suzanne Metcalf

Naomi email feedback.
I think we can meet the brief now we are doing the other days. We just need to say we are commencing the reviews next week and then back with Michael on the 19/20. Ta. Sorry to change my mind.

Laureen Hines
Manager
Healthcare Improvement Unit
Clinical Excellence Division

On 4 Apr 2018, at 1:49 pm, Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au> wrote:

Laureen

3 draft emails for your review.. your call if you want them to come from your email account.

Suzanne Metcalf (to cc Tina Zellar, you, Ted)

Suzanne

As briefly discussed with you yesterday, at the request of SCHHS, the Clinical Excellence Division has commenced a review of the SCHHS Hospital in the Home (HITH) Service, with the formal review scheduled to occur on 19th and 20 April.

Tina Zellar has kindly agreed to assist with the scheduling of all required stakeholder meetings. A meeting with you will likely be scheduled either on 19 or 20 April, however due the volume of stakeholders requiring consultation, we are keen to convene a group meeting (face-to-face, 1 hour in duration) with all nursing directors at SCUH in advance of the formal review (potentially next week, on either 10th or 11th April).

To ensure comprehensive consultation occurs with that stakeholder group (SCUH Nursing Directors), could you advise as to who should be extended an invitation via return email (with a cc to Tina Zellar). As we will be meeting with you at a later date, there is no requirement for you to be in attendance at this meeting.

Thankyou in advance for your consideration of this request.

If any further information is required, please do not hesitate to contact us.

Naomi Dwyer (to cc, you, Ted, Mick, Cang and Piotr & Tina Zellar)

Naomi – Laureen Do we need to mention in this email the need for someone to work up written HITH policies/procedures (As referred to in the last email to Cang, Piotr and Ted)???

A courtesy email to advise that the Clinical Excellence Division has commenced the Hospital in the Home (HITH) Review, as recently commissioned by the SCHHS.

HITH Review – Scope
Members of the HITH Review Team had preliminary discussions with Ted Chamberlain, Cang Dang and Piotr Sweirkowski yesterday (3 April), to clarify the scope of the review, identify current issues, opportunities for improvement, and identify key stakeholders to be consulted. It was apparent from those discussions that the scope of the proposed review was too broad, and that the immediate priority is to ensure the provision of a safe HITH Service. Unless we are advised otherwise, it was agreed by Ted, Cang and Piotr that the review be undertaken in two phases, with the initial phase to focus on a review of the current multi-partner brokerage model and the current challenges associated with that, and the second phase (to occur not long thereafter), to focus on the provision of options (with recommendations and cost/benefit/risk analysis) to enhance access and flow at SCHHS, including optimising the use of HITH and the identification of new patient cohorts. We are advised however that the long-term goal is to ensure that HITH becomes the default referral stream, therefore phase one of the review will encapsulate questioning regarding opportunity identification as it relates to enhancing the access and flow of SCHHS patients.

The draft SCHHHS Review Plan is being amended to reflect the proposed change in scope following discussions yesterday, with a copy to be forwarded to you when finalised, outlining key deliverables/dates.

Stakeholder Consultation
Essentially, due to the volume of stakeholders that require consultation, with the assistance of one of your staff, Tina Zellar, preliminary stakeholder consultations will commence on 10th and 11th April, with the remainder to be scheduled on 19 and 20 April. We have requested a meeting is scheduled with yourself, Cang Dang and Piotr Swierkowski in the late afternoon of 20 April, to verbally update you on preliminary findings.

Regular contact is occurring with Ted as the Project Owner, however should you require any further information or clarification, please do not hesitate to contact Laureen Hines, Manager, Healthcare Improvement Unit, at Laureen.Hines@health.qld.gov.au or Ph. 3328 9937.

Cang, Piotr and Ted (to cc you, Mick, and Naomi)

Cang, Piotr and Ted

Sincere thanks for your time, information and various introductions yesterday, it was very much appreciated.

As discussed with Piotr yesterday, Tina Zellar has been provided with the amended list of stakeholders requiring consultation, and she has kindly agreed to schedule these meeting on our behalf. Given the volume of stakeholders, Laureen and I will likely commence preliminary consultations next week (over 10 & 11 April), with key stakeholder meetings to occur with Mick Young (and ourselves) over 19 and 20 April as initially agreed.

The Draft Review Plan will be amended based on our discussions yesterday around scope, and an email sent to Naomi Dwyer (with a cc to you all), to update her on progress, and the need to

undertake the review in two phases (Phase 1 – review of current model and challenges, Phase 2 – provision of options to enhance access and flow at SCHHS).

As discussed, the immediate priority for SCHHS is to ensure the provision of a safe HITH Service under the current model, therefore SCHHS Executive is strongly encouraged to take whatever action is deemed necessary to ensure this occurs. It was evident from discussions yesterday, that currently there is a lack of written protocols/policies to support the current HITH model, with no resource/FTE allocated to undertake that task. Given the current challenges and safety concerns raised, it is recommended that immediate consideration be given to approving what is understood to be the current vacant HITH CN position, to undertake the task of developing written HITH protocols/policies.

Links to the HITH Referrer Survey (hard copy provided yesterday) discussed yesterday will also be provided shortly for dissemination to stakeholders you deem appropriate, to enable SCHHS to capture baseline data on current barriers and enablers to HITH, and identify future developmental opportunities.

Please feel free to contact Laureen or myself when required.

<image001.gif>

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
w: Queensland Health | **e:** Sonya.Mizzi@health.qld.gov.au

<image002.jpg> <image003.jpg> <image004.jpg> <image005.jpg>

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From: Laureen Hines
Sent: Monday, 20 May 2019 12:23 PM
To: Laureen Hines
Subject: FW: FOR REVIEW - Amended SCHHS HITH Review Plan
Attachments: SCHHS HITH Review Plan_0.2_4AprFNL.doc

Importance: High

From: Sonya Mizzi
Sent: Thursday, 5 April 2018 12:09 PM
To: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: FOR REVIEW - Amended SCHHS HITH Review Plan
Importance: High

Laureen

I've amended the draft HITH Review Plan (amendments noted as track changes, note also the new stakeholder consultation table).

We noted we'd provide to them by this Friday. Know you are busy, if you want to have a quick peruse, I can send them the marked up version (before I leave today at 2), with a view to sending it next week (or this Friday if you are happy too).

Meeting appointments still being scheduled for 10/11 April– spoke with Tina Zellar and everything is on track.

I've left a message for Petra Jones (suggesting a ph. catch up next Thursday).

I'll discuss with you how/when we should engage Nova next week.

Failing that – I'll see you up there on Tuesday (I'll becoming by the office to collect the fleet car). I'll likely just text on Monday just to check if any additional appts have been dropped in the diary.

Queensland Government

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
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Hospital in the Home Review Plan – Sunshine Coast Hospital and Health Service

Healthcare Improvement Unit

April 2018

Healthcare Improvement Unit

Published by the State of Queensland (Queensland Health), April 2018

For more information contact:
Healthcare Improvement Unit Clinical Excellence Division , Department of Health, GPO Box 48, Brisbane QLD 4001, email HIU@health.qld.gov.au, phone 33289154.

An electronic version of this document is available at http://qheps.health.qld.gov.au/caru/

Approval and endorsement

Review Lead

Name	Laureen Hines	
Position	Manager, Healthcare Improvement Unit, Clinical Excellence Division	
Signature		**Date**

Project Owner

Name	Dr Theodore (Ted) Chamberlain	
Position	Senior Medical Superintendent, Maleny Soldiers Memorial Hospital	
Signature		**Date**

Project Sponsors

Name	Adj Professor Naomi Dwyer	
Position	Chief Executive Officer, Sunshine Coast Hospital and Health Service	
Signature		**Date**

Name	Dr Piotr Swierkowski	
Position	Acting Executive Director Clinical Services, Sunshine Coast University Hospital	
Signature		**Date**

Name	Cang Dang	
Position	Service Director, Sunshine Coast University Hospital	
Signature		**Date**

Background

The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH.

To ensure ~~the continuation of~~ a safe, efficient and quality HITH Service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS has engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH Service. HIU, having undertaken recent reviews of various HITH Services statewide, has engaged Dr Michael Young (refer Consultation) to assist with the SCHHS HITH Service review, with ~~a~~ site visits to the Sunshine Coast University Hospital scheduled for 10, 11, 19 and 20 April 2018 to undertake stakeholder consultation. It is envisaged that Dr Young's experience in the clinical delivery of care of HITH, and understanding of the HITH Public Private Partnership, will enhance the quality of this review.

Review Aim

The aim of the HIU review team is to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the ~~following~~ objectives outlined below. Findings, strategic advice and options with recommendations (within current funding), including a cost-benefit and risk analysis, will be provided to SCHHS executive to ensure the provision of a safe, efficient and quality HITH Service at SCHHS into the foreseeable future. As noted in email correspondence from the HIU on 4 April 2018, SCHHS executive is strongly encouraged to take whatever action is deemed necessary to ensure the immediate provision of a safe HITH Service at SCHHS, under the current multi-partner brokerage model.

- Review of decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model will deliver consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH Service.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Admissions (PPAs) (e.g. cellulitis, COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. SCUPH

Review Scope

In scope (but not limited to)

SCHHS HITH Service.

Out of scope

Post-acute and other community services

Methodology

1. The approach used by the HIU review team will be collaborative, supportive, transparent, solution and patient focused.
2. The HIU review team (outlined below) will visit Sunshine Coast University Hospital on 10, 11, 19 and 20 April 2018, to:
    a. Meet with key internal staff across levels and clinical steams, in addition to the external HITH Service providers (refer Consultation below). Note that to maximise the time of the external reviewer, Dr Michael Young, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service, initial stakeholder consultation with nursing, allied health and administration staff will occur over 10 and 11 April, with key medical and emergency department stakeholders to be consulted with input from Dr Young over 19 and 20 April.
    b. Observe models of care and patient flow to the HITH service
3. Review and analyse data related to HITH utilisation (refer Data Collection)
4. Review the following key documents where these exist and are applicable:
    a. Written business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, HITH service provider contracts and related deeds of variation, in addition to customer feedback
    b. Admission processes and service profiles

Consultation

The HIU review team will conduct interviews with a range of internal/external stakeholders (refer ~~table 1~~ below), with the HHS to nominate additional relevant stakeholders to be consulted who may further inform the review (refer Prior to Site Visits). Stakeholders marked with a hash (#), are optional, and may be consulted over 19 and 20 April (pending availability).

Stakeholder	Mode
Chief Executive, SCHHS	face-to-face
HITH Medical Lead	face-to-face
Service Director, Community Integrated & Sub Acute Services	face-to-face
A/ Executive Director Clinical Services	face-to-face
Senior Procurement/Contracts Officer	teleconference
Nambour Hospital A/ Contract Management Director	face-to-face
Billing Officer	teleconference
Quality Improvement Officers	face-to-face
SCUH Hospital NUMs	face-to-face (group)
Gympie/Nambour Hospital NUMs	videoconference (group)
HITH Coordinator/s	face-to-face
SCUH CHIP/Discharge Planners	face-to-face (group)
Gympie Hospital CHIP/Nurse Practitioners	videoconference (group)
SCUH Director of Nursing	face-to-face
SCUH Nursing Directors	face-to-face (group)
SCUH Director of Pharmacy	face-to-face
SCUH Pharmacist	face-to-face
Gympie Hospital Pharmacist #	teleconference/videoconference
SCUH Director of Medicine	face-to-face
Gympie Hospital Director of Medicine #	teleconference/videoconference
SCUH ED Nursing Director	face-to-face
SCUH Director Emergency Department	face-to-face
SCHHS Director Emergency Department	face-to-face
Gympie Hospital Emergency Department SMO #	teleconference/videoconference
Gympie Hospital A/ Facility Manager #	teleconference/videoconference
SCUH Director of Surgery	face-to-face
SCUH Director of Orthopaedics	face-to-face
SCUH Director of Cardiology	face-to-face
SCUH Director of Renal	face-to-face
SCUH Director of Allied Health	face-to-face
Former Clinical Director HITH - SCUH	teleconference
External HITH Providers (Focus Health Care, Silverchain and Blue Care)	face-to-face (Focus Health Care and Silverchain, teleconference (Blue Care)
SCUH Staff Specialist (re Antibiotic Stewardship)	face-to-face
Caloundra Minor Injuries Clinic contact #	teleconference/videoconference

Data Collection

The review will examine the following data elements:

- Total percentage of hospital separations with a component of HITH in the episode of care for ABF reporting hospitals.
- Length of stay for the HITH service
- Percentage of unplanned readmissions within 28 days (same and all DRG)
- Percentage of deaths during the HITH episode of care
- Adverse events (RiskMan)
- DRG referred to HITH

Other data sources to include:

- Customer feedback (applicable)
- Patient chart audits (if required)
- HITH Service provider contracts, and related deeds of variation (all)

Deliverables

Deliverables	Responsibility	Proposed Timeframe
Draft HITH review plan	HIU	3 April 2018
Final HITH review plan	HIU	6 April 2018
HITH review - Interviews/data analysis	HIU Review Team	10, 11, 19 and 20 April 2018
Draft HITH review report	HIU	2 May 2018
Final HITH review report for HHS approval	HIU	9 May 2018

Review Report

The Review Report will be provided to the Chief Executive, SCHHS (and other identified Project Sponsors and the Project Owner), outlining findings and recommendations related to the specified review objectives (refer Review Aim). The service assessment, findings and recommendations will be informed by information provided by the HHS prior to the site visits (refer Prior to Site Visits) and quantitative and qualitative data collected and analysed during the site visits.

Healthcare Improvement Unit (HIU) Review Team

1. Laureen Hines, Manager, HIU
2. Dr Michael (Mick) Young, Medical Director, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service (external reviewer)
3. Sonya Mizzi, Senior Project Officer, HIU

Prior to Site Visits

The Sunshine Coast University Hospital executive will:

- Undertake a communication process advising staff of the purpose of the visit by the HIU.
    - The purpose is to work collaboratively to share knowledge and skills for the optimisation of the HITH service.
- Develop a schedule of meetings (including dissemination of Outlook meeting appointments) for the HIU review team to meet with identified key stakeholders on 10, 11, 19 and 20 April (refer consultation). Additional stakeholders requiring consultation, to also be identified (and meetings scheduled).
- Provide HIU review team with relevant RiskMan/PRIME reports, applicable~~current~~ HITH Service external provider contracts and related deeds of variation, HITH Service protocols/procedures, HITH Referral Form, HITH Nurse Competency List and any applicable customer feedback.

From: Laureen Hines
Sent: Monday, 20 May 2019 12:23 PM
To: Laureen Hines
Subject: FW: Draft Plan for approval
Attachments: SCHHS HITH Review Plan_0.2_4AprFNL.doc

From: Laureen Hines
Sent: Friday, 6 April 2018 5:06 PM
To: Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>; Cang Dang <Cang.Dang@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: Draft Plan for approval

Good Afternoon,

Please find the attached Draft Review Plan. Can you please review this document and provide feedback to Sonia by 11 April 2018. If you are happy with the document and require no changes, please can you all sign an original copy, scan it and send it to us.

Thanks again for your time.

Regards

Laureen Hines - Manager
Healthcare Improvement Unit (HIU) previously CARU
| Clinical Excellence Division|Department of Health, Queensland Government |
www.health.qld.gov.au
Level 2, 15 Butterfield Street,Herston 4006
07 3328 9937
Laureen.hines@health.qld.gov.au

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Sent: Monday, 20 May 2019 12:23 PM
To: Laureen Hines
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From: SC-ESO-EDCS
Sent: Thursday, 12 April 2018 1:36 PM
To: Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>; Cang Dang <Cang.Dang@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>; Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>
Subject: RE: Draft Plan for approval

Good afternoon

As requested, please see attached updated HITH review plan.

Please arrange sign off and return to Sonya Mizzi, HIU.

Kind Regards

Rhiane Watson
Executive Support Officer
Office of the Executive Director Clinical Services
Sunshine Coast Hospital and Health Service
P: 07 5202 0007
E: SC-ESO-EDCS@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

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From: Sonya Mizzi
Sent: Thursday, 12 April 2018 12:39 PM
To: Piotr Swierkowski
Cc: Theodore Chamberlain; Cang Dang; Laureen Hines; Rhiane Watson
Subject: RE: Draft Plan for approval

Piotr

I'll liaise direct with Rhiane shortly – appreciate your feedback.

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
w: Queensland Health | **e:** Sonya.Mizzi@health.qld.gov.au

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From: Piotr Swierkowski
Sent: Thursday, 12 April 2018 12:24 PM
To: Sonya Mizzi
Cc: Theodore Chamberlain; Cang Dang; Laureen Hines; Rhiane Watson
Subject: Re: Draft Plan for approval

Hello Sonya

Some of the titles of people listed as needing to be interviewed probably need adjustments, that's all. Rhiane can probably fix these.
Kind regards
Piotr

Sent from my iPhone

On 12 Apr 2018, at 12:16 PM, Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au> wrote:

> Good morning
>
> Just a courtesy email to advise that as we received no feedback on the draft SCHHS Review Plan by COB yesterday 11 April, I've removed the DRAFT watermark, and kindly request sign-off by the appropriate signatories.
>
> As advised previously, please just sign an original copy, scan and return via email.
>
> If amendment is required, please advise ASAP.
>
> Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
w: Queensland Health | **e:** Sonya.Mizzi@health.qld.gov.au

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Laureen Hines - Manager
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| Clinical Excellence Division|Department of Health, Queensland Government |
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Level 2, 15 Butterfield Street,Herston 4006
07 3328 9937
Laureen.hines@health.qld.gov.au

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<SCHHS HITH Review Plan_FNL_12Apr.doc>

Hospital in the Home Review Plan – Sunshine Coast Hospital and Health Service

Healthcare Improvement Unit

April 2018

Healthcare Improvement Unit

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For more information contact:
Healthcare Improvement Unit Clinical Excellence Division , Department of Health, GPO Box 48, Brisbane QLD 4001, email HIU@health.qld.gov.au, phone 33289154.

An electronic version of this document is available at http://qheps.health.qld.gov.au/caru/

Approval and endorsement

Review Lead

Name	Laureen Hines	
Position	Manager, Healthcare Improvement Unit, Clinical Excellence Division	
Signature		**Date**

Project Owner

Name	Dr Theodore (Ted) Chamberlain	
Position	Senior Medical Superintendent, Maleny Soldiers Memorial Hospital	
Signature		**Date**

Project Sponsors

Name	Adj Professor Naomi Dwyer	
Position	Chief Executive , Sunshine Coast Hospital and Health Service	
Signature		**Date**

Name	Dr Piotr Swierkowski	
Position	Acting Executive Director Clinical Services, Sunshine Coast Hospital and Health Service	
Signature		**Date**

Name	Cang Dang	
Position	Service Director, CISAS, Sunshine Coast Hospital and Health Service	
Signature		**Date**

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- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Admissions (PPAs) (e.g. cellulitis, COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. SCUPH

Review Scope

In scope (but not limited to)

SCHHS HITH Service.

Out of scope

Post-acute and other community services

Methodology

1. The approach used by the HIU review team will be collaborative, supportive, transparent, solution and patient focused.
2. The HIU review team (outlined below) will visit Sunshine Coast University Hospital on 10, 11, 19 and 20 April 2018, to:
    a. Meet with key internal staff across levels and clinical steams, in addition to the external HITH Service providers (refer Consultation below). Note that to maximise the time of the external reviewer, Dr Michael Young, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service, initial stakeholder consultation with nursing, allied health and administration staff will occur over 10 and 11 April, with key medical and emergency department stakeholders to be consulted with input from Dr Young over 19 and 20 April.
    b. Observe models of care and patient flow to the HITH service
3. Review and analyse data related to HITH utilisation (refer Data Collection)
4. Review the following key documents where these exist and are applicable:
    a. Written business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, HITH service provider contracts and related deeds of variation, in addition to customer feedback
    b. Admission processes and service profiles

Consultation

The HIU review team will conduct interviews with a range of internal/external stakeholders (refer below), with the HHS to nominate additional relevant stakeholders to be consulted who may further inform the review (refer Prior to Site Visits). Stakeholders marked with a hash (#), are optional, and may be consulted over 19 and 20 April (pending availability).

Stakeholder	Mode
Chief Executive, SCHHS	face-to-face
HITH Medical Lead	face-to-face
Service Director, Community Integrated & Sub Acute Services	face-to-face
A/ Executive Director Clinical Services	face-to-face
Director, Contracts and Procurement	teleconference
A/ Contract Management Director	face-to-face
CHIP/HITH Admin Officer	teleconference
A/Manager Patient Safety and Patient Safety Officer	face-to-face
SCUH NUMs	face-to-face (group)
Gympie/Nambour Hospital NUMs	videoconference (group)
HITH Coordinator/s	face-to-face
SCUH CHIP/Discharge Planners	face-to-face (group)
Gympie Hospital CHIP/Nurse Practitioners	videoconference (group)
SCUH Director of Nursing	face-to-face
SCUH Nursing Directors	face-to-face (group)
SCUH Director of Pharmacy	face-to-face
SCUH Pharmacist	face-to-face
Gympie Hospital Pharmacist #	teleconference/videoconference
A/Clinical Service Director, Medical Services Group	face-to-face
Clinical Director, Gympie Hospital	teleconference/videoconference
SCUH Nursing Director Emergency Department	face-to-face
SCUH Director Emergency Department	face-to-face
SCHHS Director Emergency Department	face-to-face
Gympie Hospital Emergency Department SMO	teleconference/videoconference
Gympie Hospital Director of Nursing / Facility Manager	teleconference/videoconference
Clinical Service Director, Surgical Services	face-to-face
Director of Orthopaedics	face-to-face
Director of Cardiology	face-to-face
Director of Renal	face-to-face
Executive Director Allied Health	face-to-face
Former Clinical Director HITH	teleconference
External HITH Providers (Focus Health Care, Silverchain and Blue Care)	face-to-face (Focus Health Care and Silverchain, teleconference (Blue Care)
SCUH Staff Specialist (re Antibiotic Stewardship)	face-to-face
Clinical Director, Minor Injury and Illness Clinic	teleconference/videoconference

Data Collection

The review will examine the following data elements:

- Total percentage of hospital separations with a component of HITH in the episode of care for ABF reporting hospitals.
- Length of stay for the HITH service
- Percentage of unplanned readmissions within 28 days (same and all DRG)
- Percentage of deaths during the HITH episode of care
- Adverse events (RiskMan)
- DRG referred to HITH

Other data sources to include:

- Customer feedback (applicable)
- Patient chart audits (if required)
- HITH Service provider contracts, and related deeds of variation (all)

Deliverables

Deliverables	Responsibility	Proposed Timeframe
Draft HITH review plan	HIU	3 April 2018
Final HITH review plan	HIU	6 April 2018
HITH review - Interviews/data analysis	HIU Review Team	10, 11,19 and 20 April 2018
Draft HITH review report	HIU	2 May 2018
Final HITH review report for HHS approval	HIU	9 May 2018

Review Report

The Review Report will be provided to the Chief Executive, SCHHS (and other identified Project Sponsors and the Project Owner), outlining findings and recommendations related to the specified review objectives (refer Review Aim). The service assessment, findings and recommendations will be informed by information provided by the HHS prior to the site visits (refer Prior to Site Visits) and quantitative and qualitative data collected and analysed during the site visits.

Healthcare Improvement Unit (HIU) Review Team

1. Laureen Hines, Manager, HIU
2. Dr Michael (Mick) Young, Medical Director, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service (external reviewer)
3. Sonya Mizzi, Senior Project Officer, HIU

Prior to Site Visits

The Sunshine Coast University Hospital executive will:

- Undertake a communication process advising staff of the purpose of the visit by the HIU.
    - The purpose is to work collaboratively to share knowledge and skills for the optimisation of the HITH service.
- Develop a schedule of meetings (including dissemination of Outlook meeting appointments) for the HIU review team to meet with identified key stakeholders on 10, 11, 19 and 20 April (refer consultation). Additional stakeholders requiring consultation, to also be identified (and meetings scheduled).
- Provide HIU review team with relevant RiskMan/PRIME reports, applicable HITH Service external provider contracts and related deeds of variation, HITH Service protocols/procedures, HITH Referral Form, HITH Nurse Competency List and any applicable customer feedback.

From: Laureen Hines
Sent: Monday, 20 May 2019 12:22 PM
To: Laureen Hines
Subject: FW: SCHHS HITH Review
Attachments: Meeting schedule - SCHHS HITH Review.doc

From: SCHHS-ESO-EDMS
Sent: Thursday, 12 April 2018 3:06 PM
To: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: SCHHS HITH Review

Afternoon ladies

I have confirmed as many of the appointments as possible, unfortunately Arif is not available see attached document.

Regards
Tina

Tina Zeller
Executive Support Officer
Office of the Executive Director Medical Services I Office of the Executive Director Nursing & Midwifery
Sunshine Coast University Hospital
Sunshine Coast Hospital and Health Service
P: 07 520 20008
F: 07 520 20699
E: SCHHS-ESO-EDMS@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

Sunshine Coast Hospital and Health Service acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

From: Laureen Hines
Sent: Monday, 20 May 2019 12:22 PM
To: Laureen Hines
Subject: FW: SCHHS HITH Review
Attachments: Meeting schedule - SCHHS HITH Review.doc

From: Sonya Mizzi
Sent: Thursday, 12 April 2018 3:36 PM
To: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: FW: SCHHS HITH Review

Re Tina's advice re unavailability of Dir of Medicine – Arif – that was just for 19/20 April (both of which are pretty much back-to-back meetings).

As he is a key stakeholder, Tina will request her ESO contact me directly, so we can engage with him (hopefully early next week, or after 20 April).

Tina also advised that Jacinta Thompson (Focushealthcare) is very unhappy with what has unfolded at SCHHS – understand she has requested a meeting with Piotr. Meeting confirmed with her.

Sonya

From: SCHHS-ESO-EDMS
Sent: Thursday, 12 April 2018 3:06 PM
To: Sonya Mizzi; Laureen Hines
Subject: SCHHS HITH Review

Afternoon ladies

I have confirmed as many of the appointments as possible, unfortunately Arif is not available see attached document.

Regards
Tina

Tina Zeller
Executive Support Officer
Office of the Executive Director Medical Services I Office of the Executive Director Nursing & Midwifery
Sunshine Coast University Hospital
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P: 07 520 20008
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Essential meetings with listed stakeholders below over <u>Tues 10th & Wed 11th April</u> (with both Laureen Hines and Sonya Mizzi)	**Mode (Teleconference/Videoconference)**	**<u>Essential</u> meetings to schedule over <u>Thurs 19t & Friday 20 April (with Mick Young - Michael.Young2@health.qld.gov.au, Laureen Hines and Sonya Mizzi)</u>**	**<u>Optional meetings (if can be accommodated/scheduled over Thurs 19 & 20 April</u>) – with Mick Young, Laureen Hines and Sonya Mizzi**
• From mid-morning (10am) • If possible, arrange 1 room for all meetings (with teleconference/ videoconference facilities) , so stakeholders can come to us (with the exception of those listed in next column that could be facilitated either by teleconference/videoconference) • Refer below for stakeholders and proposed meeting duration. Not in any specific order. • Red text denotes further action we (Healthcare Improvement Unit) need to take.	• HIU will dial stakeholders, however kindly request meetings/related appointments be scheduled	• From mid-morning (10am) • All 1 hr in duration (face-to-face), unless specified. • If possible, arrange 1 room for all meetings (with teleconference/ videoconference facilities , so stakeholders can come to us • Refer below for stakeholders. Not in any specific order, unless specified – refer blue text)	• From mid-morning (10am) • 30 mins in duration • Convened via teleconference/videoconference • If possible, arrange 1 room for all meetings (with teleconference/ videoconference facilities) • Refer below for stakeholders. Not in any specific order. • Green text denotes further information to be provided by Ted

Pharmacist – Manoj Nathoo (SCUH) – 30 mins Meeting booked 10/04 @ 11:00 am	Face-to-face	HITH Medical Lead - Ted Chamberlain (30 mins only, at the end of both 19th & 20 April) Meeting booked 19/04 @ 3:30 pm Meeting booked 20/04 @ 3:00 pm	Dir of Medicine (Gympie) –Brian Doolan Not available either day
Billing Officer – Carina Goodrich 30 mins Meeting booed 10/04 @ 10:30 am	Teleconference	CEO, SCHHS – Naomi Dwyer, with Cang Dang and Piotr Swierkowski (potentially last meeting on 20 April Day 2) Meeting booked 20/04 @ 3:30 pm	DON / Facility Manager (Gympie) – Nicole White Meeting booked 19/04 11:30 am
Contract Manager – Kenny Neill 1 hr Kenny Neill is on [redacted] leave Tracey Stubbs will attend in his place Meeting booked 10/04 @ 10:00 am	Teleconference	Director of Nursing – Suzanne Metcalf (Mark Adcock) Meeting booked 20/04 @ 11:00 am	SMO ED (Gympie) – Jason Lindeman Meeting booked 19/04 @ 2:00 pm
HITH Coordinator- Sonia Goodwin and/or Tanya Grant – 1 hr Meeting booked 11/04 @ 1:00 pm	Face-to-face	A/Dir of Medicine - Christine Fawcett ND Medicine – Liz Wilson Meeting booked 20/04 @ 11:30 am	Pharmacist (Gympie) – Kelly Buzza Meeting booked 19/04 @ 2:30 pm
HITH Coordinator & CHIP/Discharge Planners – Tammy Morris Melanie Colless Monique Bennett Yuletta Tait (Huntington) (as group) – 1 hr Meeting booked 10/04 @ 2:00 pm	Face-to-face	Director of Pharmacy – Brett Dalgleish Meeting booked 19/04 @ 11:00 am	Caloundra Minor Injuries Clinic contact –Ted to provide relevant contact details, in addition to the following: • Name of Patient Safety Officer assisting you with HITH patient review • Original contracts related to all applicable deeds of Variations • Comprehensive HITH Nurse Competency List
SCUH NUMs (as group) – 1 hr Suzanne Kelly Sarah Clem Lyn Marusic	Face-to-face (with SCUH NUMs) Ideally videoconference (with (Gympie/Nambour Hospital NUMs)	Director of Surgery – Ratna Aseervatham Meeting booked 19/04 @ 1:00 pm	

Vicki Steed Cindy Roker Sarah Griffiths Helen Beatty Gympie: Deanne Mitchell Juanita Hooper Karen Binger Nambour : Stephanie Nolan Jenny Selfe - MAPU Mark Sierakowski - 3FE Fran Brewster - 2FW Lynn Ashton – LGE Racquel Carr – 3FW Alaina Green - DEM Renee Hutchison - OT Meeting booked 10/04 @ 3:00 pm			
Gympie Nurse Practitioners/CHIP nurses (as group) – 1 hr Nurse Practitioners are: Jason Moloney Cheryl Brown Zane Lay Danielle (Dee) Cox Siobhan McMahon CHIP nurses : Pamela Whitehead Dianne Wilson Meeting booked 10/04 @ 11:30	Ideally Videoconference	A/Dir of Orthopaedics – James Cox Not available either day Suzanne Kelly NUM 3D Meeting booked 18/04 @ 3:00 pm via telephone contact # 5202 8818 John Endacott – CSD CISAS Meeting booked 19/04 @ 12:30 yet TBC	

Quality Improvement Officers – Karen Crocker (A/Manager) Bronwyn Sawers (Patient Safety Officer) – 1 hr Meeting booked 11/04 @ 3:00	Face-to-face	Director of Cardiology - Rohan Poulter Not available	
All Nursing Directors SCUH (group)– 1hr Deb Murray Mark Adcock Taelia Bond PACH Meeting booked 11/04 @ 2:00 pm	Face-to-face	Director of Renal – Nick Gray Not available Craig Allen – MAU Meeting booked 20/04 @ 2:00 Dr Arif Manji – CD Gen Med NOT AVAILABLE	
ED Nurse Director Jackie Clark – 30 mins Meeting booked 10/04 @ 1:30	Face-to-face	Director – ED (SCUH) – Mike Natalie Meeting booked 20/04 @ 12:00 Director ED SCHHS – Ben Close – *on RL teleconference to be arranged upon his return* Director – ED (NGH) – Dan Bitmead *on RL 16-29/04/18*	Support officer for Ben Close is Keely Ritchie Support officer for Dan Bitmead is Cait Donahoo
Director Allied Health Gemma Turato – 30 mins Meeting booked 11/04 @ 11:30	Face-to-face	Kathryn Wilks (re Antibiotic Stewardship) Meeting booked 19/04 @ 10:00 am	
A/ Contract Management Director (Nambour) - Melissa Grimes SCUPH current patients – 45 mins Meeting booked 11/04 @ 10:00 am	Face-to-face	External Provider Silverchain - Sue Meteyard Meeting booked 20/04 @ 1:00 pm	
External Provider - Blue Care –Petra Jones – 30 mins (HIU to arrange)	Teleconference	External Provider (Focused Heath Care) - Jacinta Thompson Meeting booked 19/04 @ 3:00	
Former Clinical Director HITH - Nova Jean Evans – (HIU to arrange) – 30 mins	Teleconference	Director MIIC – Dr Sandra Peters Meeting booked 20/04 @ 2:30 TBC	

Room booked at SCUH for both 10, 11, 19 and 20th of April is - SCUH, L1.SCHHS Exec & Admin. Mtg Rm 02 - 01ADM006.
Teleconference:
Videoconference:

From: Laureen Hines
Sent: Monday, 20 May 2019 12:21 PM
To: Laureen Hines
Subject: FW: SCHHS HITH Review Meeting Schedule - 19 & 20 April attached - I'll bring along some copies
Attachments: HITH Review Meeting Schedule_19_20Apr.doc

From: Sonya Mizzi
Sent: Wednesday, 18 April 2018 11:56 AM
To: Laureen Hines <Laureen.Hines@health.qld.gov.au>; Michael Young <Michael.Young2@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: SCHHS HITH Review Meeting Schedule - 19 & 20 April attached - I'll bring along some copies

Queensland Government

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
w: Queensland Health | **e:** Sonya.Mizzi@health.qld.gov.au

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SCHHS HITH Review Meeting Schedule – 19 & 20 April – Teleconference

Meetings face-to-face with SCUH staff (SCUH,L1.SCHHS Exec & Admin. Mtg Rm 02 - 01ADM006) unless noted otherwise.

