NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Spotlight on virtual care: Virtual Mental Health Emergency Care (MHEC) in NSW

Hunter New England Local Health District
Western NSW Local Health District

JUNE 2021

Virtual Care Initiative

A collaboration between local health districts, speciality health networks, the ACI and eHealth NSW.

The 'Spotlight on Virtual Care' reports showcase innovation and leadership in virtual health care delivery across NSW. The series aims to support sharing of learnings across the health system and outlines the key considerations for implementation as identified by local teams.

Each initiative within the series was selected and reviewed through a peer-based process. While many of the initiatives have not undergone a full health and economic evaluation process, they provide models that others may wish to consider and learn from.

These reports have been documented by the Virtual Care Accelerator (VCA). The VCA is a multi-agency, clinically focused unit established as a key partnership between eHealth NSW and the ACI to accelerate and optimise the use of virtual care across NSW Health as a result of COVID-19. The Virtual Care Accelerator works closely with Local Health Districts (LHDs) and Specialty Health Networks (SHNs), other Pillars and the Ministry of Health.

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Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**

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Contents

Introduction

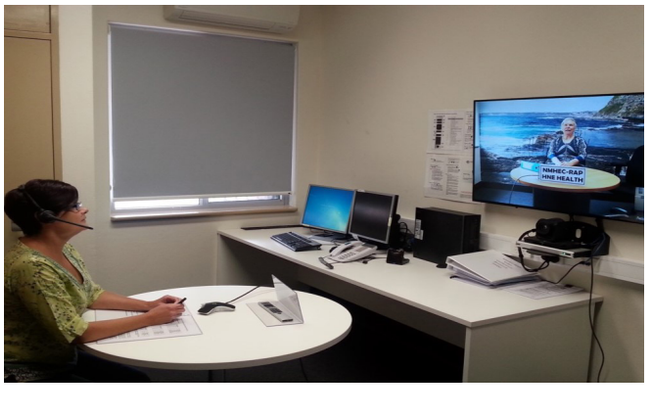
Mental health services in rural and remote NSW are dispersed over vast distances. For mental health consumers, this can mean access to specialised services is limited and the nearest mental health facility can be hundreds of kilometres away. Consumers often present to their nearest Emergency Department (ED), where they may experience extended waiting times and may be transported to another site for assessment unnecessarily. This can make a mental health emergency an even more stressful experience, as well as increasing the resource strain on the health system.

To increase access to specialist clinical mental health services in communities across rural and remote NSW, Hunter New England Local Health District (HNELHD) and Western NSW Local Health District (WNSWLHD) provide mental health assessments and care virtually to EDs within their regions.

This document outlines the common elements of successful Mental Health Emergency Care (MHEC) initiatives and details the key features of two local models in the following parts:

- Part 1 – Mental Health Emergency Care: Core Elements
- Part 2 – Hunter New England Local Health District (HNELHD) Northern Mental Health Emergency Care – Rural Access Program (NMHEC-RAP)
- Part 3 – WNSWLHD Mental Health Emergency Care (MHEC)

To form a thorough understanding of each local model and its implementation, it is necessary to consider this document in its entirety. Each local model is supplemented by the core elements section to represent the complete initiative.



NMHEC-RAP virtual assessment room James Fletcher Hospital Newcastle

Part 1
Mental Health Emergency Care: Core Elements

Overview

MHEC teams provide specialist mental health assessments via videoconferencing from mental health hubs to emergency departments (EDs) and other inpatient and outpatient facilities across rural and remote NSW.

Following videoconferencing consultations, a recommendation will be made to:

- discharge the person home with appropriate follow up, which may include the community mental health team (CMHT) or GPs
- keep the person in ED temporarily with MHEC support to enable further assessment or stabilisation or
- transfer to a mental health inpatient facility.

Reported benefits of MHEC models

Patient benefits:

- Reducing trauma associated with unnecessary transportation to mental health facilities by police or ambulance and maintaining dignity for people accessing care
- Avoiding unnecessary transport to declared mental health facilities means consumers do not have to arrange transport back home
- Timely mental health assessment conducted by experienced mental health professionals enhances the quality and safety of emergency care
- Being treated for a mental health crisis close to home reduces stress and dislocation from support and familiar surroundings
- Families and carers are often able to be included in the assessment process.

Clinician benefits:

- ED staff have 24/7 access to specialist mental health consultation and advice
- Increased confidence to manage people experiencing a mental health emergency
- Increased capacity of ED staff by significantly reducing wait times for mental health assessments.

Service benefits:

- Significant reduction in transportation required from emergency services, which can take on duty police and ambulance out of their jurisdictions for long periods of time
- Avoiding unnecessary transportation and admissions
- Comprehensive, timely and standardised clinical documentation
- Enhanced integration of care within and across LHDs
- Specialist mental health advice to support local care planning monitoring and reviewing of mental health consumers is available to all EDs.

Table 1 - Key elements of the MHEC models

Element	HNELHD: NMHEC-RAP	WNSWLHD: MHEC
Patient cohort	• People presenting with significant mental health symptoms and risks that are: – medically stable and not sedated, intoxicated or delirious; and – behaviourally settled and considered appropriate for videoconference (VC) assessment. • People under the Mental Health Act 2007 may be reviewed under certain conditions (see breakout box on page 6).	
Referral pathway	• All referrals are made from ED clinicians through a call to the dedicated NMHEC-RAP 1800 number.	• Patients can be referred for MHEC assessment from EDs, GPs, CMHTs and Aboriginal Community Controlled Health Services (ACCHSs). • All referrals are initiated with a call to the dedicated 1800 number for triage. These may be from consumers, clinicians, family members, support people or emergency workers. During the initial phone conversation, clinicians will determine if a MHEC assessment is required.
Healthcare team	MHEC teams are staffed 24/7 and generally have access to a psychiatrist for consultation. Other staff may include: • registered nurses • social workers • occupational therapists • psychologists • other allied health professionals.	
Technology	Technical set ups generally include the following devices at hub and ED sites: • Hub videoconferencing systems in private rooms and portable videoconferencing systems within each ED containing: – webcam – microphone – speakers – videoconferencing enabled screen.	

Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the supporting documents section at the end of this report also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

The clinical governance of the service is based on Consultation Liaison Psychiatry model where the ED retains the clinical responsibility for the consumer and MHEC service provides specialist recommendations to enhance care for consumers.

ED clinicians are responsible for:

- completing medical observations to ensure they are physically well prior to referral for MHEC assessment
- clinical handover to MHEC staff for the assessment
- transfer to other wards or facilities if required.

During the MHEC assessment, ED staff monitor the patient's welfare. The MHEC clinician will also alert the ED staff if any physical health concerns are identified during the assessment.

Recommendations from MHEC assessments which require referrals or follow-up also occur within this clinical governance structure:

- For people being discharged: MHEC clinicians make referrals directly to local community mental health teams, or other appropriate service providers.
- If required, ED staff make referrals to local services like social work or Drug and Alcohol services. Follow up may be required for services only available during business hours.
- If a person requires admission to another facility ED staff are responsible for organising transport.

Credentialing of medical staff

Teams implementing cross district models should seek guidance from their local medical workforce unit. District medical workforce unit managers should be familiar with the below policy directives (PDs):

- PD2019_056 – Credentialing and Delineating Clinical Privileges for Senior Medical Practitioners and Senior Dentists*
- PD2016_026 – Staff Specialist employment Arrangements across more than one Public Health Organisation†

*See PD2019_056 in Supporting documents list

†See PD2016_026 in Supporting documents list

The Mental Health Act 2007

Approximately 8% of NMHEC-RAP patients and close to 20% of WNSWLHD MHEC patients are scheduled under The Mental Health Act 2007 (the MH Act) or Section 33 of the Mental Health Forensic Provisions Act.