Thursday 19 April	**Friday 20 April** (No scheduled break)
10 – 11am - Kathryn Wilks, Staff Specialist, Infectious Disease (re Antiobiotic Stewardship)	**10 – 11am** – Suzanne Metcalf, Exec Dir Nursing & Midwifery, SCUH
11 – 12 noon – Brett Dalgliesh, Director of Pharmacy	**11-12 noon** – Christine Fawcett (A/ Dir of Medicine) & Liz Wilson (Nursing Director, Medicine) *Email rec'd noting Christine's & Dr Ratna Aservatham's interest in assisting with the review of current SCUPH activity/looking at the current data to help analyse how much could be converted to HITH.*
12 – 12:30pm – Nicole White, DoN/Facility Manager, Gympie *Dial in videoconference option -* [redacted]	**12-1pm** – Michael Natale, Director ED (Nambour)
12:30 – 1pm – John Endacott, Clinical Service Director (CISAS) *or by telephone (TBC)*	**1-2pm** – Sue Meteyard (Silverchain – External Provider) *Teleconference:* [redacted] *Videoconferencing:* [redacted]
1 – 2pm – Dr Ratna Aseervatham, Director of Surgery *Email rec'd noting his & Christine Fawcetts' interest in assisting with the review of current SCUPH activity/looking at the current data to help analyse how much could be converted to HITH.*	**2-2.30pm** – Craig Allen, NUM MAPU ½ hr break 2.30 - 3

2-2.30pm – Jason Lindeman, SMO ED (Gympie) *Teleconference:* [redacted] *Videoconferencing:* [redacted] ½ hr break 2.30 – 3, following this meeting	**2:30 – 3pm** – Sandra Peters, Clinical Director, Caloundra Minor Injuries Clinic
3 – 4pm – Jacinta Thompson (Focused Health Care – External Provider)	**3-3:30pm** – Ted Chamberlain (Project Owner)
4 – 4.30pm – Ted Chamberlain (Project Owner)	**3:30 – 4pm** – Naomi Dwyer, Cang Dang, Piotr Swierkowski, Ted Chamberlain (Project Sponsors/Owner)

From: Laureen Hines
Sent: Monday, 20 May 2019 12:21 PM
To: Laureen Hines
Subject: FW: HITH review approval page
Attachments: 20180424093800149.pdf

-----Original Message-----
From: Sonya Mizzi
Sent: Tuesday, 24 April 2018 10:52 AM
To: Rhiane Watson <Rhiane.Watson@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>; Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: FW: HITH review approval page

Rhiane

Many thanks for your assistance with this, I'll make arrangements for Laureen to sign and will forward a copy for your records.

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Department of Health
p:
07 33289079 |
a:
Level 2, 15 Butterfield Street, Herston, QLD, 4006
w:
Queensland Health | e: Sonya.Mizzi@health.qld.gov.au

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-----Original Message-----
From: Rhiane Watson
Sent: Tuesday, 24 April 2018 9:24 AM
To: Sonya Mizzi
Cc: Laureen Hines
Subject: RE: HITH review approval page

Hi Sonya

Please see attached scanned document that has now been signed by everyone except Laureen.

Kind Regards

Rhiane Watson
Executive Support Officer
Office of the Executive Director Clinical Services Sunshine Coast Hospital and Health Service
P: 07 5202 0007
E: SC-ESO-EDCS@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

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-----Original Message-----
From: Sonya Mizzi
Sent: Tuesday, 24 April 2018 8:37 AM
To: Rhiane Watson
Cc: Sonya Mizzi
Subject: RE: HITH review approval page

Rhiane

Just following up on the SCHHS HITH Review Plan - has it been signed off by Naomi Dwyer as yet?

If so, can the document be scanned and emailed back through to us?

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Department of Health
p:
07 33289079 |
a:
Level 2, 15 Butterfield Street, Herston, QLD, 4006
w:
Queensland Health | e: Sonya.Mizzi@health.qld.gov.au

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-----Original Message-----
From: Sonya Mizzi
Sent: Wednesday, 18 April 2018 9:32 AM
To: Rhiane Watson; Laureen Hines
Cc: Sonya Mizzi
Subject: RE: HITH review approval page

Rhiane

Discussed your query about the signing of the HITH Review Plan yesterday. Please make arrangements for Naomi to sign.

As you know, Laureen and I will be at SCUH tomorrow and Friday, so Laureen will be available to sign it while we are there if our paths cross.

Otherwise, just obtain Naomi's signature & scan the whole report back to us via return email.

Many thanks for your assistance.

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Department of Health
p:
07 33289079 |
a:
Level 2, 15 Butterfield Street, Herston, QLD, 4006
w:
Queensland Health | e: Sonya.Mizzi@health.qld.gov.au

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-----Original Message-----
From: Rhiane Watson
Sent: Monday, 16 April 2018 9:17 AM
To: Laureen Hines
Cc: Sonya Mizzi
Subject: HITH review approval page

Good morning again

Ted just walked by my desk so I have his signature now on the same page as Piotr and John (black and white copy though sorry).

Let me know if you want to sign before it is progressed to Naomi.

Kind Regards

Rhiane Watson
Executive Support Officer
Office of the Executive Director Clinical Services Sunshine Coast Hospital and Health Service
P: 07 5202 0007
E: SC-ESO-EDCS@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

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-----Original Message-----
From: Administration_01ADM021_C5503SP@health.qld.gov.au
[mailto:Administration_01ADM021_C5503SP@health.qld.gov.au]
Sent: Monday, 16 April 2018 9:32 AM
To: SC-ESO-EDCS
Subject: Message from "QH12365559"

This E-mail was sent from "QH12365559" (MP C5503).

Scan Date: 04.16.2018 09:31:54 (+1000)
Queries to: Administration_01ADM021_C5503SP@health.qld.gov.au

Clinical Excellence Division

Hospital in the Home Review Plan – Sunshine Coast Hospital and Health Service

Healthcare Improvement Unit
April 2018

Queensland Government

Healthcare Improvement Unit

Published by the State of Queensland (Queensland Health), April 2018

For more information contact:
Healthcare Improvement Unit Clinical Excellence Division , Department of Health, GPO Box 48, Brisbane QLD 4001, email HIU@health.qld.gov.au, phone 33289154.

An electronic version of this document is available at http://qheps.health.qld.gov.au/caru/

Approval and endorsement

Review Lead

Name	Laureen Hines
Position	Manager, Healthcare Improvement Unit, Clinical Excellence Division
Signature	Date

Project Owner

Name	Dr Theodore (Ted) Chamberlain
Position	Senior Medical Superintendent, Maleny Soldiers Memorial Hospital
Signature	T M Chamberlain Date 14/4/2018

Project Sponsors

Name	Adj Professor Naomi Dwyer
Position	Chief Executive , Sunshine Coast Hospital and Health Service
Signature	Date 23.7.18

Name	Dr Piotr Swierkowski
Position	Acting Executive Director Clinical Services, Sunshine Coast Hospital and Health Service
Signature	Date 12 / 04 /2018

Name	JOHN ENDACOTT for Cang Dang
Position	Service Director, CISAS, Sunshine Coast Hospital and Health Service
Signature	Date 13/4/18

Background

The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH.

To ensure a safe, efficient and quality HITH Service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS has engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH Service. HIU, having undertaken recent reviews of various HITH Services statewide, has engaged Dr Michael Young (refer Consultation) to assist with the SCHHS HITH Service review, with site visits to the Sunshine Coast University Hospital scheduled for 10, 11, 19 and 20 April 2018 to undertake stakeholder consultation. It is envisaged that Dr Young's experience in the clinical delivery of care of HITH, and understanding of the HITH Public Private Partnership, will enhance the quality of this review.

Review Aim

The aim of the HIU review team is to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the objectives outlined below. Findings, strategic advice and options with recommendations (within current funding), including a cost-benefit and risk analysis, will be provided to SCHHS executive to ensure the provision of a safe, efficient and quality HITH Service at SCHHS into the foreseeable future. As noted in email correspondence from the HIU on 4 April 2018, SCHHS executive is strongly encouraged to take whatever action is deemed necessary to ensure the immediate provision of a safe HITH Service at SCHHS, under the current multi-partner brokerage model.

- Review of decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model will deliver consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH Service.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Admissions (PPAs) (e.g. cellulitis, COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. SCUPH

Review Scope

In scope (but not limited to)

SCHHS HITH Service.

Out of scope

Post-acute and other community services

Methodology

1. The approach used by the HIU review team will be collaborative, supportive, transparent, solution and patient focused.
2. The HIU review team (outlined below) will visit Sunshine Coast University Hospital on 10, 11, 19 and 20 April 2018, to:
    a. Meet with key internal staff across levels and clinical steams, in addition to the external HITH Service providers (refer Consultation below). Note that to maximise the time of the external reviewer, Dr Michael Young, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service, initial stakeholder consultation with nursing, allied health and administration staff will occur over 10 and 11 April, with key medical and emergency department stakeholders to be consulted with input from Dr Young over 19 and 20 April.
    b. Observe models of care and patient flow to the HITH service
3. Review and analyse data related to HITH utilisation (refer Data Collection)
4. Review the following key documents where these exist and are applicable:
    a. Written business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, HITH service provider contracts and related deeds of variation, in addition to customer feedback
    b. Admission processes and service profiles

Consultation

The HIU review team will conduct interviews with a range of internal/external stakeholders (refer below), with the HHS to nominate additional relevant stakeholders to be consulted who may further inform the review (refer Prior to Site Visits). Stakeholders marked with a hash (#), are optional, and may be consulted over 19 and 20 April (pending availability).

Stakeholder	Mode
Chief Executive, SCHHS	face-to-face
HITH Medical Lead	face-to-face
Service Director, Community Integrated & Sub Acute Services	face-to-face
A/ Executive Director Clinical Services	face-to-face
Director, Contracts and Procurement	teleconference
A/ Contract Management Director	face-to-face
CHIP/HITH Admin Officer	teleconference
A/Manager Patient Safety and Patient Safety Officer	face-to-face
SCUH NUMs	face-to-face (group)
Gympie/Nambour Hospital NUMs	videoconference (group)
HITH Coordinator/s	face-to-face
SCUH CHIP/Discharge Planners	face-to-face (group)
Gympie Hospital CHIP/Nurse Practitioners	videoconference (group)
SCUH Director of Nursing	face-to-face
SCUH Nursing Directors	face-to-face (group)
SCUH Director of Pharmacy	face-to-face
SCUH Pharmacist	face-to-face
Gympie Hospital Pharmacist #	teleconference/videoconference
A/Clinical Service Director, Medical Services Group	face-to-face
Clinical Director, Gympie Hospital	teleconference/videoconference
SCUH Nursing Director Emergency Department	face-to-face
SCUH Director Emergency Department	face-to-face
SCHHS Director Emergency Department	face-to-face
Gympie Hospital Emergency Department SMO	teleconference/videoconference
Gympie Hospital Director of Nursing / Facility Manager	teleconference/videoconference
Clinical Service Director, Surgical Services	face-to-face
Director of Orthopaedics	face-to-face
Director of Cardiology	face-to-face
Director of Renal	face-to-face
Executive Director Allied Health	face-to-face
Former Clinical Director HITH	teleconference
External HITH Providers (Focus Health Care, Silverchain and Blue Care)	face-to-face (Focus Health Care and Silverchain, teleconference (Blue Care)
SCUH Staff Specialist (re Antibiotic Stewardship)	face-to-face
Clinical Director, Minor Injury and Illness Clinic	teleconference/videoconference

Data Collection

The review will examine the following data elements:

- Total percentage of hospital separations with a component of HITH in the episode of care for ABF reporting hospitals.
- Length of stay for the HITH service
- Percentage of unplanned readmissions within 28 days (same and all DRG)
- Percentage of deaths during the HITH episode of care
- Adverse events (RiskMan)
- DRG referred to HITH

Other data sources to include:

- Customer feedback (applicable)
- Patient chart audits (if required)
- HITH Service provider contracts, and related deeds of variation (all)

Deliverables

Deliverables	Responsibility	Proposed Timeframe
Draft HITH review plan	HIU	3 April 2018
Final HITH review plan	HIU	6 April 2018
HITH review - Interviews/data analysis	HIU Review Team	10, 11,19 and 20 April 2018
Draft HITH review report	HIU	2 May 2018
Final HITH review report for HHS approval	HIU	9 May 2018

Review Report

The Review Report will be provided to the Chief Executive, SCHHS (and other identified Project Sponsors and the Project Owner), outlining findings and recommendations related to the specified review objectives (refer Review Aim). The service assessment, findings and recommendations will be informed by information provided by the HHS prior to the site visits (refer Prior to Site Visits) and quantitative and qualitative data collected and analysed during the site visits.

Healthcare Improvement Unit (HIU) Review Team

1. Laureen Hines, Manager, HIU
2. Dr Michael (Mick) Young, Medical Director, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service (external reviewer)
3. Sonya Mizzi, Senior Project Officer, HIU

Prior to Site Visits

The Sunshine Coast University Hospital executive will:

- Undertake a communication process advising staff of the purpose of the visit by the HIU.
    - The purpose is to work collaboratively to share knowledge and skills for the optimisation of the HITH service.
- Develop a schedule of meetings (including dissemination of Outlook meeting appointments) for the HIU review team to meet with identified key stakeholders on 10, 11, 19 and 20 April (refer consultation). Additional stakeholders requiring consultation, to also be identified (and meetings scheduled).
- Provide HIU review team with relevant RiskMan/PRIME reports, applicable HITH Service external provider contracts and related deeds of variation, HITH Service protocols/procedures, HITH Referral Form, HITH Nurse Competency List and any applicable customer feedback.

From: Laureen Hines
Sent: Monday, 20 May 2019 12:21 PM
To: Laureen Hines
Subject: FW: HITH review approval page
Attachments: 20180424093800149.pdf

-----Original Message-----
From: Sonya Mizzi
Sent: Tuesday, 24 April 2018 10:52 AM
To: Rhiane Watson <Rhiane.Watson@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>; Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Subject: FW: HITH review approval page

Rhiane

Many thanks for your assistance with this, I'll make arrangements for Laureen to sign and will forward a copy for your records.

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Department of Health
p:
07 33289079 |
a:
Level 2, 15 Butterfield Street, Herston, QLD, 4006
w:
Queensland Health | e: Sonya.Mizzi@health.qld.gov.au

Queensland's health vision | By 2026 Queenslanders will be among the healthiest people in the world.

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-----Original Message-----
From: Rhiane Watson
Sent: Tuesday, 24 April 2018 9:24 AM
To: Sonya Mizzi
Cc: Laureen Hines
Subject: RE: HITH review approval page

Hi Sonya

Please see attached scanned document that has now been signed by everyone except Laureen.

Kind Regards

Rhiane Watson
Executive Support Officer
Office of the Executive Director Clinical Services Sunshine Coast Hospital and Health Service
P: 07 5202 0007
E: SC-ESO-EDCS@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

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-----Original Message-----
From: Sonya Mizzi
Sent: Tuesday, 24 April 2018 8:37 AM
To: Rhiane Watson
Cc: Sonya Mizzi
Subject: RE: HITH review approval page

Rhiane

Just following up on the SCHHS HITH Review Plan - has it been signed off by Naomi Dwyer as yet?

If so, can the document be scanned and emailed back through to us?

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Department of Health
p:
07 33289079 |
a:
Level 2, 15 Butterfield Street, Herston, QLD, 4006
w:
Queensland Health | e: Sonya.Mizzi@health.qld.gov.au

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-----Original Message-----
From: Sonya Mizzi
Sent: Wednesday, 18 April 2018 9:32 AM
To: Rhiane Watson; Laureen Hines
Cc: Sonya Mizzi
Subject: RE: HITH review approval page

Rhiane

Discussed your query about the signing of the HITH Review Plan yesterday. Please make arrangements for Naomi to sign.

As you know, Laureen and I will be at SCUH tomorrow and Friday, so Laureen will be available to sign it while we are there if our paths cross.

Otherwise, just obtain Naomi's signature & scan the whole report back to us via return email.

Many thanks for your assistance.

Kind regards

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, Department of Health
p:
07 33289079 |
a:
Level 2, 15 Butterfield Street, Herston, QLD, 4006
w:
Queensland Health | e: Sonya.Mizzi@health.qld.gov.au

Queensland's health vision | By 2026 Queenslanders will be among the healthiest people in the world.

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-----Original Message-----
From: Rhiane Watson
Sent: Monday, 16 April 2018 9:17 AM
To: Laureen Hines
Cc: Sonya Mizzi
Subject: HITH review approval page

Good morning again

Ted just walked by my desk so I have his signature now on the same page as Piotr and John (black and white copy though sorry).

Let me know if you want to sign before it is progressed to Naomi.

Kind Regards

Rhiane Watson
Executive Support Officer
Office of the Executive Director Clinical Services Sunshine Coast Hospital and Health Service
P: 07 5202 0007
E: SC-ESO-EDCS@health.qld.gov.au
W: http://www.health.qld.gov.au/sunshinecoast

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-----Original Message-----
From: Administration_01ADM021_C5503SP@health.qld.gov.au
[mailto:Administration_01ADM021_C5503SP@health.qld.gov.au]
Sent: Monday, 16 April 2018 9:32 AM
To: SC-ESO-EDCS
Subject: Message from "QH12365559"

This E-mail was sent from "QH12365559" (MP C5503).

Scan Date: 04.16.2018 09:31:54 (+1000)
Queries to: Administration_01ADM021_C5503SP@health.qld.gov.au

From: Laureen Hines
Sent: Monday, 20 May 2019 1:11 PM
To: Laureen Hines
Subject: FW: HITH Review feedback

From: Dr Michael Young <[redacted]com.au>
Sent: Thursday, 24 May 2018 11:31 AM
To: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: RE: HITH Review feedback

Thanks Laureen – well said.

Mick

From: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Sent: Wednesday, 23 May 2018 5:33 PM
To: Cang Dang <Cang.Dang@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>; Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Dr Michael Young <[redacted]com.au>
Subject: HITH Review feedback

Hi

Thank you for your feedback on the draft SCHHS HITH report. Please see the attached amended documents (dated the 23 May) noting the below changes in line with your comments:

Comment HITH activity section: *Would be good to provide some examples of "Same Day admissions" that would fit under a HITH model (noting the caution against providing outpatient care- last para, p 16 under "Promotion of Service").*

Response: Same day admissions are an exclusion for HITH in Queensland and therefor no examples have been provided.

Comment Length of Stay section: *Imp to note that if these pts were excluded from HITH in our HHS is likely that they would further contribute to hospital access block –*

Response: Wording amended

It is important to acknowledge however, that within SCHHS, if these long-term antibiotic patients were excluded from HITH and not managed through the existing Home IV Antibiotic

Service (HIAS) , they would further adversely impact on access block. Note that reducing LOS increases patient turnover, allowing more patients to be treated under HITH .

Comment referral Process section : *Some issues identified are SCUH-specific. Need to contextualise that this is a whole-of-HHS HITH model which will create facility-specific issues, barriers & solutions and therefore a potential for confusion as a result.*

Response: Wording amended

Introduction - Whilst the HITH referral process outlined below largely pertains to SCUH, it is acknowledged the current HITH service delivery model extends across the entire SCHHS, thereby creating facility specific challenges and barriers, which in turn, will require facility specific solutions.
Body of the section – Clarified the parts that refer directly to SCUH and HHS wide

Comment Referral Process section: *From memory, Townsville's more mature HITH model has dedicated HITH 'leads' in each facility which would facilitate better coordination across facilities.*

Response: Townsville only has one HITH lead however Metro North has one at each site. - Wording amended in the recommendation under Strengthen corporate governance –

Consider nominating a HITH lead at each facility to better facilitate care across SCHHS.

Comment Corporate Governance section *This is incorrect - there was a well-established HITH Clinical Working Group in place at the time the former HITH Clinical Director commenced in the role. However, chairing and maintaining that group was the Clinical Director's responsibility. The HITH Clinical Working Group had multi-facility and multi-service group representation (but with variable attendance). This Group reported to the SCHHS HITH local Governance Committee.*

Response: Wording amended

Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was a perceived lack of a forum for broad consultation or service development. Some stakeholders suggested establishment of a robust Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.
Up until the temporary appointment of the current HITH Medical Officer, the review team understands there was an established HITH Clinical Working Group chaired by the former HITH Medical Officer SCUH, which reported to the SCHHS HITH local Governance Committee. Membership had multi-facility and multi-service group representation, but it is understood attendance was variable. Clinical governance appears to have been the sole responsibility of the former HITH Medical Officer SCUH Clinical Director HITH .

Comment Corporate Governance section : *Do we need a medical model with some redundancy? E.g. two part-timers instead of the full-timer? Is it worth stating that re-engagement of HITH GPs could be considered to enable the necessary redundancy?*

Response: Added Explore alternative Clinical Governance models to recommendations

Revisit Authorised Practitioner Governance Model and consider partnering with general practice to deliver medical governance for HITH patients. Options include:

- HHS contract with credentialed GPs
- Provider contract with credentialed GPs

Comment Recommendation Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes : *?? where does 30% come from*

Response : This is a best guess based on the data we looked at and the understanding that approximately 50% of cellulitis can be managed under HITH.

Comment Recommendation Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes : *EDCS/COO needs to be involved too*

Response: Added to the responsible officer section

Comment Recommendation Improve contract arrangements: *Would add that there would also need to be adequate internal infrastructure (staffing) to accommodate flexing up*

Response: Wording amended - Ensuring the provider commits to being able to deliver flexible volumes of activity as required (i.e. appropriate staffing).

Comment recommendation Stabilise the HITH team*: Current only permanent position is HITH SMO*

Response: change wording to – Permanently recruit to the:

- HITH Senior Medical Officer role
- Establish and permanently recruit HITH administration officer role (1FTE)

Review other positions (i.e. Pharmacy) in line with the selected service delivery model selected *(Toolkit, Service delivery model options).*

Comment recommendation Stabilise the HITH team: *Could we perhaps talk about the 'medical model' rather than the single full time SMO?*
Response: No change. The dedicated HITH MO position is the preferred model and has the most impact. Shared models within other roles do not have the same impact as they get absorbed into other service activity to fix gaps and become no ones responsibility. Happy to discuss.

Comment Tool Kit: *Service Delivery Options attachment – Outsourced Single Provider, internal staffing does not include nursing – need to reconsider this to either have an internal nurse in addition OR replace outsourced provider's CHIP/Case finder with an internal nurse OR nurses in both internal/external teams. There will be longer term benefits with a dedicated internal nurse (e.g. if the HHS changes provider at any time in future)*

Response: Added Clinical Nurses (if not within Provider contract) to the HHS staffing. You can however reduce internal costs by having the provide have case finders within the hospital which negates the need for these HHS resources.

Happy to discuss any concerns. If you are happy with the change please let me know by COB Friday and we will send the final report.

Regards

Laureen Hines - Manager
Healthcare Improvement Unit (HIU) previously CARU

| Clinical Excellence Division|Department of Health, Queensland Government |
www.health.qld.gov.au
Level 2, 15 Butterfield Street,Herston 4006
07 3328 9937
Laureen.hines@health.qld.gov.au

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From: Laureen Hines
Sent: Monday, 20 May 2019 1:13 PM
To: Laureen Hines
Subject: FW: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)
Attachments: Draft_SCHHS HITH Review Final 10.05_final consolidated feedback.doc; Toolkit_Final 10.05 _Feedback.docx

---

From: Piotr Swierkowski
Sent: Friday, 18 May 2018 5:48 PM
To: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Cc: Cang Dang <Cang.Dang@health.qld.gov.au>; Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: FW: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Hello Sonya,

Here is the feedback from all main stakeholders at the SC HHS.

Kind regards
Piotr

From: Laureen Hines
Sent: Thursday, 10 May 2018 1:57 PM
To: Cang Dang <Cang.Dang@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>; Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Michael Young <Michael.Young2@health.qld.gov.au>; Damien Searle <Damien.Searle@health.qld.gov.au>
Subject: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Good Afternoon,
Thanks you for the opportunity to review the HITH service in the Sunshine Coast Hospital and Health Service. Please see the attached draft review and recommendations report including the toolkit provided in confidence. To ensure accuracy of content please review the documents for factual correctness and provide feedback (track changes) to Sonya Sonya.Mizzi@health.qld.gov.au, by close of business **Wednesday 16 May 2018**. Following the receipt of feedback the document will be amended and a final copy sent to all project owner and sponsors.

Regards
Laureen and Sonya

Laureen Hines - Manager
Healthcare Improvement Unit (HIU) previously CARU
| Clinical Excellence Division|Department of Health, Queensland Government |
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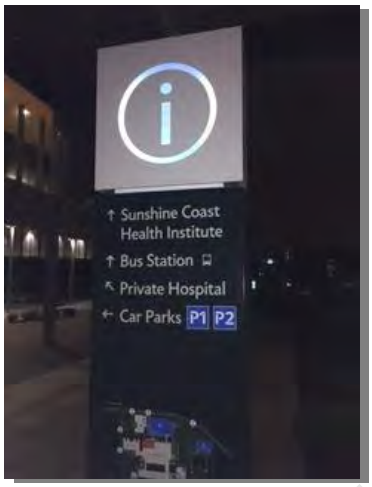
Hospital in the Home (HITH) Review

Sunshine Coast Hospital and Health Service
May 2018



Hospital in the Home (HITH) Review – Sunshine Coast University Hospital, May 2018

Published by the State of Queensland (Queensland Health), May 2018

For more information contact:
Healthcare Improvement Unit, Department of Health, GPO Box 48, Brisbane QLD 4001, email HIU@health.qld.gov.au, phone 3328 9079.

Contents

Introduction

The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the with sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH. To ensure a safe, efficient and quality HITH service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH Service. Site visits to the Sunshine Coast University Hospital (SCUH) by the review team, with input from an external reviewer, Dr Michael Young, Senior Medical Officer, Hospital in the Home Service, the Townsville Hospital, Service Townsville Hospital and Health Service, were conducted on 10 -11 April and 19 - 20 April 2018 respectively.

Review specifications

Objectives

The aim of this body of work was to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the objectives below:

- Review of the decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model delivers consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH Service.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Hospitalisations (PPHs) (e.g. cellulitis, Chronic Obstructive Pulmonary Disease COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. Sunshine Coast University Private Hospital (SCUPH)

Scope

The scope of the review encompassed the entire SCHHS HITH Service, with interviews undertaken with various internal stakeholders from the Sunshine Coast University, Gympie, Nambour, and Maleny hospitals, Caloundra Minor Injuries and Illness Clinic (MIIC), in addition to some external stakeholders (applicable external HITH providers). In scope was also a review and analysis of data related to HITH utilisation, examination of admission processes and service profiles and where applicable, a review of business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, and HITH service provider contracts and related deeds of variation.

The review team were made aware of the SCHHS Executive commissioning of an internal audit of the tendering/contract process as it relates to the *Transitional Care and Other Services Standing Offer Arrangement*, however this was out of scope for the review.

Methodology

The following information sources informed the review findings and recommendations:

- Relevant HITH-related data and other patient flow metrics were sourced from RiskMan, HBCIS, statewide HITH Dashboard and SCUPH contract data.
- Targeted stakeholder interviews to identify opportunities for improvement and growth, barriers/challenges and understand individual/group perceptions of the SCHHS HITH service and access and flow of SCHHS patients.
- Examination of relevant HITH documentation and procedures, including (but not limited to) HITH referral packs, applicable HITH service provider contracts and related deeds of variation.
- Individual opinions/perceptions were tested and validated, with only those opinions shared by two or more sources incorporated into the report to maintain the integrity of same.

Activity data

HITH specific data was obtained through the HOME ward data available in the HBCIS data collection for 2017 calendar year and 2018 available data, via the statewide HITH dashboard developed by the HIU data team. Other inpatient related data was accessed via the HBCIS data from the Health Statistics Branch. Additional data pertaining to the SCUPH and reported blood stream infection rates were sourced directly from applicable service areas within SCHHS.