These patients must be assessed by an authorised medical officer or accredited person in a Declared Mental Health Facility, as defined by the MH Act.

Accredited persons are senior mental health practitioners with a minimum of five years clinical experience in direct mental health consumer care.

MHEC clinicians who are accredited persons can schedule (Sec 19A) a consumer after an assessment via an audio-visual link using the MHEC model into a declared facility if:

- it is not reasonably practicable for an accredited person to personally examine or observe the person; and
- a MHEC clinician can examine or observe the person with sufficient skill and care so as to form the required opinion about the person.

In addition, MHEC medical staff can also do Form 1 (Sec 27A) assessments in a declared facility subject to above conditions.

Should a scheduled patient present at a non-declared ED, they need to be transported to the nearest declared hospital for further assessments under the MH Act. This transportation is generally provided by ambulance or the Rural Flying Doctors Service (RFDS).

Building engagement

Consumer and carer representation

The National Safety and Quality Health Service Standard for partnering with consumers‡ mandates that consumers are engaged in the development, design, provision and evaluation of mental healthcare services.

Consumers are represented in governance structures (e.g. implementation working groups) and consumer and carer experience is monitored through continuous quality improvement mechanisms. This supports the services to build and maintain active partnerships with consumers and ultimately ensure high quality outcomes.

Consumer engagement

Receiving mental health support virtually may be a unique experience for consumers. People undergoing a MHEC assessment in a mental health crisis may be highly agitated and anxious.

MHEC clinicians must be empathetic and understanding of consumers' situations. This is especially important in small remote EDs where people may be a significant distance from their homes or support people, or in smaller communities where consumers may be particularly concerned about their privacy.

Consumers must always remain partners in their own care. Those taking part in MHEC assessments should be asked to provide consent by ED clinicians prior to referral and can withdraw it at any time.

There are several strategies adopted by clinicians to improve service engagement and build rapport, make consumers feel more comfortable and reduce the stress of waiting in the ED:

- ED staff receive orientation about the MHEC service and are provided with information brochures and consent forms, so they can support consumers in the ED.
- Where possible, a private room is used for the videoconferencing consultation. Ideally this is a dedicated room providing a more therapeutic environment.
- When a private room is not available, staff use a space that is therapeutic, low stimulus and has the technology to support the assessment.
- Providing an estimation of the wait time for the assessment.
- MHEC staff can assist by asking questions during the assessment to build rapport and better understand the person's environment, such as:
  - Are you alone? Can you introduce people in the room to me (if they are present)? (Family or support people should be included in the consultation if they are present, with consumer consent).
  - Do you feel comfortable?
  - Do you have enough privacy?
  - Are you in a safe environment?
- Asking questions to ensure the videoconferencing platform is performing correctly:
  - Can you see me clearly?
  - Am I too speaking too loudly/softly?
  - Would you like a staff member to come into the room to make any changes?

‡See National Safety and Quality Health Services Standards in References and links list.

Engagement with Aboriginal Community Controlled Health Services (ACCHSs)

In NSW, Aboriginal people fare significantly worse than non-Aboriginal people on every indicator of economic and social disadvantage. They also experience multiple stressors that are pre-determinants of mental health problems and substance use.

Suicide and self-harm rates for Aboriginal people are unacceptable, and tragically high and growing. Aboriginal people also report higher levels of psychological distress than non-Aboriginal people. Aboriginal people who experience racism are at a greater risk of developing depression and anxiety. This continues to have a significant impact on when and why Aboriginal people seek health services and also affects acceptance of, and adherence to treatment (NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025).§

Rural and remote communities may also face additional barriers to providing care, such as access to technology and reliable internet connectivity.