Consultation

Pre-review interviews where held with the project owner and project sponsors on 3 April 2018 to clarify scope, confirm the review plan and identify key stakeholders for consultation. Extensive face-to-face consultation with internal and external stakeholders occurred over 10, 11, 19 and 20 April, where

stakeholders were unavailable for face-to-face interviews, phone interviews where held on 12,17 and 18 April (Appendix 1). Note that interviews did not occur with the following identified stakeholders, due to their unavailability/unavailability of an appropriate proxy: Nambour Director Emergency Department, SCUH Executive Director Nursing and Midwifery, Director of Cardiology, Director of Renal, Director of Medicine (Gympie), Acting Director of Orthopaedics and the Clinical Director and Emergency Department NUM (Nambour).

Interviews (face-to-face, videoconference and teleconference) convened on 10 and 11 April, phone interviews on 12, 17 and 18 April and face-to-face interviews with external providers (Focus Healthcare and Silver Chain) on 19 and 20 April respectively, were conducted by only some members of the review team (Laureen Hines, with Sonya Mizzi in attendance), to maximise involvement of the external reviewer, Dr Michael Young. The entire review team, including Dr Young did participate in all remaining interviews on 19 and 20 April. Dr Young elected not to participate in external provider interviews due to a reported conflict of interest.

SCHHS HITH Service Observations and Findings

HITH Service Delivery Model

Historically, the SCHHS has participated in a variety of HITH models. The original model commenced providing hospital substitution and post-acute care under the Home Based Acute Care Service (HBACS) model. In 2014 Silver Chain was awarded a central contract to deliver HITH in Queensland and elected to deliver this care in the SCHHS. At this point, the HBACS service was disbanded by the SCHHS and the Hospital in the Home Public Private Partnership Initiative (HITH PPP) commenced on 1 January 2014. The HITH PPP model then ran as an outsourced HITH model of care between 2014 – 2017. During this time, many medical, nursing and administration temporary staff supported the models internally under the SCHHS Minimum Obligatory Human Resource Information (MOHRI).

At the end of the centralised contract period (31 December 2017), SCHHS elected to continue to partner with the Non-Government sector to deliver HITH services. In late 2017, the SCHHS approached the market to extend the *Transitional Care and Other Services Standing Offer Arrangement* to include HITH under a fee-for-service arrangement. An expression of interest (EOI) was sent to the current panel delivering care under this arrangement and opened to other HITH providers. The EOI included HITH specific requirements, and selection was based on a written EOI and the outcome of interviews with the former SCUH Clinical Director HITH. Following this, a Deed of Variation (DoV) was signed with two providers, Silver Chain and Focus Healthcare. Whilst the DoV does outline some high-level Key Performance Indicators (KPIs), it lacks the service level detail outlined in the market documents. As a result, the current arrangement has limited ability to hold the providers to account against the key requirements for service delivery, posing a potential risk to the delivery of high quality service.

Data analysis

HITH Activity

HITH activity across SCHHS accounted for 0.32% of total hospital acute admissions in 2017, compared to the statewide average of 0.72% (Table 1). 2018 saw a slight increase in HITH activity, with 0.35% of

total acute admissions attributable to the SCHHS, compared to the statewide average of 0.66% of hospital acute admissions. Currently the SCHHS HITH activity is well under notional HITH target of 1.5% with considerable opportunity for growth. Within this cohort, no activity was attributable to same day separations which is directly in line with HITH requirements.

Table 1 - SCHHS HITH Service comparative data

Key performance indicator	SCHHS 2017	SCHHS 2018 (Jan to March)	State 2017	State 2018
HITH % total hospital separations	0.32%	0.35%	0.72%	0.66%
Same day % discharge (not present at midnight census)	0	0	0.04%	0.05%
Overnight % discharge (present at midnight census)	0.73%	0.79%	1.4%	1.33%
Readmissions % (same DRG with 28 days)	1.89%	1.61%	2.1%	2.43%
Average Length of Stay (LOS) (days)	14.07	9.63	9.27	8.92

Commented [CD1]: Would be good to provide some examples of "Same Day admissions" that would fit under a HITH model (noting the caution against providing outpatient care- last para, p 16 under "Promotion of Service").

To identify opportunity for growth, comparative data was analysed which confirms potential for growth. As identified (Table 2), each facility was compared to like hospitals, based on volume of presentations and geographical catchment. As identified, each site has a significant opportunity for expansion.

Table 2 - Site comparative data

Site	HITH volume	LOS	Volume
SCUH	193	14	0.35%
Townsville	763	4	1.28%
Nambour	92	16	0.32%
QEII	246	9	0.9%
Gympie	30	8	0.3%
Gladstone	202	8	1.89%

There are opportunities to grow the HITH service and release additional inpatient bed capacity. Table 3 below outlines how this growth can be achieved based on 2017 calendar year data.

Table 3 HITH Growth

To achieve growth of HITH separations by	1%	1.5%
Number of additional patients to be cared for by HITH	988	1481
Referrals required each day (365 days per year)	3	4
HITH beds required at current LOS (14 days)	37	56
HITH beds required if LOS is reduced to 9 days in line with state average	24	36

Readmission rates

Readmission rates are a quality measure for HITH. Low readmission rates for the same condition indicate that patients are receiving the care that is required during the episode of care. HITH patient readmission rates for the same condition for the SCHHS HITH Service

decreased from 1.89% in 2017, to 1.61% in 2018, which is lower than the state average of 2.1% in 2017 and 2.43% in 2018.This data indicates that the service delivered under the current HITH model is meeting the needs of the patients.

Length of Stay (LOS)

Length of Stay is an efficiency measure for HITH and should be reflective of the standard LOS the patient would have received in hospital. The average LOS for SCHHS HITH service has decreased substantially from 14.07 days in 2017, to 9.63 days on 2018. When compared to the HITH state average, which was 9.27 days in 2017, and 8.92 days in 2018, the SCHHS HITH service LOS has been above the state average in both years. Consultation, stakeholders reported that long-term antibiotic patients impact on the overall LOS. Due to the long LOS, the volume of patients that can be referred to HITH is limited as this creates access block. Reducing LOS increases patient turnover, allowing more patients to be treated under HITH.

Commented [CD2]: Imp to note that if these pts were excluded from HITH in our HHS is likely that they would further contribute to hospital access block

Top 10 Diagnosis Related Groups (DRGs) and LOS

Comparative analysis of the top ten DRGs treated under the SCHHS HITH service model of care is shown in Table 4. Analysis identifies that the SCHHS treats different patient cohorts to other services in the state ten. SCHHS HITH service treats a higher volume of J64B, T64B, T60B, X60A, M64A, B07A, I73A, F61A and J68A. The DRGs currently treated under HITH require long length of treatment and may be more suited to being treated in the outpatient setting. The SCHHS currently does not treat L63A Kidney and urinary tract, L63B Kidney and urinary tract, E62A Respiratory infection /inflammation, E62B Respiratory infection /inflammation, T60C Septicaemia and E65A COPD which are seen in high volumes across the state.

Table 4 - SCHHS HITH Service Top 10 DRGs and LOS (includes time spent in hospital) comparison to State – 2018 (January to March)

DRG	Condition	SCHHS % of total admit	State % of total admit	State HITH LOS	SCHHS LOS
J64B	Cellulitis minor	18%	14%	3.7	3.9
J64A	Cellulitis major	8%	13%	5.9	6.4
T64B	Other infections and other disease	21%	14%	16.6	21.9
T60B	Septicaemia	6%	5%	9.8	14.2
X60A	Injuries	4%	3%	16.3	3.3
M64A	Other male reproductive system	20%	3%	27.2	27.2
B07A	Cranl/Prphl nerv and other	50%	9%	14.1	15.6
I73A	Adtcare musck impl/pros	20%	15%	14.2	13.8
F61A	Infect endocarditis	25%	19%	30.5	30
J68A	Major skin disorder	5%	2%	4.6	4

Sunshine Coast University Private Hospital (SCUPH)

The cessation of the SCUPH contract on 20 September 2018 is identified as an opportunity for consideration of the service model. A brief review of confidential 2016-17 SCUPH data (discharging DRGs from SCUPH) identified that 2485 patients transferred to SCUPH presented with conditions traditionally treated under the HITH model of care. There appear adequate volumes for the following DRGs to be considered for treatment by SCHHS HITH service - potentially via a phased implementation across SCHHS facilities: Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations and COPD. Additionally, it would be feasible for the current iTransfer system currently utilised across SCHHS facilities, to be adapted to facilitate referrals to the HITH Service, negating the need for paper-based referrals.

Culture and Readiness

Stakeholders at all levels of the SCHHS organisation, including members of SCHHS Executive, communicated the value of a functional HITH service within SCHHS, and readiness to accept a reviewed model of care (MoC), pending the resolution of identified clinical and corporate governance issues. When asked to identify development opportunities, stakeholders were forthcoming with suggestions to optimise HITH and enhance the access and flow of patients across SCHHS.

Medical buy-in to the HITH model of care is variable and it was noted that the SCHHS, like most HHSs, is a medically-driven model of care. The review team suggests the perceived reluctance to relinquish the care of patients to HITH is likely due to a mistrust, uncertainty around service provision, lack of referral pathways, and lack of understanding of the level and quality of care.

Consistent messages expressed by stakeholders included:

- Unreliable availability
- Ad-hoc service delivery model
- No opportunity to get embedded processes and build confidence due the many internal HITH staff changes (medical/nursing)
- Lack of visibility and ownership

Contractual arrangements

Provider interviewed noted their impetus for interest in the tender process was to establish a 'footprint' in the SCHHS. Acknowledging that SCHHS's plans to grow the HITH service (potentially to 20-40 beds) was also an incentive, both providers sighted concerns regarding a lack of guaranteed volume and types of referrals (sighting more complex patients being referred) and variations of same (adversely impacting staffing). Providers interviewed reported some confusion regarding the Transitional Care and Other Services tender process, sighting difficulties with applying a HITH model to a Transitional Care model (lack of clarity regarding service expectation, expansive service catchment), which resulted in some KPIs not being appropriately aligned to HITH. Additionally, a lack of identified contract governance was sighted (lack of a clearly identified contract/case manager and escalation process). Similarly, providers suggested the current fee for service model does not provide a sustainable cost-viable option to deliver acute care requirements for HITH patients across SCHHS, with feedback suggesting the current model places most of the risk on providers.

HITH Team

SCHHS resources

- 1FTE Medical Officer (currently vacant)
- 1 FTE Administrator (temporary)
- 1 FTE HITH Coordinator (temporary)

External provider resources

- Registered Nurse
- Allied health as required
- After hours on call for patients

HITH hours of operation

SCHHS currently has access to HITH services 7 days a week. The providers deliver home visits between 8am to 6pm, with limited capacity to provide twice daily visits. Patients are identified by the SCHHS Community Hospital Interface Program (CHIP) nurses in the wards or the SCUH HITH Coordinator from Monday to Friday 8am to 4pm. The HITH Medical Officer actively manages current patients, providing oversight for all new referrals and on call coverage (after hours/weekends).

Service catchment

When compared with other HITH service catchment areas statewide, SCHHS HITH service is expansive. Many stakeholders sighted a perceived reluctance and/or inability of the current provider (due to staffing) to service patients that live greater distances from Sunshine Coast University, Nambour, Gympie, Maleny and Caloundra Hospitals especially servicing areas outside of Gympie i.e. Kilkivan, Tin Can Bay and Cooloola Cove, were sighted. Particular difficulties regarding service provision in the surrounding areas of Gympie, Tin Can Bay and Cooloola Cove were reported, resulting in what is perceived as an ad-hoc, unreliable HITH service currently.

Inclusion and Exclusion – Patient Selection

All interviews with stakeholders identified a limited knowledge or misinterpretation of HITH of the inclusion and exclusion criteria for HITH. Clinicians' perception of HITH service appears limited, it being viewed as a long term antibiotic service for patients unable to attend the Home IV Antibiotic Service (HIAS). There appears to be confusion by some medical officers/nursing staff regarding what patients are appropriate to refer to HITH versus the HIAS. Feedback suggests the demarcation between HITH and HIAS services is blurred, with the HITH service being utilised at a 'back-stop' when HIAS is at capacity. This limited understanding largely guides perceptions of HITH and the lack of uptake for any other patient groups.

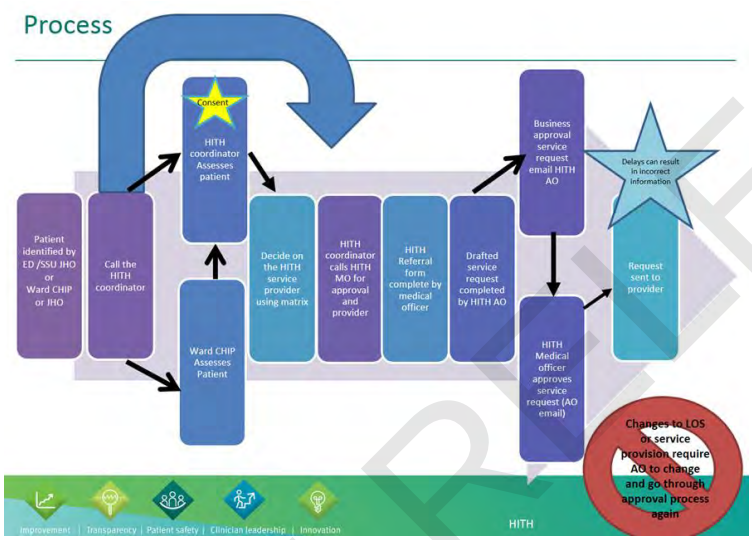
Further impacting HITH uptake there was a common belief that HITH does not see patients in Residential Aged Care Facilities (RACFs), boats, caravans and other temporary dwellings. There was also a demonstrated lack of understanding about the level of service and the number of visits per day providers can deliver.

Referral process

Commented [CD3]: Some issues identified are SCUH-specific.
Need to contextualise that this is a whole-of-HHS HITH model which will create facility-specific issues, barriers & solutions and therefore a potential for confusion as a result. From memory, Townsville's more mature HITH model has dedicated HITH 'leads' in each facility which would facilitate better coordination across facilities.

HITH patients are identified by the SCHHS CHIP nurses in the wards, medical staff or the SCUH HITH Coordinator from Monday to Friday 8 to 4pm (Figure 1). Currently most referrals are received from inpatient units with limited referrals from the Emergency Department (ED).

Figure 1 Referral Process



The referral process consists of a generic referral form and a patient consenting process. The HITH Coordinator completes most of the paperwork and reviews the patients at SCUH, however at the other sites, this is undertaken by the CHIP nurse. Whilst the packaging process is streamlined, the approval process for the fee for service contract is complex and can result in delayed acceptance time.

When discussing HITH with clinical staff from EDs, there were a number of barriers identified. The use of the generic form was considered labour intensive and did not support the understanding of what can be delivered under HITH. Delays caused by multiple acceptance processes also impacted on the timeliness of patients being accepted, resulting in access block in the ED. When the review team discussed condition-specific referral forms, stakeholders identified this would support uptake.

The review identified a lack of direct referrals to HITH from ED. There was a successful three-month trial whereby a CHIP/HITH nurse identified HITH-suitable patients in the Short Stay Unit (SSU). By utilising the SSU to package HITH patients, this created SSU access block and the position was not sustained. Following this trial, feedback from the ED identified there is a perceived limited visibility of the HITH team in the ED, adversely impacting on direct referrals to HITH from ED.

Anecdotal reports suggest that currently some patients that are transferred from the ED to the Medical Assessment Unit (MAU) could be transferred directly to HITH, if there were an easy and clearly understood referral pathway, coupled with an increased understanding of the level of care that can be provided under the HITH Service.

Advice provided suggests that the MIIC is currently providing care for patients via an intravenous antibiotic clinic. Like the MAU, with an increased understanding of HITH and referral pathways, there may be an opportunity to source direct referrals from MIIC.

Pharmacy

It is well documented in the literature that any transfers of care from one service to another, increases medication error risk, and HITH is no exception. The review identified that SCHHS does not have any dedicated pharmacy resource allocated to HITH. It is evident that one of the dispensing pharmacists at the SCUH has taken a lead in supporting HITH within their current role. Within this role some processes have been established to increase consistency and safety. When assessing the current medication management against the HITH Guideline , the service is meeting most requirements, with the exception of the medication reconciliation on discharge, which is an essential part of the transfer of care back to the General Practitioner. Whilst temporary support from this individual is beneficial, consideration needs to be given to the impact on this role if the service grows. Feedback received from Gympie Hospital, suggests there has been an increase in medication related incidents since January 2018, with junior pharmacy staff (in the absence of a Senior Pharmacist) having to make decisions they did not have to make previously under the central contract.

Allied Health

To ensure care is equivalent to that delivered within the acute facility, access to allied health is essential. The review revealed limited engagement or input from allied health in the SCHHS HITH service development and operation. Input from this cohort would broaden the scope of the HITH service and in turn support service delivery, with the cohort able to identify the following potential patient groups for consideration suitable for HITH: high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.

Antimicrobial stewardship

Antimicrobial stewardship is essential in ensuring the care provided to patients is of a high standard and equivalent to inpatient care. Stakeholders identified the need to ensure that patients admitted to HITH need to be prescribed the right antibiotic for the right duration. Currently every patient receiving intravenous antibiotics under HITH is seen by the Infectious Diseases team prior to transfer of care. Whilst reports did not identify this as a barrier to referral, the process could be streamlined with the implementation of clear pathways and agreed treatment options for identified DRGs and patient cohorts.

Governance – Corporate and Clinical

Corporate governance

Appropriate corporate and clinical governance is essential in ensuring the uptake of HITH, safety and quality of service delivery, viability and performance management. HITH in the SCHHS is governed under the Community Integrated & Sub-Acute Services (CISAS) area. The Queensland Department of Health HITH Guideline states "strong corporate governance will provide transparent monitoring/reporting systems, strong clinical leadership, advocacy and clinical risk management". Assessment against the recommended requirements for sound corporate governance are identified in Table 5.

Table 5 - Corporate governance assessment

Recommendation		Comment
The corporate governance structure is to be developed to include representation from all relevant clinical levels and professionals within the HHS and any external providers (if relevant).	✗	Previously met however all relevant clinical areas were not included
HITH services are to be incorporated into the HHS planning and demand management strategies.	✓	
Data and KPIs are to be monitored, analysed and reported via local HHS processes and communicated to all stakeholders on a regular basis.	✗	Previously met however limited to those directly involved only

Feedback reported to the review team identified the current alignment with CISAS may be adversely impacting on the uptake and ownership of the service. While there are some synergies in the delivery of the care in the community, when questioned regarding the best alignment, 90% of stakeholders identified that Medical Services Group would be better placed to provide corporate governance, as an acute HITH service needs to be visible e.g. seen and run as an 'acute virtual ward'.

Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was no forum for broad consultation or service development. Some stakeholders suggested establishment of a Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.

Up until the temporary appointment of the current HITH Medical Officer, clinical governance appears to have been the sole responsibility of the former HITH Medical Officer SCUH Clinical Director HITH.

Commented [CD4]: This is incorrect - there was a well-established HITH Clinical Working Group in place at the time the former HITH Clinical Director commenced in the role. However, chairing and maintaining that group was the Clinical Director's responsibility. The HITH Clinical Working Group had multi-facility and multi-service group representation (but with variable attendance).
This Group reported to the SCHHS HITH local Governance Committee.

Various stakeholders acknowledged the lack of consistent nursing governance and support staff for temporary nursing roles has impacted on the ability to drive HITH from a strategic perspective. Feedback received suggests that in collaboration with the HITH coordinator, and utilisation of CHIP resources, the former Clinical Director HITH was starting to gain traction in terms of communicating a clear vision for HITH/raising HITH profile across the SCHHS, formulating draft processes and procedures, with positive feedback particularly forthcoming regarding building required relationships with key stakeholders. It is suggested that a lack of internal infrastructure and permanently appointed dedicated support personnel has led to the lack of finalised documents, procedures and processes required to underpin a new MoC. As a result, the service is largely person-dependent and reactive, rendering it unsustainable in its current form.

It is acknowledged, that the current HITH Medical Officer, is providing oversight of the day-to-day functioning of the SCHHS HITH service. The role is ensuring a safe service is maintained, with positive feedback received from internal/external stakeholders alike, however this temporary arrangement is unsustainable. Whist this role straddles both clinical and operational service development, with no permanent HITH team supporting that role, this will impede expansion of the service into a sustainable robust model. For sustainability, the SCHHS HITH service should not be person-dependent. Success of the service relies on buy-in from various stakeholder groups, and the skill-set of the generalist medical officer may be well-suited to leading the service.

Commented [CD5]: Agreed – key point and is a critical success factor

Commented [PS6]: Do we need a medical model with some redundancy? E.g. two part-timers instead of the full-timer? Is it worth stating that re-engagement of HITH GPs could be considered to enable the necessary redundancy?

Clinical governance

Clear lines of clinical governance are “essential to ensure a treatment plan (medical management plan) is established and appropriate management and coordination of care is achieved” (HITH Guideline). The governance arrangements for SCHHS align with the HITH Guideline and consist of the following structures:

1. Inpatient Admitting Team Clinical Governance Model

   The treating hospital inpatient authorised practitioner retains responsibility for the care of the patient admitted to HITH throughout the episode of care.

   This model occurs for infectious disease and renal patients.

2. HITH authorised practitioner (dedicated HHS medical resource)

   Care is transferred from the admitting hospital inpatient team to a dedicated HITH authorised practitioner. The HITH authorised practitioner then takes on the responsibility for all care planning and treatment regimes.

   This model occurs for all non-specialty patients.

3. Authorised practitioner Governance Model (External governance Authorised)

   General Practitioners, credentialed with admitting rights within the SCHHS, admit patients under their care, take on the responsibility for all care planning and treatment regimes.

   This model is not currently active, however was available prior to 2018 through a Silver Chain sub-contract with a select group of medical practitioners.

Flexibility in clinical governance models is essential for a successful HITH MoC allowing for more patients to be transferred to HITH. When assessing the SCHHS HITH clinical governance the current model is sound with the SCHHS meeting all requirements (HITH Guideline) .

Patient Safety and Quality of Care

During the last five years of HITH in the SCHHS, formalised quality and safety mechanisms have varied. Throughout the centralised contract period there was a SCHHS quality and safety meeting, chaired by the former SCUH Clinical Director HITH, where processes and all reported incidents were reviewed as part of the centralised joint governance process (incidents reported monthly and discussed formally with HIU and the provider), however this was not held consistently. Since the cessation of the central contract in December 2017, these clinical safety and quality meetings have not been convened.

During the review process some stakeholders reported the lack of formalised process for the management of incidents or the deteriorating patient. Whilst providers are recording incidents (which the review team understand are not being filtered down to Patient Safety Office) and utilising the Queensland Adult Deterioration Detection System (QADDS) to identify a deteriorating process, there is no approved process for the management of these, resulting in a lack of visibility regarding HITH incidents (and related outcomes) by the Patient Safety Office.

It is understood that one impetus for this review was identified safety and quality risks related to the care of consumers, regarding blood stream infections (HCABSIs). The review process revealed that under the central contract (between 2014 – December 2017), there were no reported HCABSIs, however two HCABSIs have been attributed to HITH in January 2018 and March 2018 respectively. The review team understands this spike in HCABSIs was being examined by an Aggregate Review Team on 27 April 2018, with recommendations to follow.

Promotion of Service

The review revealed continued themes of lack of visibility, knowledge of HITH inclusion/exclusion criteria, scope of HITH and who the HITH team is (seen as long-term intravenous antibiotic service). Whilst the former Clinical Director HITH did go some way to promoting the service and building relationships to change the culture of how HITH was viewed within SCHHS, this was largely at the individual level. Some work to build the service was also undertaken with new patient cohorts having been identified, however preliminary discussions were in the early phases. Care does need to be taken to ensure that potential new patient groups, do substitute acute inpatient care and not outpatient care (e.g. Chemotherapy disconnects).

Recommendations and considerations

Recommendation	Actions	Timeframe for delivery	Accountable officer
Enhance service delivery models	Select the appropriate service Delivery model for the SCHHS HITH service *(Toolkit, Service delivery model options).*	2 weeks	SCHHS Executive team
	Immediately review the current Transitional Care and Other Services Standing Offer Arrangement to include more detailed service delivery requirements. Draft a Deed of Variation to include HITH specific requirements.	1 month	HITH Service Group Director
	Commence HITH specific procurement process.	1-6 months	Contracts team with HITH Medical Officer
	Create clear contract management structure with clear accountability, monitoring and communication.	Ongoing	Contracts team with HITH Medical Officer
Increase HITH activity	Set a goal of 1% total activity *(HITH Review, table 3).*	1-2 months	SCHHS Executive team
	Set a goal of 1.5% total activity *(HITH review, table 3).*	6-12 months	SCHHS Executive team
Manage HITH efficiency (Length of Stay)	Review HITH referrals by treating increased volume of HITH patients with a short length of stay and ensure the Infectious disease clinic is utilised for long term patients.	1-6 months	HITH Medical Officer and Director Infectious Diseases
Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Review current pathways used in Townsville Hospital *(Toolkit, Clinical pathways)* to maximise uptake of referrals including: ED direct referrals: - Cellulitis - Warfarin - Mastitis - Hyperemesis gravidarum - Urinary Tract Infection ED or inpatient referrals: - Diverticulitis - Pneumonia - Post operation wound infection - Appendicitis	2-4 months	HITH Medical Officer in partnership with applicable Service Groups

	Develop new clinical pathways to include *(Toolkit, Recommended growth areas and %):* - Heart failure - Non-complex hip and knee replacement (build patient's selection into the pre- admission pathway) - Respiratory conditions bronchiectasis, respiratory infections and Cystic Fibrosis).	6-12 months	HITH Medical Officer in partnership with applicable Service Groups
	Convert 30% of SCUPH activity for Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations to HITH.	2-4 months	EDCS, Director ED and HITH Service Group Director
	Create a direct admission pathway for patients from RACFs.	6-12 months	HITH Medical Officer
	Develop an easy electronic referral platform for pathways for ED i.e. iTransfer.	2-3 months	HITH Service Group Director
Boost culture for HITH sustainability across SCHHS	Enhance visibility of HITH service across SCHHS (including scope, reach, availability and processes) and timely communication of service developments.	1-2 months	HITH Service Group Director
Improve contract arrangements	Review current fee for service model to reflect the acuity of service delivery required for HITH. Models could include: - Percentage (%) of DRG as a costing structure for patients directly out of ED - LOS based payment for patient transferred from inpatient areas to HITH	1-6 months	HITH Service Group Director
	Review the contract to ensure equity of shared risk by: - Addition of a minimum base volume (e.g. 10 beds, as this is a safe risk for the HHS). - Ensuring the provider commits to being able to deliver flexible volumes of activity as required.	1-6 months	HITH Service Group Director

Commented [CD7]: ?? where does 30% come from

Commented [CD8]: EDCS needs to be involved too

Commented [PS9]: Agreed, although the role is being re-badged as the COO at present.

Commented [CD10]: Would add that there would also need to be adequate internal infrastructure (staffing) to accommodate flexing up

Stabilise the HITH team	Permanently recruit to the following positions: - HITH MO role - HITH administration officer Review other positions in line with the selected service delivery model selected *(Toolkit, Service delivery model options).*	1-2 months	HITH Service Group Director
	Consider internal nursing requirements to support HITH referrals and process development.	1-2 months	HITH Service Group Director
Maximise HITH hours of operation	Ensure the providers can receive referrals 24/7 with a clear after-hours approval process in place.	1-3 months	HITH Service Group Director
Extend the service catchment	Ensure the procurement process for the provider has clear expectations on the geographical catchment (e.g. on average HITH Services in Queensland have a 50 km or 45minute radius). Use volume based indicator and patient level data to assess viability of providing care across SCHHS (minimum of 5 beds per day to be viable).	1-6 months	HITH Service Group Director
Increase clarity around HITH inclusion and exclusion criteria	Create a clear flowchart to denote the difference between HIAS and HITH.	1 month	HITH Medical Officer and Director Infectious Diseases
Improve medication management practices (Pharmacy)	Create a process to ensure HITH patients receive a reconciled medication list on discharge.	2 months	Director Pharmacy and HITH Service Group Director
	Create standard process for medication management to support all clinical pharmacists across SCHHS when preparing a patient for, or managing a patient on HITH.	1-2 months	Director Pharmacy and HITH Service Group Director
	Review the HITH implications on pharmacy resources (especially in an expanded service), and consider recruitment of a dedicated HITH pharmacy resource.	1-3 months	Director Pharmacy and HITH Service Group Director
Increase patient groups requiring Allied Health input	Consider patient groups high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.	6-12 months	HITH Medical Officer and Director Allied Health

Commented [CD11]: Current only permanent position is HITH SMO
Would change wording to – permanently recruit to the vacant HITH SMO role and permanently establish and recruit HITH AO and HITH CNs
-Need to have dedicated HITH nurses to support our requirements
-Pharmacy can be considered as part of the 'review of other positions….'

Commented [PS12]: Could we perhaps talk about the 'medical model' rather than the single full time SMO?

Commented [CD13]: Agreed

Streamline antimicrobial stewardship processes	Develop standard antibiotic regimes for the top 3 patient cohorts that require antibiotics.	4-6 months	Director Infectious Diseases with Director Pharmacy
Strengthen corporate governance	Formalise a Governance group with clear Terms of Reference *(Toolkit, Terms of Reference considerations)* to include performance monitoring, quality and safety reporting, DRG expansion, communication and resource development. Membership is to representative of service groups/facilities	1 month	HITH Service Group Director
	Review current corporate governance structure and consider moving under the medical services group to better reflect the acute nature of the HITH service.	1 month	SCHHS Executive team
Embed a patient safety and quality framework	Ensure national safety and quality accreditation requirements are embedded in future HITH contracts	1-6 months	HITH Service Group Director and Contracts team
	Recommence clinical quality and safety meeting with relevant stakeholders	2 months	HITH Service Group Director
	Formalise and document incident management process with provider	1 month	HITH Service Group Director and Safety and Quality team
	Formalise the deteriorating patient process within the contracts	1 month	HITH Service Group Director
Promote HITH Service across SCHHS	Create a multi-modal communication plan for approval by the HITH governance body, including, but not limited to: Resident/Registrar orientation, grand rounds, posters, screen savers, one on one education, nursing orientation, allied health, Case presentations, consumer presentations, newsletters etc *(Toolkit, HITH Program Procedure and Patient handout)*	1-4 months	HITH Service Group Director

Appendices

Appendix 1 – Stakeholder List

Stakeholder interviewed *(SCUH stakeholders unless stated otherwise)*	Date
HITH Medical Lead/Project Owner	3, 10, 11, 19 and 20 April 2018
A/ Executive Director Clinical Services, SCHHS/Project Sponsor	3 and 20 April 2018
Service Director, CISAS, SCHHS/Project Sponsor	3 and 20 April 2018
Chief Executive, SCHHS/Project Sponsor	20 April 2018
Manager, Contracts and Procurement	10 April 2018
CHIP/HITH Administration Officer	10 April 2018
SCUH Pharmacist	10 April 2018
Nambour Hospital NUMs/CHIP nurses (group)	10 April 2018
SCUH NUM, Emergency Department	10 April 2018
SCUH HITH Coordinator	10 April 2018
Gympie Hospital NUMs	10 April 2018
A/ Contract Management Director & A/ Project Manager, Commercial and Contracts	11 April 2018
Nursing Director, PACH	11 April 2018
Executive Director, Allied Health	11 April 2018
SCUH NUMs (small group)	11 April 2018
SCUH Nursing Directors (small group)	11 April 2018
A/ Manager Patient Safety and Patient Safety Officer	11 April 2018
Business Development Manager, HITH, Blue Care	12 April 2018
SCUH Director, Emergency Department	17 April 2018
NUM CHIP, Transition Services	18 April 2018
Nambour Hospital, Director, General Medicine,	18 April 2018
SCUH NUM (Cardiology/Endocrinology)	18 April 2018
SCUH Staff Specialist, Infectious Diseases	19 April 2018
SCUH Director of Pharmacy	19 April 2018
Gympie Hospital Director of Nursing/Facility Manager	19 April 2018
Clinical Director, CISAS	19 April 2018
SCUH Director of Surgery	19 April 2018
Gympie Hospital, SMO, Emergency Department	19 April 2018
Gympie Hospital, Pharmacist	19 April 2018
External HITH Provider, Focus Health Care	19 April 2018
Former SCUH Clinical Director HITH	20 April 2018
A/ Clinical, Service Director, Medical Services Group, Nursing Director, Medicine and ID Physician, Infectious Diseases (group)	20 April 2018
Nambour Hospital, Director, Emergency Department	20 April 2018
Director, Clinical Operations Queensland, Silver Chain and General Manager, East Coast	20 April 2018
Clinical Nurse, MAPU, SCUH	20 April 2018
Clinical Director, Caloundra Minor Injury and Illness Clinic	20 April 2018

Summary

The following resources are provided for reference and consideration. If adapted, appropriate acknowledgements are to be attributed. Word versions can be provided upon request where available.

Relates to Recommendation/s:	Resource description	Comment	Document
Enhance service delivery models/Stablise the HITH Team	Service delivery model options		Service Delivery Model Options.pdf
Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Clinical Pathway – Anticoagulation with warfarin	Sourced from Townsville HHS	cf-hith-anticoagulation-war.pdf
	Clinical Pathway – Appendicitis	Sourced from Townsville HHS	cf-hith-appendicitis.pdf
	Clinical Pathway – Cellulitis	Sourced from Townsville HHS	cf-hith-cellulitis.pdf
	Clinical Pathway – Complicated urinary tract infection	Sourced	cf-hith-complicated-uti.pdf
	Clinical Pathway – Diverticulitis	Sourced from Townsville HHS	cf-hith-diverticulitis.pdf
	Clinical Pathway – Generic	Sourced from Townsville HHS	cf-hith-generic.pdf
	Clinical Pathway – Hyperemesis gravidarum	Sourced from Townsville HHS	cf-hith-hyperemisis-gravidarum.pdf
	Clinical Pathway – Mastitis	Sourced from Townsville HHS	cf-hith-mastitis.pdf

Commented [CD1]: Service Delivery Options attachment – Outsourced Single Provider, internal staffing does not include nursing – need to reconsider this to either have an internal nurse in addition OR replace outsourced provider's CHIP/Case finder with an internal nurse OR nurses in both internal/external teams. There will be longer term benefits with a dedicated internal nurse (e.g. if the HHS changes provider at any time in future)

Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Clinical Pathway – Pneumonia	Sourced from Townsville HHS	 cf-hith-pneumonia.pdf
	Clinical Pathway – Post Operative Wound Infection	Sourced from Townsville HHS	 cf-hith-post-op-wound.pdf
	Recommended growth areas and percentages (%)		 Recommended growth areas and %
Corporate Governance	Terms of reference considerations – Governance Body		 ToR considerations.pdf
Promotion of Service across SCHHS	HITH Program Procedure and Patient Handout	Sourced from Townsville HHS Sourced from Statewide HITH Group	 HITH Procedure  HITH pt handout

From: Laureen Hines
Sent: Monday, 20 May 2019 1:11 PM
To: Laureen Hines
Subject: FW: HITH Review feedback
Attachments: FINAL Report_SCHHS HITH Review_23May.doc; Toolkit_Final 23.05.docx; Amended Draft_SCHHS HITH Review Final 10.05_re SCHHS feedback_22May.doc; AMEND_Service Delivery Model Options_22May18pdf.pdf

From: Laureen Hines
Sent: Wednesday, 23 May 2018 5:33 PM
To: Cang Dang <Cang.Dang@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>; Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Dr Michael Young <michael.young@acutecare.com.au>
Subject: HITH Review feedback

Hi

Thank you for your feedback on the draft SCHHS HITH report. Please see the attached amended documents (dated the 23 May) noting the below changes in line with your comments:

Comment HITH activity section: *Would be good to provide some examples of "Same Day admissions" that would fit under a HITH model (noting the caution against providing outpatient care- last para, p 16 under "Promotion of Service").*

Response: Same day admissions are an exclusion for HITH in Queensland and therefor no examples have been provided.

Comment Length of Stay section: *Imp to note that if these pts were excluded from HITH in our HHS is likely that they would further contribute to hospital access block –*

Response: Wording amended

It is important to acknowledge however, that within SCHHS, if these long-term antibiotic patients were excluded from HITH and not managed through the existing Home IV Antibiotic Service (HIAS) , they would further adversely impact on access block. Note that reducing LOS increases patient turnover, allowing more patients to be treated under HITH .

Comment referral Process section : *Some issues identified are SCUH-specific. Need to contextualise that this is a whole-of-HHS HITH model which will create facility-specific issues, barriers & solutions and therefore a potential for confusion as a result.*

Response: Wording amended

Introduction - Whilst the HITH referral process outlined below largely pertains to SCUH, it is acknowledged the current HITH service delivery model extends across the entire SCHHS, thereby creating facility specific challenges and barriers, which in turn, will require facility specific solutions.
Body of the section – Clarified the parts that refer directly to SCUH and HHS wide

Comment Referral Process section: *From memory, Townsville's more mature HITH model has dedicated HITH 'leads' in each facility which would facilitate better coordination across facilities.*

Response: Townsville only has one HITH lead however Metro North has one at each site. - Wording amended in the recommendation under Strengthen corporate governance –

Consider nominating a HITH lead at each facility to better facilitate care across SCHHS.

Comment Corporate Governance section *This is incorrect - there was a well-established HITH Clinical Working Group in place at the time the former HITH Clinical Director commenced in the role. However, chairing and maintaining that group was the Clinical Director's responsibility. The HITH Clinical Working Group had multi-facility and multi-service group representation (but with variable attendance). This Group reported to the SCHHS HITH local Governance Committee.*

Response: Wording amended

Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was a perceived lack of a forum for broad consultation or service development. Some stakeholders suggested establishment of a robust Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.
Up until the temporary appointment of the current HITH Medical Officer, the review team understands there was an established HITH Clinical Working Group chaired by the former HITH Medical Officer SCUH, which reported to the SCHHS HITH local Governance Committee. Membership had multi-facility and multi-service group representation, but it is understood attendance was variable. Clinical governance appears to have been the sole responsibility of the former HITH Medical Officer SCUH Clinical Director HITH .

Comment Corporate Governance section : *Do we need a medical model with some redundancy? E.g. two part-timers instead of the full-timer? Is it worth stating that re-engagement of HITH GPs could be considered to enable the necessary redundancy?*

Response: Added Explore alternative Clinical Governance models to recommendations

Revisit Authorised Practitioner Governance Model and consider partnering with general practice to deliver medical governance for HITH patients. Options include:

- HHS contract with credentialed GPs
- Provider contract with credentialed GPs

Comment Recommendation Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes : *?? where does 30% come from*

Response : This is a best guess based on the data we looked at and the understanding that approximately 50% of cellulitis can be managed under HITH.

Comment Recommendation Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes : *EDCS/COO needs to be involved too*

Response: Added to the responsible officer section

Comment Recommendation Improve contract arrangements: *Would add that there would also need to be adequate internal infrastructure (staffing) to accommodate flexing up*

Response: Wording amended - Ensuring the provider commits to being able to deliver flexible volumes of activity as required (i.e. appropriate staffing).

Comment recommendation Stabilise the HITH team*: Current only permanent position is HITH SMO*

Response: change wording to – Permanently recruit to the:

- HITH Senior Medical Officer role
- Establish and permanently recruit HITH administration officer role (1FTE)

Review other positions (i.e. Pharmacy) in line with the selected service delivery model selected *(Toolkit, Service delivery model options).*

Comment recommendation Stabilise the HITH team: *Could we perhaps talk about the 'medical model' rather than the single full time SMO?*
Response: No change. The dedicated HITH MO position is the preferred model and has the most impact. Shared models within other roles do not have the same impact as they get absorbed into other service activity to fix gaps and become no ones responsibility. Happy to discuss.

Comment Tool Kit: *Service Delivery Options attachment – Outsourced Single Provider, internal staffing does not include nursing – need to reconsider this to either have an internal nurse in addition OR replace outsourced provider's CHIP/Case finder with an internal nurse OR nurses in both internal/external teams. There will be longer term benefits with a dedicated internal nurse (e.g. if the HHS changes provider at any time in future)*

Response: Added Clinical Nurses (if not within Provider contract) to the HHS staffing. You can however reduce internal costs by having the provide have case finders within the hospital which negates the need for these HHS resources.

Happy to discuss any concerns. If you are happy with the change please let me know by COB Friday and we will send the final report.

Regards

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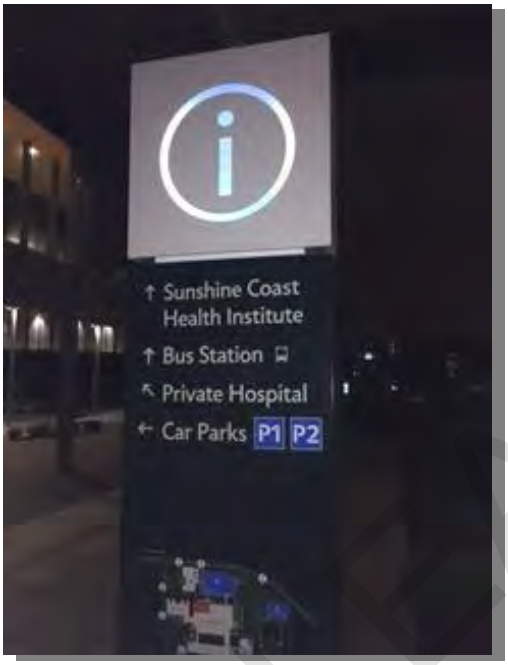
Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

Hospital in the Home (HITH) Review

Sunshine Coast Hospital and Health Service
May 2018



Hospital in the Home (HITH) Review – Sunshine Coast University Hospital, May 2018

Published by the State of Queensland (Queensland Health), May 2018

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Contents

Introduction

The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the with sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH. To ensure a safe, efficient and quality HITH service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH service. Site visits to the SCHHS by the review team, with input from an external reviewer, Dr Michael Young, Senior Medical Officer, Hospital in the Home Service, the Townsville Hospital, Service Townsville Hospital and Health Service, were conducted on 10 -11 April and 19 - 20 April 2018 respectively.

Review specifications

Objectives

The aim of this body of work was to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the objectives below:

- Review of the decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model delivers consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH service.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Hospitalisations (PPHs) (e.g. cellulitis, Chronic Obstructive Pulmonary Disease COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. Sunshine Coast University Private Hospital (SCUPH)

Scope

The scope of the review encompassed the entire SCHHS HITH service, with interviews undertaken with various internal stakeholders from the Sunshine Coast University, Gympie, Nambour, and Maleny hospitals, Caloundra Minor Injuries and Illness Clinic (MIIC), in addition to some external stakeholders (applicable external HITH providers). In scope was also a review and analysis of data related to HITH utilisation, examination of admission processes and service profiles and where applicable, a review of business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, and HITH service provider contracts and related deeds of variation.

The review team were made aware of the SCHHS Executive commissioning of an internal audit of the tendering/contract process as it relates to the *Transitional Care and Other Services Standing Offer Arrangement*, however this was out of scope for the review.

Methodology

The following information sources informed the review findings and recommendations:

- Relevant HITH-related data and other patient flow metrics were sourced from RiskMan, HBCIS, statewide HITH Dashboard and SCUPH contract data.
- Targeted stakeholder interviews to identify opportunities for improvement and growth, barriers/challenges and understand individual/group perceptions of the SCHHS HITH service and access and flow of SCHHS patients.
- Examination of relevant HITH documentation and procedures, including (but not limited to) HITH referral packs, applicable HITH service provider contracts and related deeds of variation.
- Individual opinions/perceptions were tested and validated, with only those opinions shared by two or more sources incorporated into the report to maintain the integrity of same.

Activity data

HITH specific data was obtained through the HOME ward data available in the HBCIS data collection for 2017 calendar year and 2018 available data, via the statewide HITH dashboard developed by the HIU data team. Other inpatient related data was accessed via the HBCIS data from the Health Statistics Branch. Additional data pertaining to the SCUPH and reported blood stream infection rates were sourced directly from applicable service areas within SCHHS.

Consultation

Pre-review interviews where held with the project owner and project sponsors on 3 April 2018 to clarify scope, confirm the review plan and identify key stakeholders for consultation. Extensive face-to-face consultation with internal and external stakeholders occurred over 10, 11, 19 and 20 April, where

stakeholders were unavailable for face-to-face interviews, phone interviews where held on 12,17 and 18 April (Appendix 1). Note that interviews did not occur with the following identified stakeholders, due to their unavailability/unavailability of an appropriate proxy: Nambour Director Emergency Department, Sunshine Coast University Hospital (SCUH) Executive Director Nursing and Midwifery, Director of Cardiology, Director of Renal, Director of Medicine (Gympie), Acting Director of Orthopaedics and the Clinical Director and Emergency Department NUM (Nambour).

Interviews (face-to-face, videoconference and teleconference) convened on 10 and 11 April, phone interviews on 12, 17 and 18 April and face-to-face interviews with external providers (Focus Healthcare and Silver Chain) on 19 and 20 April respectively, were conducted by only some members of the review team (Laureen Hines, with Sonya Mizzi in attendance), to maximise involvement of the external reviewer, Dr Michael Young. The entire review team, including Dr Young did participate in all remaining interviews on 19 and 20 April. Dr Young elected not to participate in external provider interviews due to a reported conflict of interest.

SCHHS HITH Service Observations and Findings

HITH Service Delivery Model

Historically, the SCHHS has participated in a variety of HITH models. The original model commenced providing hospital substitution and post-acute care under the Home Based Acute Care Service (HBACS) model. In 2014 Silver Chain was awarded a central contract to deliver HITH in Queensland and elected to deliver this care in the SCHHS. At this point, the HBACS service was disbanded by the SCHHS and the Hospital in the Home Public Private Partnership Initiative (HITH PPP) commenced on 1 January 2014. The HITH PPP model then ran as an outsourced HITH model of care between 2014 – 2017. During this time, many medical, nursing and administration temporary staff supported the models internally under the SCHHS Minimum Obligatory Human Resource Information (MOHRI).

At the end of the centralised contract period (31 December 2017), SCHHS elected to continue to partner with the Non-Government sector to deliver HITH services. In late 2017, the SCHHS approached the market to extend the *Transitional Care and Other Services Standing Offer Arrangement* to include HITH under a fee-for-service arrangement. An expression of interest (EOI) was sent to the current panel delivering care under this arrangement and opened to other HITH providers. The EOI included HITH specific requirements, and selection was based on a written EOI and the outcome of interviews with the former SCUH Clinical Director HITH. Following this, a Deed of Variation (DoV) was signed with two providers, Silver Chain and Focus Healthcare. Whilst the DoV does outline some high-level Key Performance Indicators (KPIs), it lacks the service level detail outlined in the market documents. As a result, the current arrangement has limited ability to hold the providers to account against the key requirements for service delivery, posing a potential risk to the delivery of high quality service.

Data analysis

HITH Activity

HITH activity across SCHHS accounted for 0.32% of total hospital acute admissions in 2017, compared to the statewide average of 0.72% (Table 1). 2018 saw a slight increase in HITH activity, with 0.35% of

total acute admissions attributable to the SCHHS, compared to the statewide average of 0.66% of hospital acute admissions. Currently the SCHHS HITH activity is well under notional HITH target of 1.5% with considerable opportunity for growth. Within this cohort, no activity was attributable to same day separations which is directly in line with HITH requirements.

Table 1 - SCHHS HITH Service comparative data

Key performance indicator	SCHHS 2017	SCHHS 2018 (Jan to March)	State 2017	State 2018
HITH % total hospital separations	0.32%	0.35%	0.72%	0.66%
Same day % discharge (not present at midnight census)	0	0	0.04%	0.05%
Overnight % discharge (present at midnight census)	0.73%	0.79%	1.4%	1.33%
Readmissions % (same DRG with 28 days)	1.89%	1.61%	2.1%	2.43%
Average Length of Stay (LOS) (days)	14.07	9.63	9.27	8.92

To identify opportunity for growth, comparative data was analysed which confirms potential for growth. As identified (Table 2), each facility was compared to like hospitals, based on volume of presentations and geographical catchment. As identified, each site has a significant opportunity for expansion.

Table 2 - Site comparative data

Site	HITH volume	LOS	Volume
SCUH	193	14	0.35%
Townsville	763	4	1.28%
Nambour	92	16	0.32%
QEII	246	9	0.9%
Gympie	30	8	0.3%
Gladstone	202	8	1.89%

There are opportunities to grow the HITH service and release additional inpatient bed capacity. Table 3 below outlines how this growth can be achieved based on 2017 calendar year data.

Table 3 HITH Growth

To achieve growth of HITH separations by	1%	1.5%
Number of additional patients to be cared for by HITH	988	1481
Referrals required each day (365 days per year)	3	4
HITH beds required at current LOS (14 days)	37	56
HITH beds required if LOS is reduced to 9 days in line with state average	24	36

Readmission rates

Readmission rates are a quality measure for HITH. Low readmission rates for the same condition indicate that patients are receiving the care that is required during the episode of care. HITH patient readmission rates for the same condition for the SCHHS HITH Service

decreased from 1.89% in 2017, to 1.61% in 2018, which is lower than the state average of 2.1% in 2017 and 2.43% in 2018.This data indicates that the service delivered under the current HITH model is meeting the needs of the patients.

Length of Stay (LOS)

Length of Stay is an efficiency measure for HITH and should be reflective of the standard LOS the patient would have received in hospital. The average LOS for SCHHS HITH service has decreased substantially from 14.07 days in 2017, to 9.63 days on 2018. When compared to the HITH state average, which was 9.27 days in 2017, and 8.92 days in 2018, the SCHHS HITH service LOS has been above the state average in both years. Stakeholders reported that long-term antibiotic patients impact on the overall LOS. Due to the long LOS, the volume of patients that can be referred to HITH is limited as this creates access block. It is important to acknowledge however, that within SCHHS, if these long-term antibiotic patients were excluded from HITH and not managed through the existing Home IV Antibiotic Service (HIAS), they would further adversely impact on access block. Note that reducing LOS increases patient turnover, allowing more patients to be treated under HITH.

Top 10 Diagnosis Related Groups (DRGs) and LOS

Comparative analysis of the top ten DRGs treated under the SCHHS HITH service model of care is shown in Table 4. Analysis identifies that the SCHHS treats different patient cohorts to other services in the state ten. SCHHS HITH service treats a higher volume of J64B, T64B, T60B, X60A, M64A, B07A, I73A, F61A and J68A. The DRGs currently treated under HITH require long length of treatment and may be more suited to being treated in the outpatient setting. The SCHHS currently does not treat L63A Kidney and urinary tract, L63B Kidney and urinary tract, E62A Respiratory infection /inflammation, E62B Respiratory infection /inflammation, T60C Septicaemia and E65A COPD which are seen in high volumes across the state.

Table 4 - SCHHS HITH Service Top 10 DRGs and LOS (includes time spent in hospital) comparison to State – 2018 (January to March)

DRG	Condition	SCHHS % of total admit	State % of total admit	State HITH LOS	SCHHS LOS
J64B	Cellulitis minor	18%	14%	3.7	3.9
J64A	Cellulitis major	8%	13%	5.9	6.4
T64B	Other infections and other disease	21%	14%	16.6	21.9
T60B	Septicaemia	6%	5%	9.8	14.2
X60A	Injuries	4%	3%	16.3	3.3
M64A	Other male reproductive system	20%	3%	27.2	27.2
B07A	Cranl/Prphl nerv and other	50%	9%	14.1	15.6
I73A	Adtcare musck impl/pros	20%	15%	14.2	13.8
F61A	Infect endocarditis	25%	19%	30.5	30
J68A	Major skin disorder	5%	2%	4.6	4

Sunshine Coast University Private Hospital (SCUPH)

The cessation of the SCUPH contract on 20 September 2018 is identified as an opportunity for consideration of the service model. A brief review of confidential 2016-17 SCUPH data (discharging DRGs from SCUPH) identified that 2485 patients transferred to SCUPH presented with conditions traditionally treated under the HITH model of care. There appear adequate volumes for the following DRGs to be considered for treatment by SCHHS HITH service - potentially via a phased implementation across SCHHS facilities: Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations and COPD. Additionally, it would be feasible for the current iTransfer system currently utilised across SCHHS facilities, to be adapted to facilitate referrals to the HITH service, negating the need for paper-based referrals.

Culture and Readiness

Stakeholders at all levels of the SCHHS organisation, including members of SCHHS Executive, communicated the value of a functional HITH service within SCHHS, and readiness to accept a reviewed model of care (MoC), pending the resolution of identified clinical and corporate governance issues. When asked to identify development opportunities, stakeholders were forthcoming with suggestions to optimise HITH and enhance the access and flow of patients across SCHHS.

Medical buy-in to the HITH model of care is variable and it was noted that the SCHHS, like most HHSs, is a medically-driven model of care. The review team suggests the perceived reluctance to relinquish the care of patients to HITH is likely due to a mistrust, uncertainty around service provision, lack of referral pathways, and lack of understanding of the level and quality of care.

Consistent messages expressed by stakeholders included:

- Unreliable availability
- Ad-hoc service delivery model
- No opportunity to get embedded processes and build confidence due the many internal HITH staff changes (medical/nursing)
- Lack of visibility and ownership

Contractual arrangements

Provider interviewed noted their impetus for interest in the tender process was to establish a 'footprint' in the SCHHS. Acknowledging that SCHHS's plans to grow the HITH service (potentially to 20-40 beds) was also an incentive, both providers sighted concerns regarding a lack of guaranteed volume and types of referrals (sighting more complex patients being referred) and variations of same (adversely impacting staffing). Providers interviewed reported some confusion regarding the Transitional Care and Other Services tender process, sighting difficulties with applying a HITH model to a Transitional Care model (lack of clarity regarding service expectation, expansive service catchment), which resulted in some KPIs not being appropriately aligned to HITH. Additionally, a lack of identified contract governance was sighted (lack of a clearly identified contract/case manager and escalation process). Similarly, providers suggested the current fee for service model does not provide a sustainable cost-viable option to deliver acute care requirements for HITH patients across SCHHS, with feedback suggesting the current model places most of the risk on providers.

HITH Team

SCHHS resources

- 1FTE Medical Officer (currently vacant)
- 1 FTE Administrator (temporary)
- 1 FTE HITH Coordinator (temporary)

External provider resources

- Registered Nurse
- Allied health as required
- After hours on call for patients

HITH hours of operation

SCHHS currently has access to HITH services 7 days a week. The providers deliver home visits between 8am to 6pm, with limited capacity to provide twice daily visits. Patients are identified by the SCHHS Community Hospital Interface Program (CHIP) nurses in the wards or the SCUH HITH Coordinator from Monday to Friday 8am to 4pm. The HITH Medical Officer actively manages current patients, providing oversight for all new referrals and on call coverage (after hours/weekends).

Service catchment

When compared with other HITH service catchment areas statewide, SCHHS HITH service is expansive. Many stakeholders sighted a perceived reluctance and/or inability of the current provider (due to staffing) to service patients that live greater distances from Sunshine Coast University, Nambour, Gympie, Maleny and Caloundra Hospitals especially servicing areas outside of Gympie i.e. Kilkivan, Tin Can Bay and Cooloola Cove, were sighted. Particular difficulties regarding service provision in the surrounding areas of Gympie, Tin Can Bay and Cooloola Cove were reported, resulting in what is perceived as an ad-hoc, unreliable HITH service currently.

Inclusion and Exclusion – Patient Selection

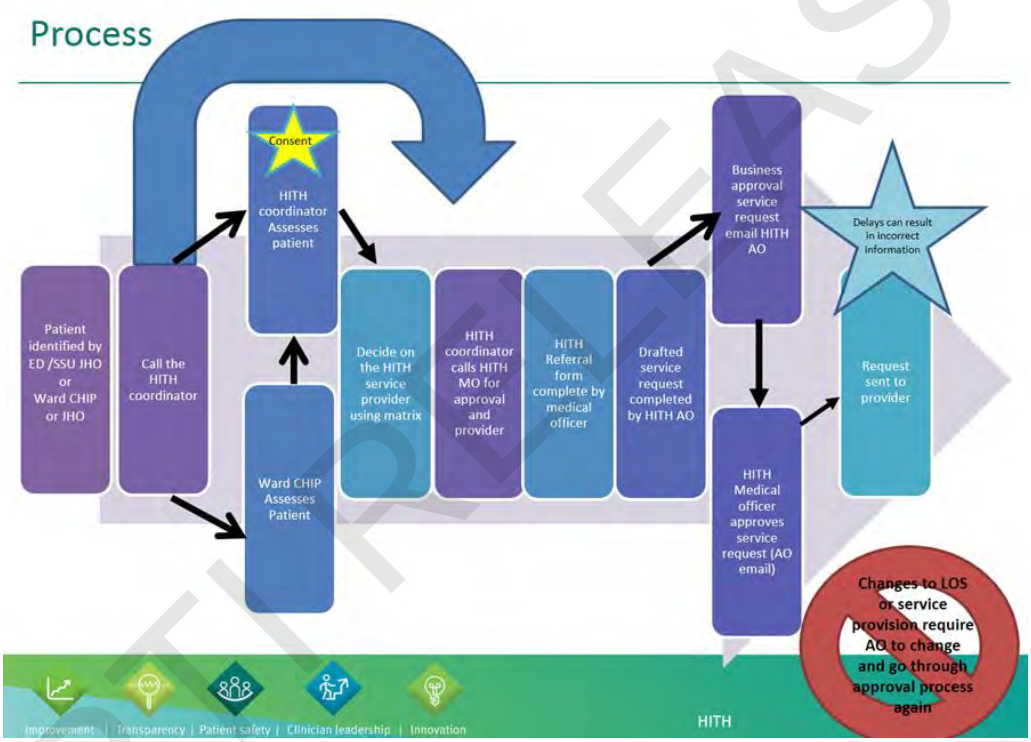
All interviews with stakeholders identified a limited knowledge or misinterpretation of HITH of the inclusion and exclusion criteria for HITH. Clinicians' perception of HITH service appears limited, it being viewed as a long-term antibiotic service for patients unable to attend the Home IV Antibiotic Service (HIAS). There appears to be confusion by some medical officers/nursing staff regarding what patients are appropriate to refer to HITH versus the HIAS. Feedback suggests the demarcation between HITH and HIAS services is blurred, with the HITH service being utilised at a 'back-stop' when HIAS is at capacity. This limited understanding largely guides perceptions of HITH and the lack of uptake for any other patient groups.

Further impacting HITH uptake there was a common belief that HITH does not see patients in Residential Aged Care Facilities (RACFs), boats, caravans and other temporary dwellings. There was also a demonstrated lack of understanding about the level of service and the number of visits per day providers can deliver.

Referral process

Whilst the HITH referral process outlined below largely pertains to SCUH, it is acknowledged the current HITH service delivery model extends across the entire SCHHS, thereby creating facility specific challenges and barriers, which in turn, will require facility specific solutions. At all facilities it was reported that HITH patients are identified by the SCHHS CHIP nurses in the wards, medical staff or the SCUH HITH Coordinator from Monday to Friday 8 to 4pm (Figure 1), with most referrals received from inpatient units and limited referrals from the HHS Emergency Departments (EDs).

Figure 1 Referral Process at SCUH



The referral process consists of a generic referral form and a patient consenting process. At the SCUH the HITH Coordinator completes most of the paperwork and reviews the SCUH patients, however at other sites, this is undertaken by the CHIP nurse. Whilst the packaging process is streamlined, the approval process for the fee for service contract is complex and can result in delayed acceptance time.

When discussing HITH with clinical staff from EDs, there were a number of barriers identified. The use of the generic form was considered labour intensive and did not support the understanding of what can be delivered under HITH. Delays caused by multiple acceptance processes also impacted on the timeliness of patients being accepted, resulting in access block in EDs. When the review team discussed condition-specific referral forms, stakeholders identified this would support uptake.

The review identified a lack of direct referrals to HITH from EDs across the HHS. There was a successful three-month trial at SCUH, whereby a CHIP/HITH nurse identified HITH-suitable patients in the Short Stay Unit (SSU). By utilising the SSU to package HITH patients, this created SSU access block and the

position was not sustained. Following this trial, feedback from the SCUH ED identified there is a perceived limited visibility of the HITH team in the ED, adversely impacting on direct referrals to HITH from ED.

Anecdotal reports from SCUH, suggest that currently some patients are transferred from the ED to the Medical Assessment Unit (MAU), could be transferred directly to HITH, if there was an easy and clearly understood referral pathway, coupled with an increased understanding of the level of care that can be provided under the HITH service.

Advice provided suggests that the MIIC is currently providing care for patients via an intravenous antibiotic clinic. Like the MAU, with an increased understanding of HITH and referral pathways, there may be an opportunity to source direct referrals from MIIC.

Pharmacy

It is well documented in the literature that any transfers of care from one service to another, increases medication error risk, and HITH is no exception. The review identified that SCHHS does not have any dedicated pharmacy resource allocated to HITH. It is evident that one of the dispensing pharmacists at the SCUH has taken a lead in supporting HITH within their current role. Within this role some processes have been established to increase consistency and safety. When assessing the current medication management against the HITH Guideline , the service is meeting most requirements, with the exception of the medication reconciliation on discharge, which is an essential part of the transfer of care back to the General Practitioner. Whilst temporary support from this individual is beneficial, consideration needs to be given to the impact on this role if the service grows. Feedback received from Gympie Hospital, suggests there has been an increase in medication related incidents since January 2018, with junior pharmacy staff (in the absence of a Senior Pharmacist) having to make decisions they did not have to make previously under the central contract.

Allied Health

To ensure care is equivalent to that delivered within the acute facility, access to allied health is essential. The review revealed limited engagement or input from allied health in the SCHHS HITH service development and operation. Input from this cohort would broaden the scope of the HITH service and in turn support service delivery, with the cohort able to identify the following potential patient groups for consideration suitable for HITH: high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.

Antimicrobial stewardship

Antimicrobial stewardship is essential in ensuring the care provided to patients is of a high standard and equivalent to inpatient care. Stakeholders identified the need to ensure that patients admitted to HITH need to be prescribed the right antibiotic for the right duration. Currently every patient receiving intravenous antibiotics under HITH is seen by the Infectious Diseases team prior to transfer of care. Whilst reports did not identify this as a barrier to referral, the process could be streamlined with the implementation of clear pathways and agreed treatment options for identified DRGs and patient cohorts.

Governance – Corporate and Clinical

Corporate governance

Appropriate corporate and clinical governance is essential in ensuring the uptake of HITH, safety and quality of service delivery, viability and performance management. HITH in the SCHHS is governed under the Community Integrated & Sub-Acute Services (CISAS) area. The Queensland Department of Health HITH Guideline states "strong corporate governance will provide transparent monitoring/reporting systems, strong clinical leadership, advocacy and clinical risk management". Assessment against the recommended requirements for sound corporate governance are identified in Table 5.

Table 5 - Corporate governance assessment

Recommendation		Comment
The corporate governance structure is to be developed to include representation from all relevant clinical levels and professionals within the HHS and any external providers (if relevant).	✗	Previously met however all relevant clinical areas were not included
HITH services are to be incorporated into the HHS planning and demand management strategies.	✓	
Data and KPIs are to be monitored, analysed and reported via local HHS processes and communicated to all stakeholders on a regular basis.	✗	Previously met however limited to those directly involved only

Feedback reported to the review team identified the current alignment with CISAS may be adversely impacting on the uptake and ownership of the service. While there are some synergies in the delivery of the care in the community, when questioned regarding the best alignment, 90% of stakeholders identified that Medical Services Group would be better placed to provide corporate governance, as an acute HITH service needs to be visible e.g. seen and run as an 'acute virtual ward'.

Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was a perceived lack of a forum for broad consultation or service development. Some stakeholders suggested establishment of a robust Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.

Up until the temporary appointment of the current HITH Medical Officer, the review team understands there was an established HITH Clinical Working Group chaired by the former HITH Medical Officer SCUH, which reported to the SCHHS HITH local Governance Committee. Membership had multi-facility and multi-service group representation, but it is understood attendance was variable..

Various stakeholders acknowledged the lack of consistent nursing governance and support staff for temporary nursing roles has impacted on the ability to drive HITH from a strategic perspective. Feedback received suggests that in collaboration with the HITH coordinator, and utilisation of CHIP resources, the former Clinical Director HITH was starting to gain traction in terms of communicating a clear vision for HITH/raising HITH profile across the SCHHS, formulating draft processes and procedures, with positive feedback particularly forthcoming regarding building required relationships with key stakeholders. It is suggested that a lack of internal infrastructure and permanently appointed dedicated support personnel has led to the lack of finalised documents, procedures and processes required to underpin a new MoC. As a result, the service is largely person-dependent and reactive, rendering it unsustainable in its current form.

It is acknowledged, that the current HITH Medical Officer, is providing oversight of the day-to-day functioning of the SCHHS HITH service. The role is ensuring a safe service is maintained, with positive feedback received from internal/external stakeholders alike, however this temporary arrangement is unsustainable. Whist this role straddles both clinical and operational service development, with no permanent HITH team supporting that role, this will impede expansion of the service into a sustainable robust model. For sustainability, the SCHHS HITH service should not be person-dependent. Success of the service relies on buy-in from various stakeholder groups, and the skill-set of the generalist medical officer may be well-suited to leading the service.

Clinical governance

Clear lines of clinical governance are “essential to ensure a treatment plan (medical management plan) is established and appropriate management and coordination of care is achieved” (HITH Guideline). The governance arrangements for SCHHS align with the HITH Guideline and consist of the following structures:

1. Inpatient Admitting Team Clinical Governance Model

   The treating hospital inpatient authorised practitioner retains responsibility for the care of the patient admitted to HITH throughout the episode of care.

   This model occurs for infectious disease and renal patients.

2. HITH authorised practitioner (dedicated HHS medical resource)

   Care is transferred from the admitting hospital inpatient team to a dedicated HITH authorised practitioner. The HITH authorised practitioner then takes on the responsibility for all care planning and treatment regimes.

   This model occurs for all non-specialty patients.

3. Authorised practitioner Governance Model (External governance Authorised)

   General Practitioners, credentialed with admitting rights within the SCHHS, admit patients under their care, take on the responsibility for all care planning and treatment regimes.

   This model is not currently active, however was available prior to 2018 through a Silver Chain sub-contract with a select group of medical practitioners.

Flexibility in clinical governance models is essential for a successful HITH MoC allowing for more patients to be transferred to HITH. When assessing the SCHHS HITH clinical governance the current model is sound with the SCHHS meeting all requirements (HITH Guideline) .

Patient Safety and Quality of Care

During the last five years of HITH in the SCHHS, formalised quality and safety mechanisms have varied. Throughout the centralised contract period there was a SCHHS quality and safety meeting, chaired by the former SCUH Clinical Director HITH, where processes and all reported incidents were reviewed as part of the centralised joint governance process (incidents reported monthly and discussed formally with HIU and the provider), however this was not held consistently. Since the cessation of the central contract in December 2017, these clinical safety and quality meetings have not been convened.

During the review process some stakeholders reported the lack of formalised process for the management of incidents or the deteriorating patient. Whilst providers are recording incidents (which the review team understand are not being filtered down to Patient Safety Office) and utilising the Queensland Adult Deterioration Detection System (QADDS) to identify a deteriorating process, there is no approved process for the management of these, resulting in a lack of visibility regarding HITH incidents (and related outcomes) by the Patient Safety Office.

It is understood that one impetus for this review was identified safety and quality risks related to the care of consumers, regarding blood stream infections (HCABSIs). The review process revealed that under the central contract (between 2014 – December 2017), there were no reported HCABSIs, however two HCABSIs have been attributed to HITH in January 2018 and March 2018 respectively. The review team understands this spike in HCABSIs was being examined by an Aggregate Review Team on 27 April 2018, with recommendations to follow.

Promotion of Service

The review revealed continued themes of lack of visibility, knowledge of HITH inclusion/exclusion criteria, scope of HITH and who the HITH team is (seen as long-term intravenous antibiotic service). Whilst the former Clinical Director HITH did go some way to promoting the service and building relationships to change the culture of how HITH was viewed within SCHHS, this was largely at the individual level. Some work to build the service was also undertaken with new patient cohorts having been identified, however preliminary discussions were in the early phases. Care does need to be taken to ensure that potential new patient groups, do substitute acute inpatient care and not outpatient care (e.g. Chemotherapy disconnects).

Recommendations and considerations

Recommendation	Actions	Timeframe for delivery	Accountable officer
Enhance service delivery models	Select the appropriate service Delivery model for the SCHHS HITH service *(Toolkit, Service delivery model options).*	2 weeks	SCHHS Executive team
	Immediately review the current Transitional Care and Other Services Standing Offer Arrangement to include more detailed service delivery requirements. Draft a Deed of Variation to include HITH specific requirements.	1 month	HITH Service Group Director
	Commence HITH specific procurement process.	1-6 months	Contracts team with HITH Medical Officer
	Create clear contract management structure with clear accountability, monitoring and communication.	Ongoing	Contracts team with HITH Medical Officer
Increase HITH activity	Set a goal of 1% total activity *(HITH Review, table 3).*	1-2 months	SCHHS Executive team
	Set a goal of 1.5% total activity *(HITH review, table 3).*	6-12 months	SCHHS Executive team
Manage HITH efficiency (Length of Stay)	Review HITH referrals by treating increased volume of HITH patients with a short length of stay and ensure the Infectious disease clinic is utilised for long term patients.	1-6 months	HITH Medical Officer and Director Infectious Diseases
Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Review current pathways used in Townsville Hospital *(Toolkit, Clinical pathways)* to maximise uptake of referrals including: ED direct referrals: - Cellulitis - Warfarin - Mastitis - Hyperemesis gravidarum - Urinary Tract Infection	2-4 months	HITH Medical Officer in partnership with applicable Service Groups

	ED or inpatient referrals: - Diverticulitis - Pneumonia - Post operation wound infection - Appendicitis		
	Develop new clinical pathways to include *(Toolkit, Recommended growth areas and %):* - Heart failure - Non-complex hip and knee replacement (build patient's selection into the pre-admission pathway) - Respiratory conditions bronchiectasis, respiratory infections and Cystic Fibrosis).	6-12 months	HITH Medical Officer in partnership with applicable Service Groups
	Convert 30% of SCUPH activity for Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations to HITH.	2-4 months	Executive Director of Clinical Services /Chief Operating Officer, Director ED and HITH Service Group Director
	Create a direct admission pathway for patients from RACFs.	6-12 months	HITH Medical Officer
	Develop an easy electronic referral platform for pathways for ED i.e. iTransfer.	2-3 months	HITH Service Group Director
Boost culture for HITH sustainability across SCHHS	Enhance visibility of HITH service across SCHHS (including scope, reach, availability and processes) and timely communication of service developments.	1-2 months	HITH Service Group Director
Improve contract arrangements	Review current fee for service model to reflect the acuity of service delivery required for HITH. Models could include: - Percentage (%) of DRG as a costing structure for patients directly out of ED	1-6 months	HITH Service Group Director

	- LOS based payment for patient transferred from inpatient areas to HITH		
	Review the contract to ensure equity of shared risk by: - Addition of a minimum base volume (e.g. 10 beds, as this is a safe risk for the HHS). - Ensuring the provider commits to being able to deliver flexible volumes of activity as required (i.e. appropriate staffing).	1-6 months	HITH Service Group Director
Stabilise the HITH team	Permanently recruit to the: - HITH Senior Medical Officer role - Establish and permanently recruit HITH administration officer role (1FTE) Review other positions (i.e. Pharmacy) in line with the selected service delivery model selected *(Toolkit, Service delivery model options).*	1-2 months	HITH Service Group Director
	Consider internal nursing requirements to support HITH referrals and process development.	1-2 months	HITH Service Group Director
Maximise HITH hours of operation	Ensure the providers can receive referrals 24/7 with a clear after-hours approval process in place.	1-3 months	HITH Service Group Director
Extend the service catchment	Ensure the procurement process for the provider has clear expectations on the geographical catchment (e.g. on average HITH Services in Queensland have a 50 km or 45minute radius). Use volume based indicator and patient level data to assess viability of providing care across SCHHS (minimum of 5 beds per day to be viable).	1-6 months	HITH Service Group Director

Increase clarity around HITH inclusion and exclusion criteria	Create a clear flowchart to denote the difference between HIAS and HITH.	1 month	HITH Medical Officer and Director Infectious Diseases
Improve medication management practices (Pharmacy)	Create a process to ensure HITH patients receive a reconciled medication list on discharge.	2 months	Director Pharmacy and HITH Service Group Director
	Create standard process for medication management to support all clinical pharmacists across SCHHS when preparing a patient for, or managing a patient on HITH.	1-2 months	Director Pharmacy and HITH Service Group Director
	Review the HITH implications on pharmacy resources (especially in an expanded service), and consider recruitment of a dedicated HITH pharmacy resource.	1-3 months	Director Pharmacy and HITH Service Group Director
Increase patient groups requiring Allied Health input	Consider patient groups high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.	6-12 months	HITH Medical Officer and Director Allied Health
Streamline antimicrobial stewardship processes	Develop standard antibiotic regimes for the top 3 patient cohorts that require antibiotics.	4-6 months	Director Infectious Diseases with Director Pharmacy
Strengthen corporate governance	Formalise a Governance group with clear Terms of Reference *(Toolkit, Terms of Reference considerations)* to include performance monitoring, quality and safety reporting, DRG expansion, communication and resource development. Membership is to representative of service groups/facilities	1 month	HITH Service Group Director
	Review current corporate governance structure and consider moving under the medical services group to better reflect the acute nature of the HITH service.	1 month	SCHHS Executive team
	Consider nominating a HITH lead at each facility to better facilitate care across SCHHS.	2 months	HITH Service Group Director

Explore alternative Clinical Governance models	Revisit Authorised Practitioner Governance Model and consider partnering with general practice to deliver medical governance for HITH patients. Options include: • HHS contract with credentialed GPs • Provider contract with credentialed GPs	6-12 Months	HITH Service Group Director and Contracts team
Embed a patient safety and quality framework	Ensure national safety and quality accreditation requirements are embedded in future HITH contracts	1-6 months	HITH Service Group Director and Contracts team
	Recommence clinical quality and safety meeting with relevant stakeholders	2 months	HITH Service Group Director
	Formalise and document incident management process with provider	1 month	HITH Service Group Director and Safety and Quality team
	Formalise the deteriorating patient process within the contracts	1 month	HITH Service Group Director
Promote HITH Service across SCHHS	Create a multi-modal communication plan for approval by the HITH governance body, including, but not limited to: Resident/Registrar orientation, grand rounds, posters, screen savers, one on one education, nursing orientation, allied health, Case presentations, consumer presentations, newsletters etc *(Toolkit, HITH Program Procedure and Patient handout)*	1-4 months	HITH Service Group Director

Appendices

Appendix 1 – Stakeholder List

Stakeholder interviewed *(SCUH stakeholders unless stated otherwise)*	Date
HITH Medical Lead/Project Owner	3, 10, 11, 19 and 20 April 2018
A/ Executive Director Clinical Services, SCHHS/Project Sponsor	3 and 20 April 2018
Service Director, CISAS, SCHHS/Project Sponsor	3 and 20 April 2018
Chief Executive, SCHHS/Project Sponsor	20 April 2018
Manager, Contracts and Procurement	10 April 2018
CHIP/HITH Administration Officer	10 April 2018
SCUH Pharmacist	10 April 2018
Nambour Hospital NUMs/CHIP nurses (group)	10 April 2018
SCUH NUM, Emergency Department	10 April 2018
SCUH HITH Coordinator	10 April 2018
Gympie Hospital NUMs	10 April 2018
A/ Contract Management Director & A/ Project Manager, Commercial and Contracts	11 April 2018
Nursing Director, PACH	11 April 2018
Executive Director, Allied Health	11 April 2018
SCUH NUMs (small group)	11 April 2018
SCUH Nursing Directors (small group)	11 April 2018
A/ Manager Patient Safety and Patient Safety Officer	11 April 2018
Business Development Manager, HITH, Blue Care	12 April 2018
SCUH Director, Emergency Department	17 April 2018
NUM CHIP, Transition Services	18 April 2018
Nambour Hospital, Director, General Medicine,	18 April 2018
SCUH NUM (Cardiology/Endocrinology)	18 April 2018
SCUH Staff Specialist, Infectious Diseases	19 April 2018
SCUH Director of Pharmacy	19 April 2018
Gympie Hospital Director of Nursing/Facility Manager	19 April 2018
Clinical Director, CISAS	19 April 2018
SCUH Director of Surgery	19 April 2018
Gympie Hospital, SMO, Emergency Department	19 April 2018
Gympie Hospital, Pharmacist	19 April 2018
External HITH Provider, Focus Health Care	19 April 2018
Former SCUH Clinical Director HITH	20 April 2018
A/ Clinical, Service Director, Medical Services Group, Nursing Director, Medicine and ID Physician, Infectious Diseases (group)	20 April 2018
Nambour Hospital, Director, Emergency Department	20 April 2018
Director, Clinical Operations Queensland, Silver Chain and General Manager, East Coast	20 April 2018
Clinical Nurse, MAPU, SCUH	20 April 2018
Clinical Director, Caloundra Minor Injury and Illness Clinic	20 April 2018

Summary

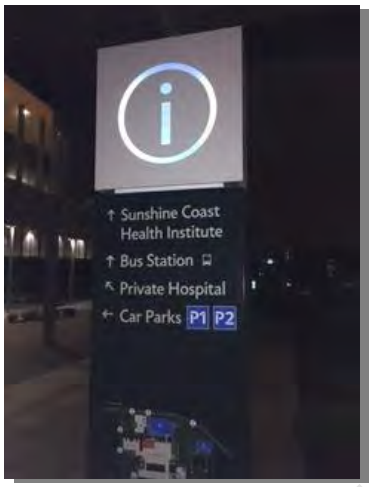
The following resources are provided for reference and consideration. If adapted, appropriate acknowledgements are to be attributed. Word versions can be provided upon request where available.

Relates to Recommendation/s:	Resource description	Comment	Document
Enhance service delivery models/Stablise the HITH Team	Service delivery model options		Service Delivery Model Options
Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Clinical Pathway – Anticoagulation with warfarin	Sourced from Townsville HHS	cf-hith-anticoagulation-war.pdf
	Clinical Pathway – Appendicitis	Sourced from Townsville HHS	cf-hith-appendicitis.pdf
	Clinical Pathway – Cellulitis	Sourced from Townsville HHS	cf-hith-cellulitis.pdf
	Clinical Pathway – Complicated urinary tract infection	Sourced from Townsville HHS	cf-hith-complicated-uti.pdf
	Clinical Pathway – Diverticulitis	Sourced from Townsville HHS	cf-hith-diverticulitis.pdf
	Clinical Pathway – Generic	Sourced from Townsville HHS	cf-hith-generic.pdf
	Clinical Pathway – Hyperemesis gravidarum	Sourced from Townsville HHS	cf-hith-hyperemisis-gravidarum.pdf
	Clinical Pathway – Mastitis	Sourced from Townsville HHS	cf-hith-mastitis.pdf

Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Clinical Pathway – Pneumonia	Sourced from Townsville HHS	 cf-hith-pneumonia.pdf
	Clinical Pathway – Post Operative Wound Infection	Sourced from Townsville HHS	 cf-hith-post-op-wound.pdf
	Recommended growth areas and percentages (%)		 Recommended growth areas and %
Corporate Governance	Terms of reference considerations – Governance Body		 ToR considerations.pdf
Promotion of Service across SCHHS	HITH Program Procedure and Patient Handout	Sourced from Townsville HHS Sourced from Statewide HITH Group	 HITH Procedure  HITH pt handout

Hospital in the Home (HITH) Review

Sunshine Coast Hospital and Health Service
May 2018



Hospital in the Home (HITH) Review – Sunshine Coast University Hospital, May 2018

Published by the State of Queensland (Queensland Health), May 2018

For more information contact:
Healthcare Improvement Unit, Department of Health, GPO Box 48, Brisbane QLD 4001, email HIU@health.qld.gov.au, phone 3328 9079.

Contents

Introduction

The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the with sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH. To ensure a safe, efficient and quality HITH service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH sService. Site visits to the ~~Sunshine Coast University Hospital (SCUH)~~SCHHS by the review team, with input from an external reviewer, Dr Michael Young, Senior Medical Officer, Hospital in the Home Service, the Townsville Hospital, Service Townsville Hospital and Health Service, were conducted on 10 -11 April and 19 - 20 April 2018 respectively.

Commented [SM1]:

Review specifications

Objectives

The aim of this body of work was to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the objectives below:

- Review of the decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model delivers consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH sService.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Hospitalisations (PPHs) (e.g. cellulitis, Chronic Obstructive Pulmonary Disease COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. Sunshine Coast University Private Hospital (SCUPH)

Scope

The scope of the review encompassed the entire SCHHS HITH sService, with interviews undertaken with various internal stakeholders from the Sunshine Coast University, Gympie, Nambour, and Maleny hospitals, Caloundra Minor Injuries and Illness Clinic (MIIC), in addition to some external stakeholders (applicable external HITH providers). In scope was also a review and analysis of data related to HITH utilisation, examination of admission processes and service profiles and where applicable, a review of business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, and HITH service provider contracts and related deeds of variation.

The review team were made aware of the SCHHS Executive commissioning of an internal audit of the tendering/contract process as it relates to the *Transitional Care and Other Services Standing Offer Arrangement*, however this was out of scope for the review.

Methodology

The following information sources informed the review findings and recommendations:

- Relevant HITH-related data and other patient flow metrics were sourced from RiskMan, HBCIS, statewide HITH Dashboard and SCUPH contract data.
- Targeted stakeholder interviews to identify opportunities for improvement and growth, barriers/challenges and understand individual/group perceptions of the SCHHS HITH service and access and flow of SCHHS patients.
- Examination of relevant HITH documentation and procedures, including (but not limited to) HITH referral packs, applicable HITH service provider contracts and related deeds of variation.
- Individual opinions/perceptions were tested and validated, with only those opinions shared by two or more sources incorporated into the report to maintain the integrity of same.

Activity data

HITH specific data was obtained through the HOME ward data available in the HBCIS data collection for 2017 calendar year and 2018 available data, via the statewide HITH dashboard developed by the HIU data team. Other inpatient related data was accessed via the HBCIS data from the Health Statistics Branch. Additional data pertaining to the SCUPH and reported blood stream infection rates were sourced directly from applicable service areas within SCHHS.

Consultation

Pre-review interviews where held with the project owner and project sponsors on 3 April 2018 to clarify scope, confirm the review plan and identify key stakeholders for consultation. Extensive face-to-face consultation with internal and external stakeholders occurred over 10, 11, 19 and 20 April, where

stakeholders were unavailable for face-to-face interviews, phone interviews where held on 12,17 and 18 April (Appendix 1). Note that interviews did not occur with the following identified stakeholders, due to their unavailability/unavailability of an appropriate proxy: Nambour Director Emergency Department, Sunshine Coast University Hospital (SCUH) Executive Director Nursing and Midwifery, Director of Cardiology, Director of Renal, Director of Medicine (Gympie), Acting Director of Orthopaedics and the Clinical Director and Emergency Department NUM (Nambour).

Interviews (face-to-face, videoconference and teleconference) convened on 10 and 11 April, phone interviews on 12, 17 and 18 April and face-to-face interviews with external providers (Focus Healthcare and Silver Chain) on 19 and 20 April respectively, were conducted by only some members of the review team (Laureen Hines, with Sonya Mizzi in attendance), to maximise involvement of the external reviewer, Dr Michael Young. The entire review team, including Dr Young did participate in all remaining interviews on 19 and 20 April. Dr Young elected not to participate in external provider interviews due to a reported conflict of interest.

SCHHS HITH Service Observations and Findings

HITH Service Delivery Model

Historically, the SCHHS has participated in a variety of HITH models. The original model commenced providing hospital substitution and post-acute care under the Home Based Acute Care Service (HBACS) model. In 2014 Silver Chain was awarded a central contract to deliver HITH in Queensland and elected to deliver this care in the SCHHS. At this point, the HBACS service was disbanded by the SCHHS and the Hospital in the Home Public Private Partnership Initiative (HITH PPP) commenced on 1 January 2014. The HITH PPP model then ran as an outsourced HITH model of care between 2014 – 2017. During this time, many medical, nursing and administration temporary staff supported the models internally under the SCHHS Minimum Obligatory Human Resource Information (MOHRI).

At the end of the centralised contract period (31 December 2017), SCHHS elected to continue to partner with the Non-Government sector to deliver HITH services. In late 2017, the SCHHS approached the market to extend the *Transitional Care and Other Services Standing Offer Arrangement* to include HITH under a fee-for-service arrangement. An expression of interest (EOI) was sent to the current panel delivering care under this arrangement and opened to other HITH providers. The EOI included HITH specific requirements, and selection was based on a written EOI and the outcome of interviews with the former SCUH Clinical Director HITH. Following this, a Deed of Variation (DoV) was signed with two providers, Silver Chain and Focus Healthcare. Whilst the DoV does outline some high-level Key Performance Indicators (KPIs), it lacks the service level detail outlined in the market documents. As a result, the current arrangement has limited ability to hold the providers to account against the key requirements for service delivery, posing a potential risk to the delivery of high quality service.

Data analysis

HITH Activity

HITH activity across SCHHS accounted for 0.32% of total hospital acute admissions in 2017, compared to the statewide average of 0.72% (Table 1). 2018 saw a slight increase in HITH activity, with 0.35% of

total acute admissions attributable to the SCHHS, compared to the statewide average of 0.66% of hospital acute admissions. Currently the SCHHS HITH activity is well under notional HITH target of 1.5% with considerable opportunity for growth. Within this cohort, no activity was attributable to same day separations which is directly in line with HITH requirements.

Table 1 - SCHHS HITH Service comparative data

Key performance indicator	SCHHS 2017	SCHHS 2018 (Jan to March)	State 2017	State 2018
HITH % total hospital separations	0.32%	0.35%	0.72%	0.66%
Same day % discharge (not present at midnight census)	0	0	0.04%	0.05%
Overnight % discharge (present at midnight census)	0.73%	0.79%	1.4%	1.33%
Readmissions % (same DRG with 28 days)	1.89%	1.61%	2.1%	2.43%
Average Length of Stay (LOS) (days)	14.07	9.63	9.27	8.92

Commented [CD2]: Would be good to provide some examples of "Same Day admissions" that would fit under a HITH model (noting the caution against providing outpatient care- last para, p 16 under "Promotion of Service").

To identify opportunity for growth, comparative data was analysed which confirms potential for growth. As identified (Table 2), each facility was compared to like hospitals, based on volume of presentations and geographical catchment. As identified, each site has a significant opportunity for expansion.

Table 2 - Site comparative data

Site	HITH volume	LOS	Volume
SCUH	193	14	0.35%
Townsville	763	4	1.28%
Nambour	92	16	0.32%
QEII	246	9	0.9%
Gympie	30	8	0.3%
Gladstone	202	8	1.89%

There are opportunities to grow the HITH service and release additional inpatient bed capacity. Table 3 below outlines how this growth can be achieved based on 2017 calendar year data.

Table 3 HITH Growth

To achieve growth of HITH separations by	1%	1.5%
Number of additional patients to be cared for by HITH	988	1481
Referrals required each day (365 days per year)	3	4
HITH beds required at current LOS (14 days)	37	56
HITH beds required if LOS is reduced to 9 days in line with state average	24	36

Readmission rates

Readmission rates are a quality measure for HITH. Low readmission rates for the same condition indicate that patients are receiving the care that is required during the episode of care. HITH patient readmission rates for the same condition for the SCHHS HITH Service

decreased from 1.89% in 2017, to 1.61% in 2018, which is lower than the state average of 2.1% in 2017 and 2.43% in 2018.This data indicates that the service delivered under the current HITH model is meeting the needs of the patients.

Length of Stay (LOS)

Length of Stay is an efficiency measure for HITH and should be reflective of the standard LOS the patient would have received in hospital. The average LOS for SCHHS HITH service has decreased substantially from 14.07 days in 2017, to 9.63 days on 2018. When compared to the HITH state average, which was 9.27 days in 2017, and 8.92 days in 2018, the SCHHS HITH service LOS has been above the state average in both years. ~~Consultation, S~~stakeholders reported that long-term antibiotic patients impact on the overall LOS. Due to the long LOS, the volume of patients that can be referred to HITH is limited as this creates access block. It is important to acknowledge however, that within SCHHS, if these long-term antibiotic patients were excluded from HITH, they would further adversely impact on access block. Note that r~~R~~educing LOS increases patient turnover, allowing more patients to be treated under HITH.

Commented [CD3]: Imp to note that if these pts were excluded from HITH in our HHS is likely that they would further contribute to hospital access block

Top 10 Diagnosis Related Groups (DRGs) and LOS

Comparative analysis of the top ten DRGs treated under the SCHHS HITH service model of care is shown in Table 4. Analysis identifies that the SCHHS treats different patient cohorts to other services in the state ten. SCHHS HITH service treats a higher volume of J64B, T64B, T60B, X60A, M64A, B07A, I73A, F61A and J68A. The DRGs currently treated under HITH require long length of treatment and may be more suited to being treated in the outpatient setting. The SCHHS currently does not treat L63A Kidney and urinary tract, L63B Kidney and urinary tract, E62A Respiratory infection /inflammation, E62B Respiratory infection /inflammation, T60C Septicaemia and E65A COPD which are seen in high volumes across the state.

Table 4 - SCHHS HITH Service Top 10 DRGs and LOS (includes time spent in hospital) comparison to State – 2018 (January to March)

DRG	Condition	SCHHS % of total admit	State % of total admit	State HITH LOS	SCHHS LOS
J64B	Cellulitis minor	18%	14%	3.7	3.9
J64A	Cellulitis major	8%	13%	5.9	6.4
T64B	Other infections and other disease	21%	14%	16.6	21.9
T60B	Septicaemia	6%	5%	9.8	14.2
X60A	Injuries	4%	3%	16.3	3.3
M64A	Other male reproductive system	20%	3%	27.2	27.2
B07A	Cranl/Prphl nerv and other	50%	9%	14.1	15.6
I73A	Adtcare musck impl/pros	20%	15%	14.2	13.8
F61A	Infect endocarditis	25%	19%	30.5	30
J68A	Major skin disorder	5%	2%	4.6	4

Sunshine Coast University Private Hospital (SCUPH)

The cessation of the SCUPH contract on 20 September 2018 is identified as an opportunity for consideration of the service model. A brief review of confidential 2016-17 SCUPH data (discharging DRGs from SCUPH) identified that 2485 patients transferred to SCUPH presented with conditions traditionally treated under the HITH model of care. There appear adequate volumes for the following DRGs to be considered for treatment by SCHHS HITH service - potentially via a phased implementation across SCHHS facilities: Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations and COPD. Additionally, it would be feasible for the current iTransfer system currently utilised across SCHHS facilities, to be adapted to facilitate referrals to the HITH s~~S~~ervice, negating the need for paper-based referrals.

Culture and Readiness

Stakeholders at all levels of the SCHHS organisation, including members of SCHHS Executive, communicated the value of a functional HITH service within SCHHS, and readiness to accept a reviewed model of care (MoC), pending the resolution of identified clinical and corporate governance issues. When asked to identify development opportunities, stakeholders were forthcoming with suggestions to optimise HITH and enhance the access and flow of patients across SCHHS.

Medical buy-in to the HITH model of care is variable and it was noted that the SCHHS, like most HHSs, is a medically-driven model of care. The review team suggests the perceived reluctance to relinquish the care of patients to HITH is likely due to a mistrust, uncertainty around service provision, lack of referral pathways, and lack of understanding of the level and quality of care.

Consistent messages expressed by stakeholders included:

- Unreliable availability
- Ad-hoc service delivery model
- No opportunity to get embedded processes and build confidence due the many internal HITH staff changes (medical/nursing)
- Lack of visibility and ownership

Contractual arrangements

Provider interviewed noted their impetus for interest in the tender process was to establish a 'footprint' in the SCHHS. Acknowledging that SCHHS's plans to grow the HITH service (potentially to 20-40 beds) was also an incentive, both providers sighted concerns regarding a lack of guaranteed volume and types of referrals (sighting more complex patients being referred) and variations of same (adversely impacting staffing). Providers interviewed reported some confusion regarding the Transitional Care and Other Services tender process, sighting difficulties with applying a HITH model to a Transitional Care model (lack of clarity regarding service expectation, expansive service catchment), which resulted in some KPIs not being appropriately aligned to HITH. Additionally, a lack of identified contract governance was sighted (lack of a clearly identified contract/case manager and escalation process). Similarly, providers suggested the current fee for service model does not provide a sustainable cost-viable option to deliver acute care requirements for HITH patients across SCHHS, with feedback suggesting the current model places most of the risk on providers.

HITH Team

SCHHS resources

- 1FTE Medical Officer (currently vacant)
- 1 FTE Administrator (temporary)
- 1 FTE HITH Coordinator (temporary)

External provider resources

- Registered Nurse
- Allied health as required
- After hours on call for patients

HITH hours of operation

SCHHS currently has access to HITH services 7 days a week. The providers deliver home visits between 8am to 6pm, with limited capacity to provide twice daily visits. Patients are identified by the SCHHS Community Hospital Interface Program (CHIP) nurses in the wards or the SCUH HITH Coordinator from Monday to Friday 8am to 4pm. The HITH Medical Officer actively manages current patients, providing oversight for all new referrals and on call coverage (after hours/weekends).

Service catchment

When compared with other HITH service catchment areas statewide, SCHHS HITH service is expansive. Many stakeholders sighted a perceived reluctance and/or inability of the current provider (due to staffing) to service patients that live greater distances from Sunshine Coast University, Nambour, Gympie, Maleny and Caloundra Hospitals especially servicing areas outside of Gympie i.e. Kilkivan, Tin Can Bay and Cooloola Cove, were sighted. Particular difficulties regarding service provision in the surrounding areas of Gympie, Tin Can Bay and Cooloola Cove were reported, resulting in what is perceived as an ad-hoc, unreliable HITH service currently.

Inclusion and Exclusion – Patient Selection

All interviews with stakeholders identified a limited knowledge or misinterpretation of HITH of the inclusion and exclusion criteria for HITH. Clinicians' perception of HITH service appears limited, it being viewed as a ~~long term~~long-term antibiotic service for patients unable to attend the Home IV Antibiotic Service (HIAS). There appears to be confusion by some medical officers/nursing staff regarding what patients are appropriate to refer to HITH versus the HIAS. Feedback suggests the demarcation between HITH and HIAS services is blurred, with the HITH service being utilised at a 'back-stop' when HIAS is at capacity. This limited understanding largely guides perceptions of HITH and the lack of uptake for any other patient groups.

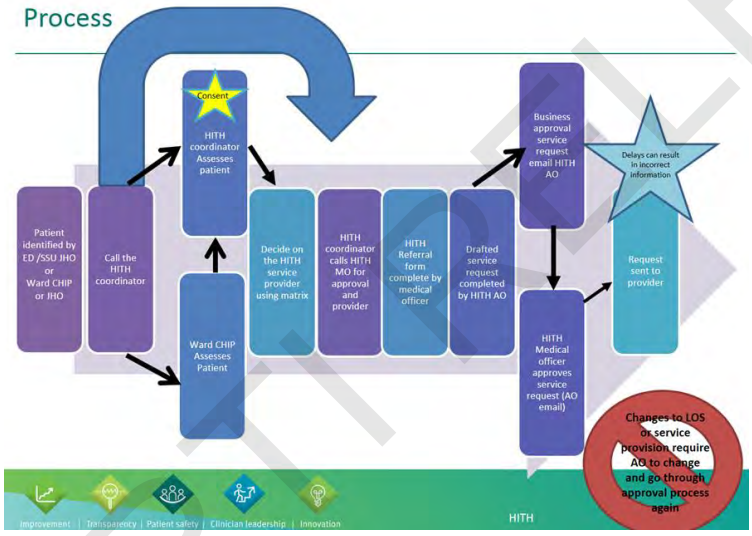
Further impacting HITH uptake there was a common belief that HITH does not see patients in Residential Aged Care Facilities (RACFs), boats, caravans and other temporary dwellings. There was also a demonstrated lack of understanding about the level of service and the number of visits per day providers can deliver.

Referral process

Whilst the HITH referral process outlined below largely pertains to SCUH, it is acknowledged the current HITH service delivery model extends across the entire SCHHS, thereby creating facility specific challenges and barriers, which in turn, will require facility specific solutions. HITH patients are identified by the SCHHS CHIP nurses in the wards, medical staff or the SCUH HITH Coordinator from Monday to Friday 8 to 4pm (Figure 1). Currently most referrals are received from inpatient units with limited referrals from the Emergency Department (ED).

Commented [CD4]: Some issues identified are SCUH-specific.
Need to contextualise that this is a whole-of-HHS HITH model which will create facility-specific issues, barriers & solutions and therefore a potential for confusion as a result. From memory, Townsville's more mature HITH model has dedicated HITH 'leads' in each facility which would facilitate better coordination across facilities.

Figure 1 Referral Process



The referral process consists of a generic referral form and a patient consenting process. The HITH Coordinator completes most of the paperwork and reviews the patients at SCUH, however at the other sites, this is undertaken by the CHIP nurse. Whilst the packaging process is streamlined, the approval process for the fee for service contract is complex and can result in delayed acceptance time.

When discussing HITH with clinical staff from EDs, there were a number of barriers identified. The use of the generic form was considered labour intensive and did not support the understanding of what can be delivered under HITH. Delays caused by multiple acceptance processes also impacted on the timeliness

of patients being accepted, resulting in access block in the ED. When the review team discussed condition-specific referral forms, stakeholders identified this would support uptake.

The review identified a lack of direct referrals to HITH from ED. There was a successful three-month trial whereby a CHIP/HITH nurse identified HITH-suitable patients in the Short Stay Unit (SSU). By utilising the SSU to package HITH patients, this created SSU access block and the position was not sustained. Following this trial, feedback from the ED identified there is a perceived limited visibility of the HITH team in the ED, adversely impacting on direct referrals to HITH from ED.

Anecdotal reports suggest that currently some patients that are transferred from the ED to the Medical Assessment Unit (MAU) could be transferred directly to HITH, if there were an easy and clearly understood referral pathway, coupled with an increased understanding of the level of care that can be provided under the HITH sService.

Advice provided suggests that the MIIC is currently providing care for patients via an intravenous antibiotic clinic. Like the MAU, with an increased understanding of HITH and referral pathways, there may be an opportunity to source direct referrals from MIIC.

Pharmacy

It is well documented in the literature that any transfers of care from one service to another, increases medication error risk, and HITH is no exception. The review identified that SCHHS does not have any dedicated pharmacy resource allocated to HITH. It is evident that one of the dispensing pharmacists at the SCUH has taken a lead in supporting HITH within their current role. Within this role some processes have been established to increase consistency and safety. When assessing the current medication management against the HITH Guideline , the service is meeting most requirements, with the exception of the medication reconciliation on discharge, which is an essential part of the transfer of care back to the General Practitioner. Whilst temporary support from this individual is beneficial, consideration needs to be given to the impact on this role if the service grows. Feedback received from Gympie Hospital, suggests there has been an increase in medication related incidents since January 2018, with junior pharmacy staff (in the absence of a Senior Pharmacist) having to make decisions they did not have to make previously under the central contract.

Allied Health

To ensure care is equivalent to that delivered within the acute facility, access to allied health is essential. The review revealed limited engagement or input from allied health in the SCHHS HITH service development and operation. Input from this cohort would broaden the scope of the HITH service and in turn support service delivery, with the cohort able to identify the following potential patient groups for consideration suitable for HITH: high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.

Antimicrobial stewardship

Antimicrobial stewardship is essential in ensuring the care provided to patients is of a high standard and equivalent to inpatient care. Stakeholders identified the need to ensure that patients admitted to HITH need to be prescribed the right antibiotic for the right duration. Currently every patient receiving intravenous antibiotics under HITH is seen by the Infectious Diseases team prior to transfer of care. Whilst reports did not identify this as a barrier to referral, the process could be streamlined with the implementation of clear pathways and agreed treatment options for identified DRGs and patient cohorts.

Governance – Corporate and Clinical

Corporate governance

Appropriate corporate and clinical governance is essential in ensuring the uptake of HITH, safety and quality of service delivery, viability and performance management. HITH in the SCHHS is governed under the Community Integrated & Sub-Acute Services (CISAS) area. The Queensland Department of Health HITH Guideline states "strong corporate governance will provide transparent monitoring/reporting systems, strong clinical leadership, advocacy and clinical risk management". Assessment against the recommended requirements for sound corporate governance are identified in Table 5.

Table 5 - Corporate governance assessment

Recommendation		Comment
The corporate governance structure is to be developed to include representation from all relevant clinical levels and professionals within the HHS and any external providers (if relevant).	✗	Previously met however all relevant clinical areas were not included
HITH services are to be incorporated into the HHS planning and demand management strategies.	✓	
Data and KPIs are to be monitored, analysed and reported via local HHS processes and communicated to all stakeholders on a regular basis.	✗	Previously met however limited to those directly involved only

Feedback reported to the review team identified the current alignment with CISAS may be adversely impacting on the uptake and ownership of the service. While there are some synergies in the delivery of the care in the community, when questioned regarding the best alignment, 90% of stakeholders identified that Medical Services Group would be better placed to provide corporate governance, as an acute HITH service needs to be visible e.g. seen and run as an 'acute virtual ward'.

Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was a perceived lack of a ~~no~~ forum for broad consultation or service development. Some stakeholders suggested establishment of a robust Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.

Up until the temporary appointment of the current HITH Medical Officer, the review team understands there was an established HITH Clinical Working Group chaired by the former HITH Medical Officer SCUH, which reported to the SCHHS HITH local Governance Committee. Membership had multi-facility and multi-service group representation, but it is understood attendance was variable.~~clinical governance appears to have been the sole responsibility of the former HITH Medical Officer SCUH Clinical Director HITH~~.

Commented [CD5]: This is incorrect - there was a well-established HITH Clinical Working Group in place at the time the former HITH Clinical Director commenced in the role. However, chairing and maintaining that group was the Clinical Director's responsibility. The HITH Clinical Working Group had multi-facility and multi-service group representation (but with variable attendance).
This Group reported to the SCHHS HITH local Governance Committee.

Various stakeholders acknowledged the lack of consistent nursing governance and support staff for temporary nursing roles has impacted on the ability to drive HITH from a strategic perspective. Feedback received suggests that in collaboration with the HITH coordinator, and utilisation of CHIP resources, the former Clinical Director HITH was starting to gain traction in terms of communicating a clear vision for HITH/raising HITH profile across the SCHHS, formulating draft processes and procedures, with positive feedback particularly forthcoming regarding building required relationships with key stakeholders. It is suggested that a lack of internal infrastructure and permanently appointed dedicated support personnel has led to the lack of finalised documents, procedures and processes required to underpin a new MoC. As a result, the service is largely person-dependent and reactive, rendering it unsustainable in its current form.

It is acknowledged, that the current HITH Medical Officer, is providing oversight of the day-to-day functioning of the SCHHS HITH service. The role is ensuring a safe service is maintained, with positive feedback received from internal/external stakeholders alike, however this temporary arrangement is unsustainable. Whist this role straddles both clinical and operational service development, with no permanent HITH team supporting that role, this will impede expansion of the service into a sustainable robust model. For sustainability, the SCHHS HITH service should not be person-dependent. Success of the service relies on buy-in from various stakeholder groups, and the skill-set of the generalist medical officer may be well-suited to leading the service.?

Commented [CD6]: Agreed – key point and is a critical success factor

Commented [PS7]: Do we need a medical model with some redundancy? E.g. two part-timers instead of the full-timer? Is it worth stating that re-engagement of HITH GPs could be considered to enable the necessary redundancy?

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Clinical governance

Clear lines of clinical governance are "essential to ensure a treatment plan (medical management plan) is established and appropriate management and coordination of care is achieved" (HITH Guideline). The governance arrangements for SCHHS align with the HITH Guideline and consist of the following structures:

1. Inpatient Admitting Team Clinical Governance Model

   The treating hospital inpatient authorised practitioner retains responsibility for the care of the patient admitted to HITH throughout the episode of care.

   This model occurs for infectious disease and renal patients.

2. HITH authorised practitioner (dedicated HHS medical resource)

   Care is transferred from the admitting hospital inpatient team to a dedicated HITH authorised practitioner. The HITH authorised practitioner then takes on the responsibility for all care planning and treatment regimes.

   This model occurs for all non-specialty patients.

3. Authorised practitioner Governance Model (External governance Authorised)

   General Practitioners, credentialed with admitting rights within the SCHHS, admit patients under their care, take on the responsibility for all care planning and treatment regimes.

   This model is not currently active, however was available prior to 2018 through a Silver Chain sub-contract with a select group of medical practitioners.

Flexibility in clinical governance models is essential for a successful HITH MoC allowing for more patients to be transferred to HITH. When assessing the SCHHS HITH clinical governance the current model is sound with the SCHHS meeting all requirements (HITH Guideline) .

Patient Safety and Quality of Care

During the last five years of HITH in the SCHHS, formalised quality and safety mechanisms have varied. Throughout the centralised contract period there was a SCHHS quality and safety meeting, chaired by the former SCUH Clinical Director HITH, where processes and all reported incidents were reviewed as part of the centralised joint governance process (incidents reported monthly and discussed formally with HIU and the provider), however this was not held consistently. Since the cessation of the central contract in December 2017, these clinical safety and quality meetings have not been convened.

During the review process some stakeholders reported the lack of formalised process for the management of incidents or the deteriorating patient. Whilst providers are recording incidents (which the review team understand are not being filtered down to Patient Safety Office) and utilising the Queensland Adult Deterioration Detection System (QADDS) to identify a deteriorating process, there is no approved process for the management of these, resulting in a lack of visibility regarding HITH incidents (and related outcomes) by the Patient Safety Office.

It is understood that one impetus for this review was identified safety and quality risks related to the care of consumers, regarding blood stream infections (HCABSIs). The review process revealed that under the central contract (between 2014 – December 2017), there were no reported HCABSIs, however two HCABSIs have been attributed to HITH in January 2018 and March 2018 respectively. The review team understands this spike in HCABSIs was being examined by an Aggregate Review Team on 27 April 2018, with recommendations to follow.

Promotion of Service

The review revealed continued themes of lack of visibility, knowledge of HITH inclusion/exclusion criteria, scope of HITH and who the HITH team is (seen as long-term intravenous antibiotic service). Whilst the former Clinical Director HITH did go some way to promoting the service and building relationships to change the culture of how HITH was viewed within SCHHS, this was largely at the individual level. Some work to build the service was also undertaken with new patient cohorts having

been identified, however preliminary discussions were in the early phases. Care does need to be taken to ensure that potential new patient groups, do substitute acute inpatient care and not outpatient care (e.g. Chemotherapy disconnects). Refer Cangs second comment p 7– e.g. of same day admissions

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Recommendations and considerations

Recommendation	Actions	Timeframe for delivery	Accountable officer
Enhance service delivery models	Select the appropriate service Delivery model for the SCHHS HITH service *(Toolkit, Service delivery model options).*	2 weeks	SCHHS Executive team
	Immediately review the current Transitional Care and Other Services Standing Offer Arrangement to include more detailed service delivery requirements. Draft a Deed of Variation to include HITH specific requirements.	1 month	HITH Service Group Director
	Commence HITH specific procurement process.	1-6 months	Contracts team with HITH Medical Officer
	Create clear contract management structure with clear accountability, monitoring and communication.	Ongoing	Contracts team with HITH Medical Officer
Increase HITH activity	Set a goal of 1% total activity *(HITH Review, table 3).*	1-2 months	SCHHS Executive team
	Set a goal of 1.5% total activity *(HITH review, table 3).*	6-12 months	SCHHS Executive team
Manage HITH efficiency (Length of Stay)	Review HITH referrals by treating increased volume of HITH patients with a short length of stay and ensure the Infectious disease clinic is utilised for long term patients.	1-6 months	HITH Medical Officer and Director Infectious Diseases
Expand patient	Review current pathways used in	2-4 months	HITH Medical

cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Townsville Hospital *(Toolkit, Clinical pathways)* to maximise uptake of referrals including: ED direct referrals: - Cellulitis - Warfarin - Mastitis - Hyperemesis gravidarum - Urinary Tract Infection ED or inpatient referrals: - Diverticulitis - Pneumonia - Post operation wound infection - Appendicitis Consider appointing a HITH lead at each facility as the HITH service matures, to better facilitate care across SCHHS		Officer in partnership with applicable Service Groups
	Develop new clinical pathways to include *(Toolkit, Recommended growth areas and %):* - Heart failure - Non-complex hip and knee replacement (build patient's selection into the pre- admission pathway) - Respiratory conditions bronchiectasis, respiratory infections and Cystic Fibrosis).	6-12 months	HITH Medical Officer in partnership with applicable Service Groups
	Convert 30% of SCUPH activity for Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations to HITH.	2-4 months	EDCS, Chief Operating Officer, Director ED and HITH Service Group Director
	Create a direct admission pathway for patients from RACFs.	6-12 months	HITH Medical Officer
	Develop an easy electronic referral platform for pathways for ED i.e. iTransfer.	2-3 months	HITH Service Group Director
Boost culture for HITH sustainability across SCHHS	Enhance visibility of HITH service across SCHHS (including scope, reach, availability and processes) and timely communication of service developments.	1-2 months	HITH Service Group Director
Improve contract	Review current fee for service model to	1-6 months	HITH Service

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Commented [CD8]: ?? where does 30% come from

Commented [CD9]: EDCS needs to be involved too

Commented [PS10]: Agreed, although the role is being re-badged as the COO at present.

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arrangements	reflect the acuity of service delivery required for HITH. Models could include: - Percentage (%) of DRG as a costing structure for patients directly out of ED - LOS based payment for patient transferred from inpatient areas to HITH		Group Director
	Review the contract to ensure equity of shared risk by: - Addition of a minimum base volume (e.g. 10 beds, as this is a safe risk for the HHS). - Ensuring the provider commits to being able to deliver flexible volumes of activity as required (i.e. appropriate staffing).	1-6 months	HITH Service Group Director
Stabilise the HITH team	Permanently recruit to the following positions: - HITH MO role - HITH administration officer Review other positions (i.e. Pharmacy) in line with the selected service delivery model selected *(Toolkit, Service delivery model options).*	1-2 months	HITH Service Group Director
	Consider internal nursing requirements to support HITH referrals and process development.	1-2 months	HITH Service Group Director
Maximise HITH hours of operation	Ensure the providers can receive referrals 24/7 with a clear after-hours approval process in place.	1-3 months	HITH Service Group Director
Extend the service catchment	Ensure the procurement process for the provider has clear expectations on the geographical catchment (e.g. on average HITH Services in Queensland have a 50 km or 45minute radius). Use volume based indicator and patient level data to assess viability of providing care across SCHHS (minimum of 5 beds per day to be viable).	1-6 months	HITH Service Group Director
Increase clarity around HITH	Create a clear flowchart to denote the difference between HIAS and HITH.	1 month	HITH Medical Officer and

Commented [CD11]: Would add that there would also need to be adequate internal infrastructure (staffing) to accommodate flexing up

Commented [CD12]: Current only permanent position is HITH SMO
Would change wording to – permanently recruit to the vacant HITH SMO role and permanently establish and recruit HITH AO and HITH CNs
-Need to have dedicated HITH nurses to support our requirements
-Pharmacy can be considered as part of the 'review of other positions….'

Commented [PS13]: Could we perhaps talk about the 'medical model' rather than the single full time SMO?

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Commented [CD14]: Agreed

inclusion and exclusion criteria			Director Infectious Diseases
Improve medication management practices (Pharmacy)	Create a process to ensure HITH patients receive a reconciled medication list on discharge.	2 months	Director Pharmacy and HITH Service Group Director
	Create standard process for medication management to support all clinical pharmacists across SCHHS when preparing a patient for, or managing a patient on HITH.	1-2 months	Director Pharmacy and HITH Service Group Director
	Review the HITH implications on pharmacy resources (especially in an expanded service), and consider recruitment of a dedicated HITH pharmacy resource.	1-3 months	Director Pharmacy and HITH Service Group Director
Increase patient groups requiring Allied Health input	Consider patient groups high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.	6-12 months	HITH Medical Officer and Director Allied Health
Streamline antimicrobial stewardship processes	Develop standard antibiotic regimes for the top 3 patient cohorts that require antibiotics.	4-6 months	Director Infectious Diseases with Director Pharmacy
Strengthen corporate governance	Formalise a Governance group with clear Terms of Reference *(Toolkit, Terms of Reference considerations)* to include performance monitoring, quality and safety reporting, DRG expansion, communication and resource development. Membership is to representative of service groups/facilities	1 month	HITH Service Group Director
	Review current corporate governance structure and consider moving under the medical services group to better reflect the acute nature of the HITH service.	1 month	SCHHS Executive team
Embed a patient safety and quality framework	Ensure national safety and quality accreditation requirements are embedded in future HITH contracts	1-6 months	HITH Service Group Director and Contracts team
	Recommence clinical quality and safety meeting with relevant stakeholders	2 months	HITH Service Group Director
	Formalise and document incident	1 month	HITH Service

	management process with provider		Group Director and Safety and Quality team
	Formalise the deteriorating patient process within the contracts	1 month	HITH Service Group Director
Promote HITH Service across SCHHS	Create a multi-modal communication plan for approval by the HITH governance body, including, but not limited to: Resident/Registrar orientation, grand rounds, posters, screen savers, one on one education, nursing orientation, allied health, Case presentations, consumer presentations, newsletters etc *(Toolkit, HITH Program Procedure and Patient handout)*	1-4 months	HITH Service Group Director

Appendices

Appendix 1 – Stakeholder List

Stakeholder interviewed *(SCUH stakeholders unless stated otherwise)*	Date
HITH Medical Lead/Project Owner	3, 10, 11, 19 and 20 April 2018
A/ Executive Director Clinical Services, SCHHS/Project Sponsor	3 and 20 April 2018
Service Director, CISAS, SCHHS/Project Sponsor	3 and 20 April 2018
Chief Executive, SCHHS/Project Sponsor	20 April 2018
Manager, Contracts and Procurement	10 April 2018
CHIP/HITH Administration Officer	10 April 2018
SCUH Pharmacist	10 April 2018
Nambour Hospital NUMs/CHIP nurses (group)	10 April 2018
SCUH NUM, Emergency Department	10 April 2018
SCUH HITH Coordinator	10 April 2018
Gympie Hospital NUMs	10 April 2018
A/ Contract Management Director & A/ Project Manager, Commercial and Contracts	11 April 2018
Nursing Director, PACH	11 April 2018
Executive Director, Allied Health	11 April 2018
SCUH NUMs (small group)	11 April 2018
SCUH Nursing Directors (small group)	11 April 2018
A/ Manager Patient Safety and Patient Safety Officer	11 April 2018
Business Development Manager, HITH, Blue Care	12 April 2018
SCUH Director, Emergency Department	17 April 2018
NUM CHIP, Transition Services	18 April 2018
Nambour Hospital, Director, General Medicine,	18 April 2018
SCUH NUM (Cardiology/Endocrinology)	18 April 2018
SCUH Staff Specialist, Infectious Diseases	19 April 2018
SCUH Director of Pharmacy	19 April 2018
Gympie Hospital Director of Nursing/Facility Manager	19 April 2018
Clinical Director, CISAS	19 April 2018
SCUH Director of Surgery	19 April 2018
Gympie Hospital, SMO, Emergency Department	19 April 2018
Gympie Hospital, Pharmacist	19 April 2018
External HITH Provider, Focus Health Care	19 April 2018
Former SCUH Clinical Director HITH	20 April 2018
A/ Clinical, Service Director, Medical Services Group, Nursing Director, Medicine and ID Physician, Infectious Diseases (group)	20 April 2018
Nambour Hospital, Director, Emergency Department	20 April 2018
Director, Clinical Operations Queensland, Silver Chain [redacted] nd General Manager, East Coast	20 April 2018
Clinical Nurse, MAPU, SCUH	20 April 2018
Clinical Director, Caloundra Minor Injury and Illness Clinic	20 April 2018

Service Delivery Model Options

	Outsourced Multi provider	**Outsourced Single Provider**	**Internal model**
Staffing Internal HHS	Pharmacy Medical Clinical Nurse Consultant Administration CHIP/case finder Contract management time	Pharmacy Medical Clinical Nurse Consultant Administration Contract management time (minimal)	Pharmacy Medical Clinical Nurse Consultant Administration CHIP/case finders Nursing (1.2 FTE per 5-6 beds) Access to Allied health Project officer
Staffing External Provider	Nursing Access to Allied Health	Nursing Access to Allied Health Clinical Nurse Consultant Administration CHIP/Case finder	Nil
Risk/Benefits	Increased • Flexibility of volumes • HHS hold most of the risk • Confusion regarding service delivery • Potential for inequitable distribution of referrals • Internal cost to support program • Flexibility of activity • Contract and invoice flexibility Reduced • Consistency of service delivery • External cost • Internal driver for new groups • Ability to manage against KPIs	Increased • Consistency • External cost • Ability to manage against KPIs • Consistency of service delivery Reduced • HHS holds less of the risk • Confusion regarding service delivery • Internal cost to support program • Flexibility of activity to meet demand • Contract and invoice complexity	Increased • HHS has all the risk • Internal cost (staffing costs high) • Delays in commencing due to HHS processes and availability of skilled community workforce • Contract risk • LOS Reduced • Confusion • External cost

From: Laureen Hines
Sent: Monday, 20 May 2019 1:11 PM
To: Laureen Hines
Subject: FW: HITH Review feedback
Attachments: image001.gif

-----Original Message-----
From: Theodore Chamberlain
Sent: Wednesday, 23 May 2018 5:36 PM
To: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: Re: HITH Review feedback

Thanks laureen

Sent from my iPhone

> On 23 May 2018, at 5:33 pm, Laureen Hines <Laureen.Hines@health.qld.gov.au> wrote:
>
>
> Hi
>
> Thank you for your feedback on the draft SCHHS HITH report. Please see the attached amended documents (dated the 23 May) noting the below changes in line with your comments:
>
> Comment HITH activity section: Would be good to provide some examples of “Same Day admissions” that would fit under a HITH model (noting the caution against providing outpatient care- last para, p 16 under “Promotion of Service”).
>
> Response: Same day admissions are an exclusion for HITH in Queensland and therefor no examples have been provided.
>
>
>
> Comment Length of Stay section: Imp to note that if these pts were
> excluded from HITH in our HHS is likely that they would further
> contribute to hospital access block –
>
> Response: Wording amended
>
> It is important to acknowledge however, that within SCHHS, if these long-term antibiotic patients were excluded from HITH and not managed through the existing Home IV Antibiotic Service (HIAS) , they would further adversely impact on access block. Note that reducing LOS increases patient turnover, allowing more patients to be treated under HITH .
>
>
> Comment referral Process section : Some issues identified are SCUH-specific. Need to contextualise that this is a whole-of-HHS HITH model which will create facility-specific issues, barriers & solutions and therefore a potential for confusion as a result.
>
> Response: Wording amended
>

> Introduction - Whilst the HITH referral process outlined below largely pertains to SCUH, it is acknowledged the current HITH service delivery model extends across the entire SCHHS, thereby creating facility specific challenges and barriers, which in turn, will require facility specific solutions.
> Body of the section – Clarified the parts that refer directly to SCUH
> and HHS wide
>
> Comment Referral Process section: From memory, Townsville's more mature HITH model has dedicated HITH 'leads' in each facility which would facilitate better coordination across facilities.
>
> Response: Townsville only has one HITH lead however Metro North has
> one at each site. - Wording amended in the recommendation under
> Strengthen corporate governance –
>
> Consider nominating a HITH lead at each facility to better facilitate care across SCHHS.
>
>
> Comment Corporate Governance section This is incorrect - there was a well-established HITH Clinical Working Group in place at the time the former HITH Clinical Director commenced in the role. However, chairing and maintaining that group was the Clinical Director's responsibility. The HITH Clinical Working Group had multi-facility and multi-service group representation (but with variable attendance). This Group reported to the SCHHS HITH local Governance Committee.
>
> Response: Wording amended
> Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was a perceived lack of a forum for broad consultation or service development. Some stakeholders suggested establishment of a robust Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.
> Up until the temporary appointment of the current HITH Medical Officer, the review team understands there was an established HITH Clinical Working Group chaired by the former HITH Medical Officer SCUH, which reported to the SCHHS HITH local Governance Committee. Membership had multi-facility and multi-service group representation, but it is understood attendance was variable. Clinical governance appears to have been the sole responsibility of the former HITH Medical Officer SCUH Clinical Director HITH .
>
> Comment Corporate Governance section : Do we need a medical model with some redundancy? E.g. two part-timers instead of the full-timer? Is it worth stating that re-engagement of HITH GPs could be considered to enable the necessary redundancy?
>
> Response: Added Explore alternative Clinical Governance models to
> recommendations
>
> Revisit Authorised Practitioner Governance Model and consider partnering with general practice to deliver medical governance for HITH patients. Options include:
>
> * HHS contract with credentialed GPs
> * Provider contract with credentialed GPs
>
> Comment Recommendation Expand patient cohorts to increase DRGs treated
> under the HITH model of care and enhance referral processes : ?? where
> does 30% come from
>
> Response : This is a best guess based on the data we looked at and the understanding that approximately 50% of cellulitis can be managed under HITH.
>
> Comment Recommendation Expand patient cohorts to increase DRGs treated
> under the HITH model of care and enhance referral processes : EDCS/COO

> needs to be involved too
>
> Response: Added to the responsible officer section
>
> Comment Recommendation Improve contract arrangements: Would add that
> there would also need to be adequate internal infrastructure
> (staffing) to accommodate flexing up
>
> Response: Wording amended - Ensuring the provider commits to being able to deliver flexible volumes of activity as required (i.e. appropriate staffing).
>
> Comment recommendation Stabilise the HITH team: Current only permanent
> position is HITH SMO
>
> Response: change wording to – Permanently recruit to the:
>
> * HITH Senior Medical Officer role
> * Establish and permanently recruit HITH administration officer role (1FTE)
> Review other positions (i.e. Pharmacy) in line with the selected service delivery model selected (Toolkit, Service delivery model options).
>
> Comment recommendation Stabilise the HITH team: Could we perhaps talk about the 'medical model' rather than the single full time SMO?
> Response: No change. The dedicated HITH MO position is the preferred model and has the most impact. Shared models within other roles do not have the same impact as they get absorbed into other service activity to fix gaps and become no ones responsibility. Happy to discuss.
>
> Comment Tool Kit: Service Delivery Options attachment – Outsourced
> Single Provider, internal staffing does not include nursing – need to
> reconsider this to either have an internal nurse in addition OR
> replace outsourced provider's CHIP/Case finder with an internal nurse
> OR nurses in both internal/external teams. There will be longer term
> benefits with a dedicated internal nurse (e.g. if the HHS changes
> provider at any time in future)
>
> Response: Added Clinical Nurses (if not within Provider contract) to the HHS staffing. You can however reduce internal costs by having the provide have case finders within the hospital which negates the need for these HHS resources.
>
> Happy to discuss any concerns. If you are happy with the change please let me know by COB Friday and we will send the final report.
>
> Regards
>
> Laureen Hines - Manager
> Healthcare Improvement Unit (HIU) previously CARU
> | Clinical Excellence Division|Department of Health, Queensland
> | Government | www.health.qld.gov.au<http://www.health.qld.gov.au/>
> Level 2, 15 Butterfield Street,Herston 4006
> 07 3328 9937
> Laureen.hines@health.qld.gov.au<mailto:Laureen.hines@health.qld.gov.au
> >
>
> Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.
>

> <image001.gif>
> <FINAL Report_SCHHS HITH Review_23May.doc> <Toolkit_Final 23.05.docx>
> <Amended Draft_SCHHS HITH Review Final 10.05_re SCHHS
> feedback_22May.doc> <AMEND_Service Delivery Model
> Options_22May18pdf.pdf>

From: Laureen Hines
Sent: Monday, 20 May 2019 1:06 PM
To: Laureen Hines
Subject: FW: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

From: Sonya Mizzi
Sent: Tuesday, 29 May 2018 8:37 AM
To: Michael Young <Michael.Young2@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: RE: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Mick

Appreciate this feedback, many thanks.

Kind regards

Queensland Government

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
w: Queensland Health | **e:** Sonya.Mizzi@health.qld.gov.au

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From: Michael Young
Sent: Friday, 25 May 2018 9:26 AM
To: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: RE: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Sonya and Laureen,

I was pretty happy with the content and discussions. They seem to have a handle on what is required and keen to progress the service. I had a chat with John Endacott on Wed morning as well to clarify some points around our model.

Cheers and thanks for all your hard work

Mick

From: Sonya Mizzi
Sent: Tuesday, 22 May 2018 4:23 PM
To: Michael Young
Cc: Sonya Mizzi; Laureen Hines
Subject: FW: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Mick

Just sharing the feedback from the SCHHS on the Draft HITH Report for your information (refer embedded comments).

Laureen and I will be updating the Draft Final Report to incorporate the feedback received tomorrow a.m., so if you have any additional comments, be sure to let us know.

Sonya

From: Piotr Swierkowski
Sent: Friday, 18 May 2018 5:48 PM
To: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>
Cc: Cang Dang <Cang.Dang@health.qld.gov.au>; Laureen Hines <Laureen.Hines@health.qld.gov.au>
Subject: FW: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Hello Sonya,

Here is the feedback from all main stakeholders at the SC HHS.

Kind regards
Piotr

From: Laureen Hines
Sent: Thursday, 10 May 2018 1:57 PM
To: Cang Dang <Cang.Dang@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>; Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>
Cc: Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Michael Young <Michael.Young2@health.qld.gov.au>; Damien Searle <Damien.Searle@health.qld.gov.au>
Subject: Feedback Required by COB 16.05.18 - Draft SCHHS HITH Review (in confidence)

Good Afternoon,
Thanks you for the opportunity to review the HITH service in the Sunshine Coast Hospital and Health Service. Please see the attached draft review and recommendations report including the toolkit provided in confidence. To ensure accuracy of content please review the documents for factual correctness and provide feedback (track changes) to Sonya Sonya.Mizzi@health.qld.gov.au, by close of business **Wednesday 16 May 2018**. Following the receipt of feedback the document will be amended and a final copy sent to all project owner and sponsors.

Regards
Laureen and Sonya

Laureen Hines - Manager
Healthcare Improvement Unit (HIU) previously CARU
| Clinical Excellence Division|Department of Health, Queensland Government |
www.health.qld.gov.au

Level 2, 15 Butterfield Street,Herston 4006
07 3328 9937
Laureen.hines@health.qld.gov.au

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From: Laureen Hines
Sent: Monday, 20 May 2019 1:23 PM
To: Laureen Hines
Subject: FW: FOR NOTING: Final Hospital in the Home (HITH) Review Report and Toolkit, and related HITH Review Plan
Attachments: EDHIU_HITH Review Report SCHHS.pdf; FINAL Report_SCHHS HITH Review_31May.pdf; Toolkit_Final 23.05.docx; SIGNED SCHHS HITH Review Plan.pdf

From: Sonya Mizzi
Sent: Tuesday, 12 June 2018 4:11 PM
To: SCHHS Chief Executive <SCHHS_Chief_Executive@health.qld.gov.au>
Cc: Laureen Hines <Laureen.Hines@health.qld.gov.au>; Sonya Mizzi <Sonya.Mizzi@health.qld.gov.au>; Theodore Chamberlain <Theodore.Chamberlain@health.qld.gov.au>; Piotr Swierkowski <Piotr.Swierkowski@health.qld.gov.au>; Cang Dang <Cang.Dang@health.qld.gov.au>
Subject: FOR NOTING: Final Hospital in the Home (HITH) Review Report and Toolkit, and related HITH Review Plan

Adjunct Professor Dwyer

Please find attached correspondence from Michael Zanco, Executive Director, Healthcare Improvement Unit, Clinical Excellence, regarding formal submission of the following documents:

- Final Hospital in the Home (HITH) Review Report, and related Toolkit (previously provided to Ted Chamberlain, Cang Dang and Piotr Swierkowski); and
- Signed HITH Review Plan

Kind regards

Queensland Government

Sonya Mizzi
Senior Project Officer
Healthcare Improvement Unit, Healthcare Innovation and Research Branch, **Department of Health**
p: 07 33289079 |
a: Level 2, 15 Butterfield Street, Herston, QLD, 4006
w: Queensland Health | **e:** Sonya.Mizzi@health.qld.gov.au

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Queensland Government

Department of Health

Enquiries to: Laureen Hines
Manager
Healthcare Improvement Unit
Clinical Excellence Division

Telephone: 3328 9079
File Ref: HITH2018

Adjunct Professor Naomi Dwyer
Health Service Chief Executive
Sunshine Coast Hospital and Health Service

Email: SCHHS_Chief_Executive@health.qld.gov.au

Dear Adjunct Professor Dwyer

Thank you for engaging the Healthcare Improvement Unit to undertake the recent review of the Sunshine Coast Hospital and Health Service (SCHHS) Hospital in the Home (HITH) Service in May 2018. Please find attached the HITH Review Final Report and related Toolkit for your consideration, in addition to a copy of the signed Review Plan for your records.

Healthcare Improvement Unit looks forward to seeing the continued growth of the SCHHS HITH Service, and will continue to support your health service by focussing on the enhancement of promotion of HITH statewide. We look forward to the continued involvement of SCHHS in that process.

Should you require any further information in relation to this matter, I have arranged for Laureen Hines, Manager, Healthcare Improvement Unit, Clinical Excellence Division on telephone 3328 9937, to be available to assist you.

Yours sincerely

MICHAEL ZANCO
Executive Director
Healthcare Improvement Unit
Clinical Excellence Division
8/6/18

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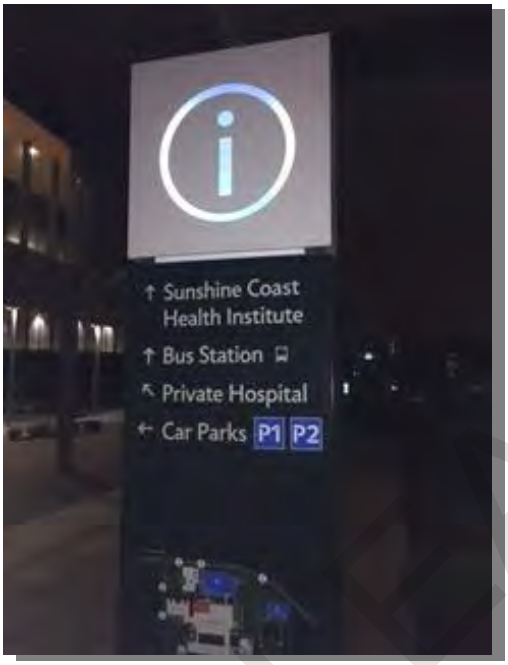
Hospital in the Home (HITH) Review

Sunshine Coast Hospital and Health Service
May 2018



Hospital in the Home (HITH) Review – Sunshine Coast University Hospital, May 2018

Published by the State of Queensland (Queensland Health), May 2018

For more information contact:
Healthcare Improvement Unit, Department of Health, GPO Box 48, Brisbane QLD 4001, email HIU@health.qld.gov.au, phone 3328 9079.

Contents

Introduction

The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the with sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH. To ensure a safe, efficient and quality HITH service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH service. Site visits to the SCHHS by the review team, with input from an external reviewer, Dr Michael Young, Senior Medical Officer, Hospital in the Home Service, the Townsville Hospital, Service Townsville Hospital and Health Service, were conducted on 10 -11 April and 19 - 20 April 2018 respectively.

Review specifications

Objectives

The aim of this body of work was to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the objectives below:

- Review of the decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model delivers consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH service.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Hospitalisations (PPHs) (e.g. cellulitis, Chronic Obstructive Pulmonary Disease COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. Sunshine Coast University Private Hospital (SCUPH)

Scope

The scope of the review encompassed the entire SCHHS HITH service, with interviews undertaken with various internal stakeholders from the Sunshine Coast University, Gympie, Nambour, and Maleny hospitals, Caloundra Minor Injuries and Illness Clinic (MIIC), in addition to some external stakeholders (applicable external HITH providers). In scope was also a review and analysis of data related to HITH utilisation, examination of admission processes and service profiles and where applicable, a review of business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, and HITH service provider contracts and related deeds of variation.

The review team were made aware of the SCHHS Executive commissioning of an internal audit of the tendering/contract process as it relates to the *Transitional Care and Other Services Standing Offer Arrangement*, however this was out of scope for the review.

Methodology

The following information sources informed the review findings and recommendations:

- Relevant HITH-related data and other patient flow metrics were sourced from RiskMan, HBCIS, statewide HITH Dashboard and SCUPH contract data.
- Targeted stakeholder interviews to identify opportunities for improvement and growth, barriers/challenges and understand individual/group perceptions of the SCHHS HITH service and access and flow of SCHHS patients.
- Examination of relevant HITH documentation and procedures, including (but not limited to) HITH referral packs, applicable HITH service provider contracts and related deeds of variation.
- Individual opinions/perceptions were tested and validated, with only those opinions shared by two or more sources incorporated into the report to maintain the integrity of same.

Activity data

HITH specific data was obtained through the HOME ward data available in the HBCIS data collection for 2017 calendar year and 2018 available data, via the statewide HITH dashboard developed by the HIU data team. Other inpatient related data was accessed via the HBCIS data from the Health Statistics Branch. Additional data pertaining to the SCUPH and reported blood stream infection rates were sourced directly from applicable service areas within SCHHS.

Consultation

Pre-review interviews where held with the project owner and project sponsors on 3 April 2018 to clarify scope, confirm the review plan and identify key stakeholders for consultation. Extensive face-to-face consultation with internal and external stakeholders occurred over 10, 11, 19 and 20 April, where

stakeholders were unavailable for face-to-face interviews, phone interviews where held on 12,17 and 18 April (Appendix 1). Note that interviews did not occur with the following identified stakeholders, due to their unavailability/unavailability of an appropriate proxy: Nambour Director Emergency Department, Sunshine Coast University Hospital (SCUH) Executive Director Nursing and Midwifery, Director of Cardiology, Director of Renal, Director of Medicine (Gympie), Acting Director of Orthopaedics and the Clinical Director and Emergency Department NUM (Nambour).

Interviews (face-to-face, videoconference and teleconference) convened on 10 and 11 April, phone interviews on 12, 17 and 18 April and face-to-face interviews with external providers (Focus Healthcare and Silver Chain) on 19 and 20 April respectively, were conducted by only some members of the review team (Laureen Hines, with Sonya Mizzi in attendance), to maximise involvement of the external reviewer, Dr Michael Young. The entire review team, including Dr Young did participate in all remaining interviews on 19 and 20 April. Dr Young elected not to participate in external provider interviews due to a reported conflict of interest.

SCHHS HITH Service Observations and Findings

HITH Service Delivery Model

Historically, the SCHHS has participated in a variety of HITH models. The original model commenced providing hospital substitution and post-acute care under the Home Based Acute Care Service (HBACS) model. In 2014 Silver Chain was awarded a central contract to deliver HITH in Queensland and elected to deliver this care in the SCHHS. At this point, the HBACS service was disbanded by the SCHHS and the Hospital in the Home Public Private Partnership Initiative (HITH PPP) commenced on 1 January 2014. The HITH PPP model then ran as an outsourced HITH model of care between 2014 – 2017. During this time, many medical, nursing and administration temporary staff supported the models internally under the SCHHS Minimum Obligatory Human Resource Information (MOHRI).

At the end of the centralised contract period (31 December 2017), SCHHS elected to continue to partner with the Non-Government sector to deliver HITH services. In late 2017, the SCHHS approached the market to extend the *Transitional Care and Other Services Standing Offer Arrangement* to include HITH under a fee-for-service arrangement. An expression of interest (EOI) was sent to the current panel delivering care under this arrangement and opened to other HITH providers. The EOI included HITH specific requirements, and selection was based on a written EOI and the outcome of interviews with the former SCUH Clinical Director HITH. Following this, a Deed of Variation (DoV) was signed with two providers, Silver Chain and Focus Healthcare. Whilst the DoV does outline some high-level Key Performance Indicators (KPIs), it lacks the service level detail outlined in the market documents. As a result, the current arrangement has limited ability to hold the providers to account against the key requirements for service delivery, posing a potential risk to the delivery of high quality service.

Data analysis

HITH Activity

HITH activity across SCHHS accounted for 0.32% of total hospital acute admissions in 2017, compared to the statewide average of 0.72% (Table 1). 2018 saw a slight increase in HITH activity, with 0.35% of

total acute admissions attributable to the SCHHS, compared to the statewide average of 0.66% of hospital acute admissions. Currently the SCHHS HITH activity is well under notional HITH target of 1.5% with considerable opportunity for growth. Within this cohort, no activity was attributable to same day separations which is directly in line with HITH requirements.

Table 1 - SCHHS HITH Service comparative data

Key performance indicator	SCHHS 2017	SCHHS 2018 (Jan to March)	State 2017	State 2018
HITH % total hospital separations	0.32%	0.35%	0.72%	0.66%
Same day % discharge (not present at midnight census)	0	0	0.04%	0.05%
Overnight % discharge (present at midnight census)	0.73%	0.79%	1.4%	1.33%
Readmissions % (same DRG with 28 days)	1.89%	1.61%	2.1%	2.43%
Average Length of Stay (LOS) (days)	14.07	9.63	9.27	8.92

To identify opportunity for growth, comparative data was analysed which confirms potential for growth. As identified (Table 2), each facility was compared to like hospitals, based on volume of presentations and geographical catchment. As identified, each site has a significant opportunity for expansion.

Table 2 - Site comparative data

Site	HITH volume	LOS	Volume
SCUH	193	14	0.35%
Townsville	763	4	1.28%
Nambour	92	16	0.32%
QEII	246	9	0.9%
Gympie	30	8	0.3%
Gladstone	202	8	1.89%

There are opportunities to grow the HITH service and release additional inpatient bed capacity. Table 3 below outlines how this growth can be achieved based on 2017 calendar year data.

Table 3 HITH Growth

To achieve growth of HITH separations by	1%	1.5%
Number of additional patients to be cared for by HITH	988	1481
Referrals required each day (365 days per year)	3	4
HITH beds required at current LOS (14 days)	37	56
HITH beds required if LOS is reduced to 9 days in line with state average	24	36

Readmission rates

Readmission rates are a quality measure for HITH. Low readmission rates for the same condition indicate that patients are receiving the care that is required during the episode of care. HITH patient readmission rates for the same condition for the SCHHS HITH Service

decreased from 1.89% in 2017, to 1.61% in 2018, which is lower than the state average of 2.1% in 2017 and 2.43% in 2018.This data indicates that the service delivered under the current HITH model is meeting the needs of the patients.

Length of Stay (LOS)

Length of Stay is an efficiency measure for HITH and should be reflective of the standard LOS the patient would have received in hospital. The average LOS for SCHHS HITH service has decreased substantially from 14.07 days in 2017, to 9.63 days on 2018. When compared to the HITH state average, which was 9.27 days in 2017, and 8.92 days in 2018, the SCHHS HITH service LOS has been above the state average in both years. Stakeholders reported that long-term antibiotic patients impact on the overall LOS. Due to the long LOS, the volume of patients that can be referred to HITH is limited as this creates access block. It is important to acknowledge however, that within SCHHS, if these long-term antibiotic patients were excluded from HITH and not managed through the existing Home IV Antibiotic Service (HIAS), they would further adversely impact on access block. Note that reducing LOS increases patient turnover, allowing more patients to be treated under HITH.

Top 10 Diagnosis Related Groups (DRGs) and LOS

Comparative analysis of the top ten DRGs treated under the SCHHS HITH service model of care is shown in Table 4. Analysis identifies that the SCHHS treats different patient cohorts to other services in the state ten. SCHHS HITH service treats a higher volume of J64B, T64B, T60B, X60A, M64A, B07A, I73A, F61A and J68A. The DRGs currently treated under HITH require long length of treatment and may be more suited to being treated in the outpatient setting. The SCHHS currently does not treat L63A Kidney and urinary tract, L63B Kidney and urinary tract, E62A Respiratory infection /inflammation, E62B Respiratory infection /inflammation, T60C Septicaemia and E65A COPD which are seen in high volumes across the state.

Table 4 - SCHHS HITH Service Top 10 DRGs and LOS (includes time spent in hospital) comparison to State – 2018 (January to March)

DRG	Condition	SCHHS % of total admit	State % of total admit	State HITH LOS	SCHHS LOS
J64B	Cellulitis minor	18%	14%	3.7	3.9
J64A	Cellulitis major	8%	13%	5.9	6.4
T64B	Other infections and other disease	21%	14%	16.6	21.9
T60B	Septicaemia	6%	5%	9.8	14.2
X60A	Injuries	4%	3%	16.3	3.3
M64A	Other male reproductive system	20%	3%	27.2	27.2
B07A	Cranl/Prphl nerv and other	50%	9%	14.1	15.6
I73A	Adtcare musck impl/pros	20%	15%	14.2	13.8
F61A	Infect endocarditis	25%	19%	30.5	30
J68A	Major skin disorder	5%	2%	4.6	4

Sunshine Coast University Private Hospital (SCUPH)

The cessation of the SCUPH contract on 20 September 2018 is identified as an opportunity for consideration of the service model. A brief review of confidential 2016-17 SCUPH data (discharging DRGs from SCUPH) identified that 2485 patients transferred to SCUPH presented with conditions traditionally treated under the HITH model of care. There appear adequate volumes for the following DRGs to be considered for treatment by SCHHS HITH service - potentially via a phased implementation across SCHHS facilities: Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations and COPD. Additionally, it would be feasible for the current iTransfer system currently utilised across SCHHS facilities, to be adapted to facilitate referrals to the HITH service, negating the need for paper-based referrals.

Culture and Readiness

Stakeholders at all levels of the SCHHS organisation, including members of SCHHS Executive, communicated the value of a functional HITH service within SCHHS, and readiness to accept a reviewed model of care (MoC), pending the resolution of identified clinical and corporate governance issues. When asked to identify development opportunities, stakeholders were forthcoming with suggestions to optimise HITH and enhance the access and flow of patients across SCHHS.

Medical buy-in to the HITH model of care is variable and it was noted that the SCHHS, like most HHSs, is a medically-driven model of care. The review team suggests the perceived reluctance to relinquish the care of patients to HITH is likely due to a mistrust, uncertainty around service provision, lack of referral pathways, and lack of understanding of the level and quality of care.

Consistent messages expressed by stakeholders included:

- Unreliable availability
- Ad-hoc service delivery model
- No opportunity to get embedded processes and build confidence due the many internal HITH staff changes (medical/nursing)
- Lack of visibility and ownership

Contractual arrangements

Provider interviewed noted their impetus for interest in the tender process was to establish a 'footprint' in the SCHHS. Acknowledging that SCHHS's plans to grow the HITH service (potentially to 20-40 beds) was also an incentive, both providers sighted concerns regarding a lack of guaranteed volume and types of referrals (sighting more complex patients being referred) and variations of same (adversely impacting staffing). Providers interviewed reported some confusion regarding the Transitional Care and Other Services tender process, sighting difficulties with applying a HITH model to a Transitional Care model (lack of clarity regarding service expectation, expansive service catchment), which resulted in some KPIs not being appropriately aligned to HITH. Additionally, a lack of identified contract governance was sighted (lack of a clearly identified contract/case manager and escalation process). Similarly, providers suggested the current fee for service model does not provide a sustainable cost-viable option to deliver acute care requirements for HITH patients across SCHHS, with feedback suggesting the current model places most of the risk on providers.

HITH Team

SCHHS resources

- 1FTE Medical Officer (currently vacant)
- 1 FTE Administrator (temporary)
- 1 FTE HITH Coordinator (temporary)

External provider resources

- Registered Nurse
- Allied health as required
- After hours on call for patients

HITH hours of operation

SCHHS currently has access to HITH services 7 days a week. The providers deliver home visits between 8am to 6pm, with limited capacity to provide twice daily visits. Patients are identified by the SCHHS Community Hospital Interface Program (CHIP) nurses in the wards or the SCUH HITH Coordinator from Monday to Friday 8am to 4pm. The HITH Medical Officer actively manages current patients, providing oversight for all new referrals and on call coverage (after hours/weekends).

Service catchment

When compared with other HITH service catchment areas statewide, SCHHS HITH service is expansive. Many stakeholders sighted a perceived reluctance and/or inability of the current provider (due to staffing) to service patients that live greater distances from Sunshine Coast University, Nambour, Gympie, Maleny and Caloundra Hospitals especially servicing areas outside of Gympie i.e. Kilkivan, Tin Can Bay and Cooloola Cove, were sighted. Particular difficulties regarding service provision in the surrounding areas of Gympie, Tin Can Bay and Cooloola Cove were reported, resulting in what is perceived as an ad-hoc, unreliable HITH service currently.

Inclusion and Exclusion – Patient Selection

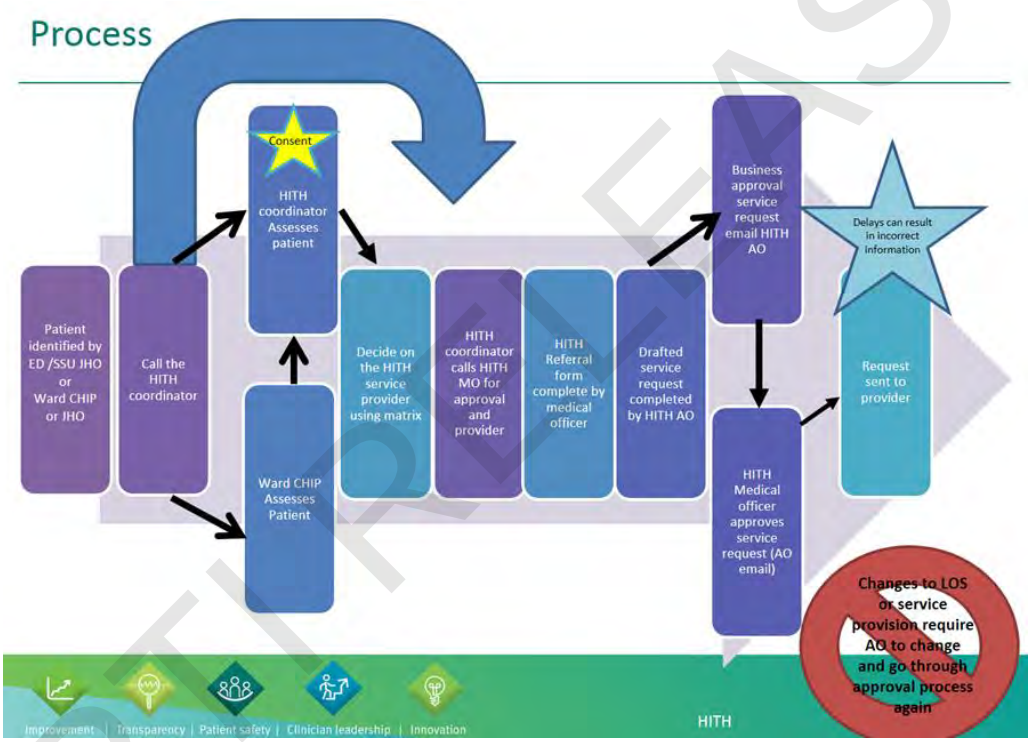
All interviews with stakeholders identified a limited knowledge or misinterpretation of HITH of the inclusion and exclusion criteria for HITH. Clinicians' perception of HITH service appears limited, it being viewed as a long-term antibiotic service for patients unable to attend the Home IV Antibiotic Service (HIAS). There appears to be confusion by some medical officers/nursing staff regarding what patients are appropriate to refer to HITH versus the HIAS. Feedback suggests the demarcation between HITH and HIAS services is blurred, with the HITH service being utilised at a 'back-stop' when HIAS is at capacity. This limited understanding largely guides perceptions of HITH and the lack of uptake for any other patient groups.

Further impacting HITH uptake there was a common belief that HITH does not see patients in Residential Aged Care Facilities (RACFs), boats, caravans and other temporary dwellings. There was also a demonstrated lack of understanding about the level of service and the number of visits per day providers can deliver.

Referral process

Whilst the HITH referral process outlined below largely pertains to SCUH, it is acknowledged the current HITH service delivery model extends across the entire SCHHS, thereby creating facility specific challenges and barriers, which in turn, will require facility specific solutions. At all facilities it was reported that HITH patients are identified by the SCHHS CHIP nurses in the wards, medical staff or the SCUH HITH Coordinator from Monday to Friday 8 to 4pm (Figure 1), with most referrals received from inpatient units and limited referrals from the HHS Emergency Departments (EDs).

Figure 1 Referral Process at SCUH



The referral process consists of a generic referral form and a patient consenting process. At the SCUH the HITH Coordinator completes most of the paperwork and reviews the SCUH patients, however at other sites, this is undertaken by the CHIP nurse. Whilst the packaging process is streamlined, the approval process for the fee for service contract is complex and can result in delayed acceptance time.

When discussing HITH with clinical staff from EDs, there were a number of barriers identified. The use of the generic form was considered labour intensive and did not support the understanding of what can be delivered under HITH. Delays caused by multiple acceptance processes also impacted on the timeliness of patients being accepted, resulting in access block in EDs. When the review team discussed condition-specific referral forms, stakeholders identified this would support uptake.

The review identified a lack of direct referrals to HITH from EDs across the HHS. There was a successful three-month trial at SCUH, whereby a CHIP/HITH nurse identified HITH-suitable patients in the Short Stay Unit (SSU). By utilising the SSU to package HITH patients, this created SSU access block and the

position was not sustained. Following this trial, feedback from the SCUH ED identified there is a perceived limited visibility of the HITH team in the ED, adversely impacting on direct referrals to HITH from ED.

Anecdotal reports from SCUH, suggest that currently some patients are transferred from the ED to the Medical Assessment Unit (MAU), could be transferred directly to HITH, if there was an easy and clearly understood referral pathway, coupled with an increased understanding of the level of care that can be provided under the HITH service.

Advice provided suggests that the MIIC is currently providing care for patients via an intravenous antibiotic clinic. Like the MAU, with an increased understanding of HITH and referral pathways, there may be an opportunity to source direct referrals from MIIC.

Pharmacy

It is well documented in the literature that any transfers of care from one service to another, increases medication error risk, and HITH is no exception. The review identified that SCHHS does not have any dedicated pharmacy resource allocated to HITH. It is evident that one of the dispensing pharmacists at the SCUH has taken a lead in supporting HITH within their current role. Within this role some processes have been established to increase consistency and safety. When assessing the current medication management against the HITH Guideline , the service is meeting most requirements, with the exception of the medication reconciliation on discharge, which is an essential part of the transfer of care back to the General Practitioner. Whilst temporary support from this individual is beneficial, consideration needs to be given to the impact on this role if the service grows. Feedback received from Gympie Hospital, suggests there has been an increase in medication related incidents since January 2018, with junior pharmacy staff (in the absence of a Senior Pharmacist) having to make decisions they did not have to make previously under the central contract.

Allied Health

To ensure care is equivalent to that delivered within the acute facility, access to allied health is essential. The review revealed limited engagement or input from allied health in the SCHHS HITH service development and operation. Input from this cohort would broaden the scope of the HITH service and in turn support service delivery, with the cohort able to identify the following potential patient groups for consideration suitable for HITH: high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.

Antimicrobial stewardship

Antimicrobial stewardship is essential in ensuring the care provided to patients is of a high standard and equivalent to inpatient care. Stakeholders identified the need to ensure that patients admitted to HITH need to be prescribed the right antibiotic for the right duration. Currently every patient receiving intravenous antibiotics under HITH is seen by the Infectious Diseases team prior to transfer of care. Whilst reports did not identify this as a barrier to referral, the process could be streamlined with the implementation of clear pathways and agreed treatment options for identified DRGs and patient cohorts.

Governance – Corporate and Clinical

Corporate governance

Appropriate corporate and clinical governance is essential in ensuring the uptake of HITH, safety and quality of service delivery, viability and performance management. HITH in the SCHHS is governed under the Community Integrated & Sub-Acute Services (CISAS) area. The Queensland Department of Health HITH Guideline states "strong corporate governance will provide transparent monitoring/reporting systems, strong clinical leadership, advocacy and clinical risk management". Assessment against the recommended requirements for sound corporate governance are identified in Table 5.

Table 5 - Corporate governance assessment

Recommendation		Comment
The corporate governance structure is to be developed to include representation from all relevant clinical levels and professionals within the HHS and any external providers (if relevant).	✗	Previously met however all relevant clinical areas were not included
HITH services are to be incorporated into the HHS planning and demand management strategies.	✓	
Data and KPIs are to be monitored, analysed and reported via local HHS processes and communicated to all stakeholders on a regular basis.	✗	Previously met however limited to those directly involved only

Feedback reported to the review team identified the current alignment with CISAS may be adversely impacting on the uptake and ownership of the service. While there are some synergies in the delivery of the care in the community, when questioned regarding the best alignment, 90% of stakeholders identified that Medical Services Group would be better placed to provide corporate governance, as an acute HITH service needs to be visible e.g. seen and run as an 'acute virtual ward'.

Acknowledging that a HITH service requires buy-in from various stakeholder groups, feedback received identified this may have occurred on an individual basis, however there was a perceived lack of a forum for broad consultation or service development. Some stakeholders suggested establishment of a robust Governance Body, representative of all applicable service groups, would be beneficial, especially in terms of monitoring HITH KPIs and outcomes data, and ensuring appropriate utilisation of HITH across SCHHS.

Up until the temporary appointment of the current HITH Medical Officer, the review team understands there was an established HITH Clinical Working Group chaired by the former HITH Medical Officer SCUH, which reported to the SCHHS HITH local Governance Committee. Membership had multi-facility and multi-service group representation, but it is understood attendance was variable..

Various stakeholders acknowledged the lack of consistent nursing governance and support staff for temporary nursing roles has impacted on the ability to drive HITH from a strategic perspective. Feedback received suggests that in collaboration with the HITH coordinator, and utilisation of CHIP resources, the former Clinical Director HITH was starting to gain traction in terms of communicating a clear vision for HITH/raising HITH profile across the SCHHS, formulating draft processes and procedures, with positive feedback particularly forthcoming regarding building required relationships with key stakeholders. It is suggested that a lack of internal infrastructure and permanently appointed dedicated support personnel has led to the lack of finalised documents, procedures and processes required to underpin a new MoC. As a result, the service is largely person-dependent and reactive, rendering it unsustainable in its current form.

It is acknowledged, that the current HITH Medical Officer, is providing oversight of the day-to-day functioning of the SCHHS HITH service. The role is ensuring a safe service is maintained, with positive feedback received from internal/external stakeholders alike, however this temporary arrangement is unsustainable. Whist this role straddles both clinical and operational service development, with no permanent HITH team supporting that role, this will impede expansion of the service into a sustainable robust model. For sustainability, the SCHHS HITH service should not be person-dependent. Success of the service relies on buy-in from various stakeholder groups, and the skill-set of the generalist medical officer may be well-suited to leading the service.

Clinical governance

Clear lines of clinical governance are “essential to ensure a treatment plan (medical management plan) is established and appropriate management and coordination of care is achieved” (HITH Guideline). The governance arrangements for SCHHS align with the HITH Guideline and consist of the following structures:

1. Inpatient Admitting Team Clinical Governance Model

   The treating hospital inpatient authorised practitioner retains responsibility for the care of the patient admitted to HITH throughout the episode of care.

   This model occurs for infectious disease and renal patients.

2. HITH authorised practitioner (dedicated HHS medical resource)

   Care is transferred from the admitting hospital inpatient team to a dedicated HITH authorised practitioner. The HITH authorised practitioner then takes on the responsibility for all care planning and treatment regimes.

   This model occurs for all non-specialty patients.

3. Authorised practitioner Governance Model (External governance Authorised)

   General Practitioners, credentialed with admitting rights within the SCHHS, admit patients under their care, take on the responsibility for all care planning and treatment regimes.

   This model is not currently active, however was available prior to 2018 through a Silver Chain sub-contract with a select group of medical practitioners.

Flexibility in clinical governance models is essential for a successful HITH MoC allowing for more patients to be transferred to HITH. When assessing the SCHHS HITH clinical governance the current model is sound with the SCHHS meeting all requirements (HITH Guideline) .

Patient Safety and Quality of Care

During the last five years of HITH in the SCHHS, formalised quality and safety mechanisms have varied. Throughout the centralised contract period there was a SCHHS quality and safety meeting, chaired by the former SCUH Clinical Director HITH, where processes and all reported incidents were reviewed as part of the centralised joint governance process (incidents reported monthly and discussed formally with HIU and the provider), however this was not held consistently. Since the cessation of the central contract in December 2017, these clinical safety and quality meetings have not been convened.

During the review process some stakeholders reported the lack of formalised process for the management of incidents or the deteriorating patient. Whilst providers are recording incidents (which the review team understand are not being filtered down to Patient Safety Office) and utilising the Queensland Adult Deterioration Detection System (QADDS) to identify a deteriorating process, there is no approved process for the management of these, resulting in a lack of visibility regarding HITH incidents (and related outcomes) by the Patient Safety Office.

It is understood that one impetus for this review was identified safety and quality risks related to the care of consumers, regarding blood stream infections (HCABSIs). The review process revealed that under the central contract (between 2014 – December 2017), there were no reported HCABSIs, however two HCABSIs have been attributed to HITH in January 2018 and March 2018 respectively. The review team understands this spike in HCABSIs was being examined by an Aggregate Review Team on 27 April 2018, with recommendations to follow.

Promotion of Service

The review revealed continued themes of lack of visibility, knowledge of HITH inclusion/exclusion criteria, scope of HITH and who the HITH team is (seen as long-term intravenous antibiotic service). Whilst the former Clinical Director HITH did go some way to promoting the service and building relationships to change the culture of how HITH was viewed within SCHHS, this was largely at the individual level. Some work to build the service was also undertaken with new patient cohorts having been identified, however preliminary discussions were in the early phases. Care does need to be taken to ensure that potential new patient groups, do substitute acute inpatient care and not outpatient care (e.g. Chemotherapy disconnects).

Recommended Actions

Recommendation	Actions	Timeframe for delivery	Accountable officer
Enhance service delivery models	Select the appropriate service Delivery model for the SCHHS HITH service *(Toolkit, Service delivery model options).*	2 weeks	SCHHS Executive team
	Immediately review the current Transitional Care and Other Services Standing Offer Arrangement to include more detailed service delivery requirements. Draft a Deed of Variation to include HITH specific requirements.	1 month	HITH Service Group Director
	Commence HITH specific procurement process.	1-6 months	Contracts team with HITH Medical Officer
	Create clear contract management structure with clear accountability, monitoring and communication.	Ongoing	Contracts team with HITH Medical Officer
Increase HITH activity	Set a goal of 1% total activity *(HITH Review, table 3).*	1-2 months	SCHHS Executive team
	Set a goal of 1.5% total activity *(HITH review, table 3).*	6-12 months	SCHHS Executive team
Manage HITH efficiency (Length of Stay)	Review HITH referrals by treating increased volume of HITH patients with a short length of stay and ensure the Infectious disease clinic is utilised for long term patients.	1-6 months	HITH Medical Officer and Director Infectious Diseases
Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Review current pathways used in Townsville Hospital *(Toolkit, Clinical pathways)* to maximise uptake of referrals including: ED direct referrals: - Cellulitis - Warfarin - Mastitis - Hyperemesis gravidarum - Urinary Tract Infection	2-4 months	HITH Medical Officer in partnership with applicable Service Groups

	ED or inpatient referrals: - Diverticulitis - Pneumonia - Post operation wound infection - Appendicitis		
	Develop new clinical pathways to include *(Toolkit, Recommended growth areas and %):* - Heart failure - Non-complex hip and knee replacement (build patient's selection into the pre-admission pathway) - Respiratory conditions bronchiectasis, respiratory infections and Cystic Fibrosis).	6-12 months	HITH Medical Officer in partnership with applicable Service Groups
	Convert 30% of SCUPH activity for Cellulitis, Kidney and Urinary Tract Infections, Respiratory Infections/Inflammations to HITH.	2-4 months	Executive Director of Clinical Services /Chief Operating Officer, Director ED and HITH Service Group Director
	Create a direct admission pathway for patients from RACFs.	6-12 months	HITH Medical Officer
	Develop an easy electronic referral platform for pathways for ED i.e. iTransfer.	2-3 months	HITH Service Group Director
Boost culture for HITH sustainability across SCHHS	Enhance visibility of HITH service across SCHHS (including scope, reach, availability and processes) and timely communication of service developments.	1-2 months	HITH Service Group Director
Improve contract arrangements	Review current fee for service model to reflect the acuity of service delivery required for HITH. Models could include: - Percentage (%) of DRG as a costing structure for patients directly out of ED	1-6 months	HITH Service Group Director

	- LOS based payment for patient transferred from inpatient areas to HITH		
	Review the contract to ensure equity of shared risk by: - Addition of a minimum base volume (e.g. 10 beds, as this is a safe risk for the HHS). - Ensuring the provider commits to being able to deliver flexible volumes of activity as required (i.e. appropriate staffing).	1-6 months	HITH Service Group Director
Stabilise the HITH team	Permanently recruit to the: - HITH Senior Medical Officer role - Establish and permanently recruit HITH administration officer role (1FTE) Review other positions (i.e. Pharmacy) in line with the selected service delivery model selected *(Toolkit, Service delivery model options).*	1-2 months	HITH Service Group Director
	Consider internal nursing requirements to support HITH referrals and process development.	1-2 months	HITH Service Group Director
Maximise HITH hours of operation	Ensure the providers can receive referrals 24/7 with a clear after-hours approval process in place.	1-3 months	HITH Service Group Director
Extend the service catchment	Ensure the procurement process for the provider has clear expectations on the geographical catchment (e.g. on average HITH Services in Queensland have a 50 km or 45minute radius). Use volume based indicator and patient level data to assess viability of providing care across SCHHS (minimum of 5 beds per day to be viable).	1-6 months	HITH Service Group Director

Increase clarity around HITH inclusion and exclusion criteria	Create a clear flowchart to denote the difference between HIAS and HITH.	1 month	HITH Medical Officer and Director Infectious Diseases
Improve medication management practices (Pharmacy)	Create a process to ensure HITH patients receive a reconciled medication list on discharge.	2 months	Director Pharmacy and HITH Service Group Director
	Create standard process for medication management to support all clinical pharmacists across SCHHS when preparing a patient for, or managing a patient on HITH.	1-2 months	Director Pharmacy and HITH Service Group Director
	Review the HITH implications on pharmacy resources (especially in an expanded service), and consider recruitment of a dedicated HITH pharmacy resource.	1-3 months	Director Pharmacy and HITH Service Group Director
Increase patient groups requiring Allied Health input	Consider patient groups high risk foot, delirium, cystic fibrosis, post traumatic amnesia follow-up / head injury management, oedema management and respiratory patients.	6-12 months	HITH Medical Officer and Director Allied Health
Streamline antimicrobial stewardship processes	Develop standard antibiotic regimes for the top 3 patient cohorts that require antibiotics.	4-6 months	Director Infectious Diseases with Director Pharmacy
Strengthen corporate governance	Formalise a Governance group with clear Terms of Reference *(Toolkit, Terms of Reference considerations)* to include performance monitoring, quality and safety reporting, DRG expansion, communication and resource development. Membership is to representative of service groups/facilities	1 month	HITH Service Group Director
	Review current corporate governance structure and consider moving under the medical services group to better reflect the acute nature of the HITH service.	1 month	SCHHS Executive team
	Consider nominating a HITH lead at each facility to better facilitate care across SCHHS.	2 months	HITH Service Group Director

Explore alternative Clinical Governance models	Revisit Authorised Practitioner Governance Model and consider partnering with general practice to deliver medical governance for HITH patients. Options include: • HHS contract with credentialed GPs • Provider contract with credentialed GPs	6-12 Months	HITH Service Group Director and Contracts team
Embed a patient safety and quality framework	Ensure national safety and quality accreditation requirements are embedded in future HITH contracts	1-6 months	HITH Service Group Director and Contracts team
	Recommence clinical quality and safety meeting with relevant stakeholders	2 months	HITH Service Group Director
	Formalise and document incident management process with provider	1 month	HITH Service Group Director and Safety and Quality team
	Formalise the deteriorating patient process within the contracts	1 month	HITH Service Group Director
Promote HITH Service across SCHHS	Create a multi-modal communication plan for approval by the HITH governance body, including, but not limited to: Resident/Registrar orientation, grand rounds, posters, screen savers, one on one education, nursing orientation, allied health, Case presentations, consumer presentations, newsletters etc *(Toolkit, HITH Program Procedure and Patient handout)*	1-4 months	HITH Service Group Director

Appendices

Appendix 1 – Stakeholder List

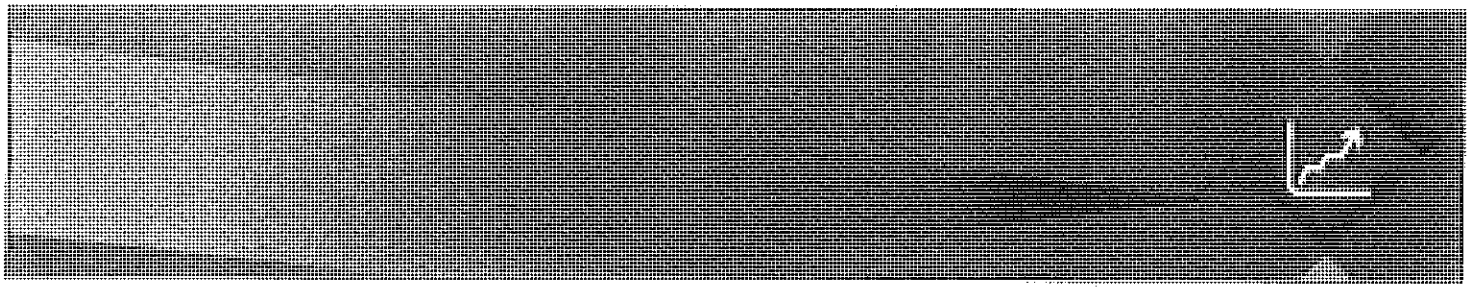
Stakeholder interviewed *(SCUH stakeholders unless stated otherwise)*	Date
HITH Medical Lead/Project Owner	3, 10, 11, 19 and 20 April 2018
A/ Executive Director Clinical Services, SCHHS/Project Sponsor	3 and 20 April 2018
Service Director, CISAS, SCHHS/Project Sponsor	3 and 20 April 2018
Chief Executive, SCHHS/Project Sponsor	20 April 2018
Manager, Contracts and Procurement	10 April 2018
CHIP/HITH Administration Officer	10 April 2018
SCUH Pharmacist	10 April 2018
Nambour Hospital NUMs/CHIP nurses (group)	10 April 2018
SCUH NUM, Emergency Department	10 April 2018
SCUH HITH Coordinator	10 April 2018
Gympie Hospital NUMs	10 April 2018
A/ Contract Management Director & A/ Project Manager, Commercial and Contracts	11 April 2018
Nursing Director, PACH	11 April 2018
Executive Director, Allied Health	11 April 2018
SCUH NUMs (small group)	11 April 2018
SCUH Nursing Directors (small group)	11 April 2018
A/ Manager Patient Safety and Patient Safety Officer	11 April 2018
Business Development Manager, HITH, Blue Care	12 April 2018
SCUH Director, Emergency Department	17 April 2018
NUM CHIP, Transition Services	18 April 2018
Nambour Hospital, Director, General Medicine,	18 April 2018
SCUH NUM (Cardiology/Endocrinology)	18 April 2018
SCUH Staff Specialist, Infectious Diseases	19 April 2018
SCUH Director of Pharmacy	19 April 2018
Gympie Hospital Director of Nursing/Facility Manager	19 April 2018
Clinical Director, CISAS	19 April 2018
SCUH Director of Surgery	19 April 2018
Gympie Hospital, SMO, Emergency Department	19 April 2018
Gympie Hospital, Pharmacist	19 April 2018
External HITH Provider, Focus Health Care	19 April 2018
Former SCUH Clinical Director HITH	20 April 2018
A/ Clinical, Service Director, Medical Services Group, Nursing Director, Medicine and ID Physician, Infectious Diseases (group)	20 April 2018
Nambour Hospital, Director, Emergency Department	20 April 2018
Director, Clinical Operations Queensland, Silver Chain and General Manager, East Coast	20 April 2018
Clinical Nurse, MAPU, SCUH	20 April 2018
Clinical Director, Caloundra Minor Injury and Illness Clinic	20 April 2018

Clinical Excellence Division

Hospital in the Home Review Plan – Sunshine Coast Hospital and Health Service

Healthcare Improvement Unit
April 2018

Queensland Government



Healthcare Improvement Unit

Published by the State of Queensland (Queensland Health), April 2018

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An electronic version of this document is available at http://qheps.health.qld.gov.au/caru/

Approval and endorsement

Review Lead

Name	Laureen Hines
Position	Manager, Healthcare Improvement Unit, Clinical Excellence Division
Signature	Date 1/5/2018

Project Owner

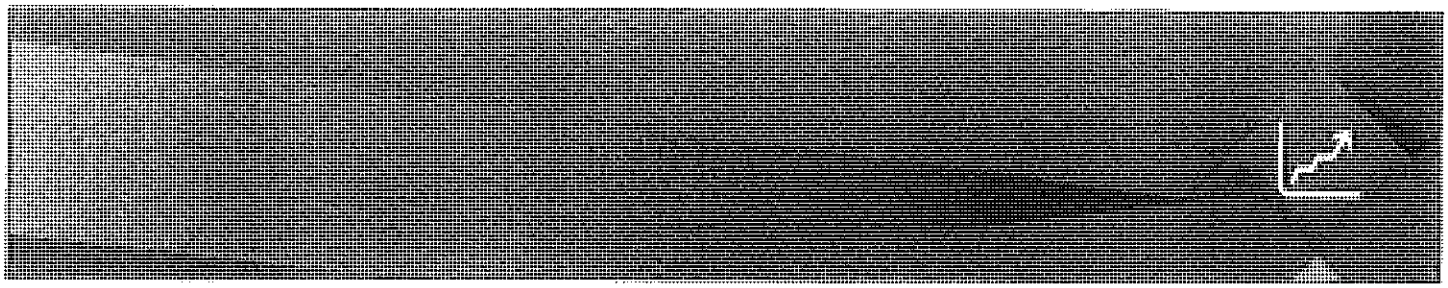
Name	Dr Theodore (Ted) Chamberlain
Position	Senior Medical Superintendent, Maleny Soldiers Memorial Hospital
Signature	T M Chamberlain Date 14/4/2018

Project Sponsors

Name	Adj Professor Naomi Dwyer
Position	Chief Executive, Sunshine Coast Hospital and Health Service
Signature	Date 23.7.18

Name	Dr Piotr Swierkowski
Position	Acting Executive Director Clinical Services, Sunshine Coast Hospital and Health Service
Signature	Date 12/04/2018

Name	JOHN ENDACOTT for Cang Dang
Position	Service Director, CISAS, Sunshine Coast Hospital and Health Service
Signature	Date 13/4/18



Background

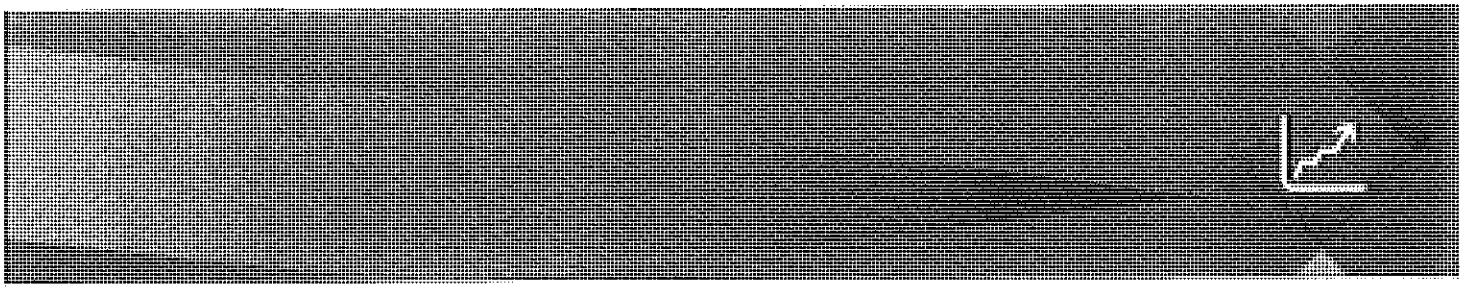
The Sunshine Coast Hospital and Health Service (SCHHS) recently identified risks (related to the safety and quality of care of consumers) associated the sustainability of the multi-partner brokerage Hospital in the Home (HITH) service model, formally implemented by SCHHS on 1 January 2018. Additionally, having undertaken a recent review of access and flow, SCHHS identified opportunities to optimise alternative care pathways for patients into models, such as HITH.

To ensure a safe, efficient and quality HITH Service moving forward and identify options to enhance access and flow of patients through optimised use of HITH into the future, SCHHS has engaged the Healthcare Improvement Unit (HIU), Clinical Excellence Division, to undertake a review of the SCHHS HITH Service. HIU, having undertaken recent reviews of various HITH Services statewide, has engaged Dr Michael Young (refer Consultation) to assist with the SCHHS HITH Service review, with site visits to the Sunshine Coast University Hospital scheduled for 10, 11, 19 and 20 April 2018 to undertake stakeholder consultation. It is envisaged that Dr Young's experience in the clinical delivery of care of HITH, and understanding of the HITH Public Private Partnership, will enhance the quality of this review.

Review Aim

The aim of the HIU review team is to undertake an independent review of the current function, structure and governance of the SCHHS HITH Service, by conducting a quantitative and qualitative analysis relating to the objectives outlined below. Findings, strategic advice and options with recommendations (within current funding), including a cost-benefit and risk analysis, will be provided to SCHHS executive to ensure the provision of a safe, efficient and quality HITH Service at SCHHS into the foreseeable future. As noted in email correspondence from the HIU on 4 April 2018, SCHHS executive is strongly encouraged to take whatever action is deemed necessary to ensure the immediate provision of a safe HITH Service at SCHHS, under the current multi-partner brokerage model.

- Review of decision to transition from a single partnership to a multi-partner brokerage model, and quality of implementation planning and governance that informed that decision.
- Evaluate the extent to which the current model will deliver consistently reliable and sustainable safe, quality care to consumers.
- Evaluate the quality of the clinical governance implemented to assure the safety of care delivered to consumers admitted to HITH.
- Evaluate the planned and implemented scope of the program, and whether it is consistent with what would be expected of a contemporary HITH Service.
- Identify issues from key clinical stakeholders regarding factors relevant to the scope and optimisation of patient admission into HITH, and how this compares with other Health Services with high performing HITH services.
- Evaluate the leadership, governance, stakeholder engagement, performance and productivity of the program and provide recommendations as to how this could be strengthened within a continuous improvement framework.
- Provision of options to enhance access and flow of SCHHS patients through optimised use of HITH, including for seasonal surges, reduction in Possible Preventable Admissions (PPAs) (e.g. cellulitis, COPD, and congestive heart failure) and other patient conditions that would be suitable for the HITH model of care e.g. SCUPH



Review Scope

In scope (but not limited to)

SCHHS HITH Service.

Out of scope

Post-acute and other community services

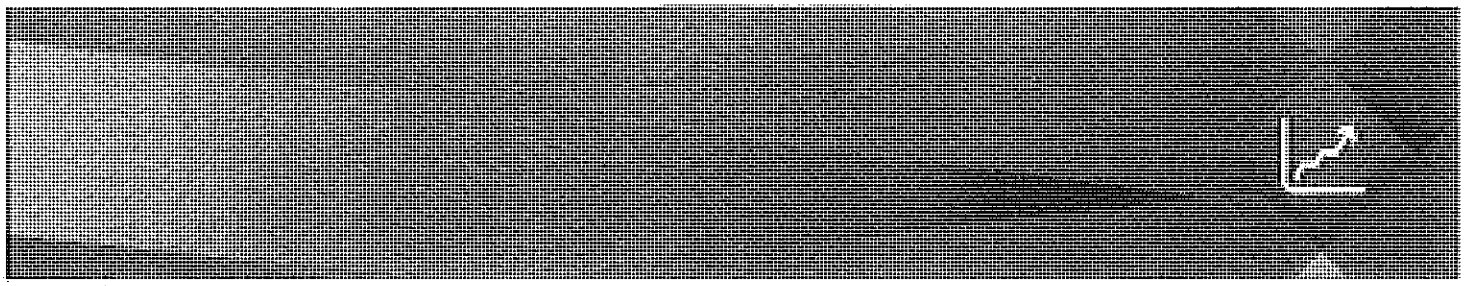
Methodology

1. The approach used by the HIU review team will be collaborative, supportive, transparent, solution and patient focused.
2. The HIU review team (outlined below) will visit Sunshine Coast University Hospital on 10, 11, 19 and 20 April 2018, to:
    a. Meet with key internal staff across levels and clinical steams, in addition to the external HITH Service providers (refer Consultation below). Note that to maximise the time of the external reviewer, Dr Michael Young, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service, initial stakeholder consultation with nursing, allied health and administration staff will occur over 10 and 11 April, with key medical and emergency department stakeholders to be consulted with input from Dr Young over 19 and 20 April.
    b. Observe models of care and patient flow to the HITH service
3. Review and analyse data related to HITH utilisation (refer Data Collection)
4. Review the following key documents where these exist and are applicable:
    a. Written business rules, protocols, procedures, guidelines, work instructions, models, pathways, patient charts, HITH service provider contracts and related deeds of variation, in addition to customer feedback
    b. Admission processes and service profiles

Consultation

The HIU review team will conduct interviews with a range of internal/external stakeholders (refer below), with the HHS to nominate additional relevant stakeholders to be consulted who may further inform the review (refer Prior to Site Visits). Stakeholders marked with a hash (#), are optional, and may be consulted over 19 and 20 April (pending availability).

Stakeholder	Mode
Chief Executive, SCHHS	face-to-face
HITH Medical Lead	face-to-face
Service Director, Community Integrated & Sub Acute Services	face-to-face
A/ Executive Director Clinical Services	face-to-face
Director, Contracts and Procurement	teleconference
A/ Contract Management Director	face-to-face
CHIP/HITH Admin Officer	teleconference
A/Manager Patient Safety and Patient Safety Officer	face-to-face
SCUH NUMs	face-to-face (group)
Gympie/Nambour Hospital NUMs	videoconference (group)
HITH Coordinator/s	face-to-face
SCUH CHIP/Discharge Planners	face-to-face (group)
Gympie Hospital CHIP/Nurse Practitioners	videoconference (group)
SCUH Director of Nursing	face-to-face
SCUH Nursing Directors	face-to-face (group)
SCUH Director of Pharmacy	face-to-face
SCUH Pharmacist	face-to-face
Gympie Hospital Pharmacist #	teleconference/videoconference
A/Clinical Service Director, Medical Services Group	face-to-face
Clinical Director, Gympie Hospital	teleconference/videoconference
SCUH Nursing Director Emergency Department	face-to-face
SCUH Director Emergency Department	face-to-face
SCHHS Director Emergency Department	face-to-face
Gympie Hospital Emergency Department SMO	teleconference/videoconference
Gympie Hospital Director of Nursing / Facility Manager	teleconference/videoconference
Clinical Service Director, Surgical Services	face-to-face
Director of Orthopaedics	face-to-face
Director of Cardiology	face-to-face
Director of Renal	face-to-face
Executive Director Allied Health	face-to-face
Former Clinical Director HITH	teleconference
External HITH Providers (Focus Health Care, Silverchain and Blue Care)	face-to-face (Focus Health Care and Silverchain, teleconference (Blue Care)
SCUH Staff Specialist (re Antibiotic Stewardship)	face-to-face
Clinical Director, Minor Injury and Illness Clinic	teleconference/videoconference



Data Collection

The review will examine the following data elements:

- Total percentage of hospital separations with a component of HITH in the episode of care for ABF reporting hospitals.
- Length of stay for the HITH service
- Percentage of unplanned readmissions within 28 days (same and all DRG)
- Percentage of deaths during the HITH episode of care
- Adverse events (RiskMan)
- DRG referred to HITH

Other data sources to include:

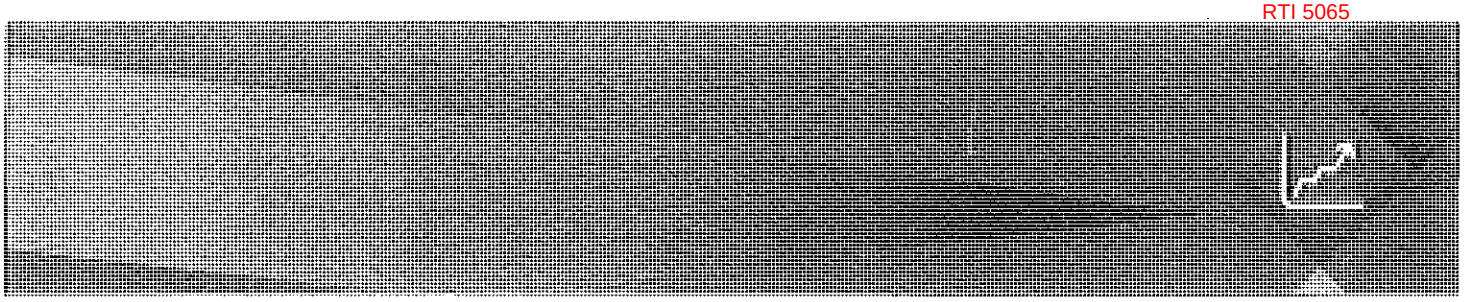
- Customer feedback (applicable)
- Patient chart audits (if required)
- HITH Service provider contracts, and related deeds of variation (all)

Deliverables

Deliverables	Responsibility	Proposed Timeframe
Draft HITH review plan	HIU	3 April 2018
Final HITH review plan	HIU	6 April 2018
HITH review - Interviews/data analysis	HIU Review Team	10, 11,19 and 20 April 2018
Draft HITH review report	HIU	2 May 2018
Final HITH review report for HHS approval	HIU	9 May 2018

Review Report

The Review Report will be provided to the Chief Executive, SCHHS (and other identified Project Sponsors and the Project Owner), outlining findings and recommendations related to the specified review objectives (refer Review Aim). The service assessment, findings and recommendations will be informed by information provided by the HHS prior to the site visits (refer Prior to Site Visits) and quantitative and qualitative data collected and analysed during the site visits.



Healthcare Improvement Unit (HIU) Review Team

1. Laureen Hines, Manager, HIU
2. Dr Michael (Mick) Young, Medical Director, Rural Hospitals and Indigenous Service Group, Townsville Hospital and Health Service (external reviewer)
3. Sonya Mizzi, Senior Project Officer, HIU

Prior to Site Visits

The Sunshine Coast University Hospital executive will:

- Undertake a communication process advising staff of the purpose of the visit by the HIU.
    - The purpose is to work collaboratively to share knowledge and skills for the optimisation of the HITH service.
- Develop a schedule of meetings (including dissemination of Outlook meeting appointments) for the HIU review team to meet with identified key stakeholders on 10, 11, 19 and 20 April (refer consultation). Additional stakeholders requiring consultation, to also be identified (and meetings scheduled).
- Provide HIU review team with relevant RiskMan/PRIME reports, applicable HITH Service external provider contracts and related deeds of variation, HITH Service protocols/procedures, HITH Referral Form, HITH Nurse Competency List and any applicable customer feedback.

Summary

The following resources are provided for reference and consideration. If adapted, appropriate acknowledgements are to be attributed. Word versions can be provided upon request where available.

Relates to Recommendation/s:	Resource description	Comment	Document
Enhance service delivery models/Stablise the HITH Team	Service delivery model options		Service Delivery Model Options
Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Clinical Pathway – Anticoagulation with warfarin	Sourced from Townsville HHS	cf-hith-anticoagulation-war.pdf
	Clinical Pathway – Appendicitis	Sourced from Townsville HHS	cf-hith-appendicitis.pdf
	Clinical Pathway – Cellulitis	Sourced from Townsville HHS	cf-hith-cellulitis.pdf
	Clinical Pathway – Complicated urinary tract infection	Sourced from Townsville HHS	cf-hith-complicated-uti.pdf
	Clinical Pathway – Diverticulitis	Sourced from Townsville HHS	cf-hith-diverticulitis.pdf
	Clinical Pathway – Generic	Sourced from Townsville HHS	cf-hith-generic.pdf
	Clinical Pathway – Hyperemesis gravidarum	Sourced from Townsville HHS	cf-hith-hyperemisis-gravidarum.pdf
	Clinical Pathway – Mastitis	Sourced from Townsville HHS	cf-hith-mastitis.pdf

Expand patient cohorts to increase DRGs treated under the HITH model of care and enhance referral processes	Clinical Pathway – Pneumonia	Sourced from Townsville HHS	cf-hith-pneumonia.pdf
	Clinical Pathway – Post Operative Wound Infection	Sourced from Townsville HHS	cf-hith-post-op-wound.pdf
	Recommended growth areas and percentages (%)		Recommended growth areas and %
Corporate Governance	Terms of reference considerations – Governance Body		ToR considerations.pdf
Promotion of Service across SCHHS	HITH Program Procedure and Patient Handout	Sourced from Townsville HHS Sourced from Statewide HITH Group	HITH Procedure HITH pt handout