To manage the challenges and enhance engagement with the Aboriginal and Torres Strait Islander communities, the MHEC model must be offered in a culturally appropriate and safe manner. The following strategies have been implemented to support this:

- Representatives from ACCHSs and/or key Aboriginal community representatives are included as key stakeholders in the model governance, design and implementation.
- Education is provided to clinicians from ACCHSs and the communities they work with. This raises awareness of the MHEC service and builds staff confidence in providing mental health support to their communities.
- During assessments and triage, consumers are always asked if a support person is present, or if they would like an Aboriginal Health Worker or other support person to join the consultation.
- Virtual consultations provide the opportunity for multiple family members to join and support consumers.
- MHEC teams recognise the range of facets that contribute to social and emotional wellbeing and align their care to the holistic approach to healthcare which underlies ACCHSs.

Staff onboarding, training and development

ED staff at receiving sites (and police and ambulance staff) must be inducted to the model.

- Clinicians from the hub site visit ED sites to provide training which includes:
  - the clinical value of MHEC
  - when and how to engage the MHEC team from both clinical and practical perspectives
  - governance structures and patient safety protocols
  - how to use technology
  - team discussion to cover questions and any other details of the model.
- At a minimum, the ED Nurse Unit Manager (NUM) of each site is required to attend the sessions, but all staff including ED medical officers and community mental health teams are encouraged to attend.
- A train the trainer approach is used. Those who took part in the session take on the role of clinical champions and are responsible for disseminating this education within their facility and local area.
- The rapid turnover of workforce in small facilities means it is necessary to maintain at least one training champion at each site.

§ NSW Ministry of Health, Mental Health Branch. (2020). NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025.

Funding

One-off establishment funding is commonly used to procure the technology required to set up MHEC services.

In both models described in this document, LHDs are allocated recurrent funding to provide the service. This includes block mental health emergency funding for the districts in which outreach services are provided.

The ongoing cost of technology maintenance is covered in this block funding.

Reduced patient transportation costs and fewer unnecessary admissions contribute to service sustainability.

Core benefits

- Significant reduction in transportation required across rural and remote NSW as well as associated trauma.
- Enhanced quality, safety and access of specialist emergency mental health care available locally and ability to be treated for mental health crisis close to home.
- Reduction in ED waiting times through access to timely mental health assessments.
- Enhanced integration within and across LHDs, with advice on care planning and support in monitoring and reviewing mental health consumers available to all EDs.

Part 2
Hunter New England Local Health District (HNELHD) Northern Mental Health Emergency Care – Rural Access Program (NMHEC-RAP)

Overview

The NSW Ministry of Health (MoH) funded the roll out of NMHEC-RAP in August 2016 to provide specialist mental health assessments and care virtually to rural and remote emergency departments (EDs) in northern NSW.

The NMHEC-RAP service operates 24 hours a day, seven days a week and provides mental health assessments across all age ranges to the EDs in Hunter New England (HNELHD), Northern NSW Local Health District (NNSWLHD) and Mid North Coast Local Health Districts (MNCLHD).

The model aims to increase positive outcomes for people experiencing mental health crises.

This is achieved by supporting local EDs to make timely and safe decisions as to whether people that have been reviewed can be safely discharged with an appropriate follow-up, if further observation in ED is needed, or if admission to an inpatient facility is required.

NMHEC-RAP services 30 EDs across the region, providing a consultation-liaison psychiatry model that supplements existing local mental health services.

The NMHEC-RAP service is provided remotely in conjunction with the 24-hour mental health telephone access service and the recently implemented Mental Health First Responder service by the multidisciplinary HNELHD mental health team based at James Fletcher Hospital in Newcastle.

The NMHEC-RAP service is staffed by the multidisciplinary HNELHD mental health team based at James Fletcher Hospital in Newcastle. It works in conjunction with the 24-hour Mental Health Line doing telephone triage and the recently commissioned Mental Health First Responder service that interfaces with the police and ambulance services.

James Fletcher Hospital Newcastle

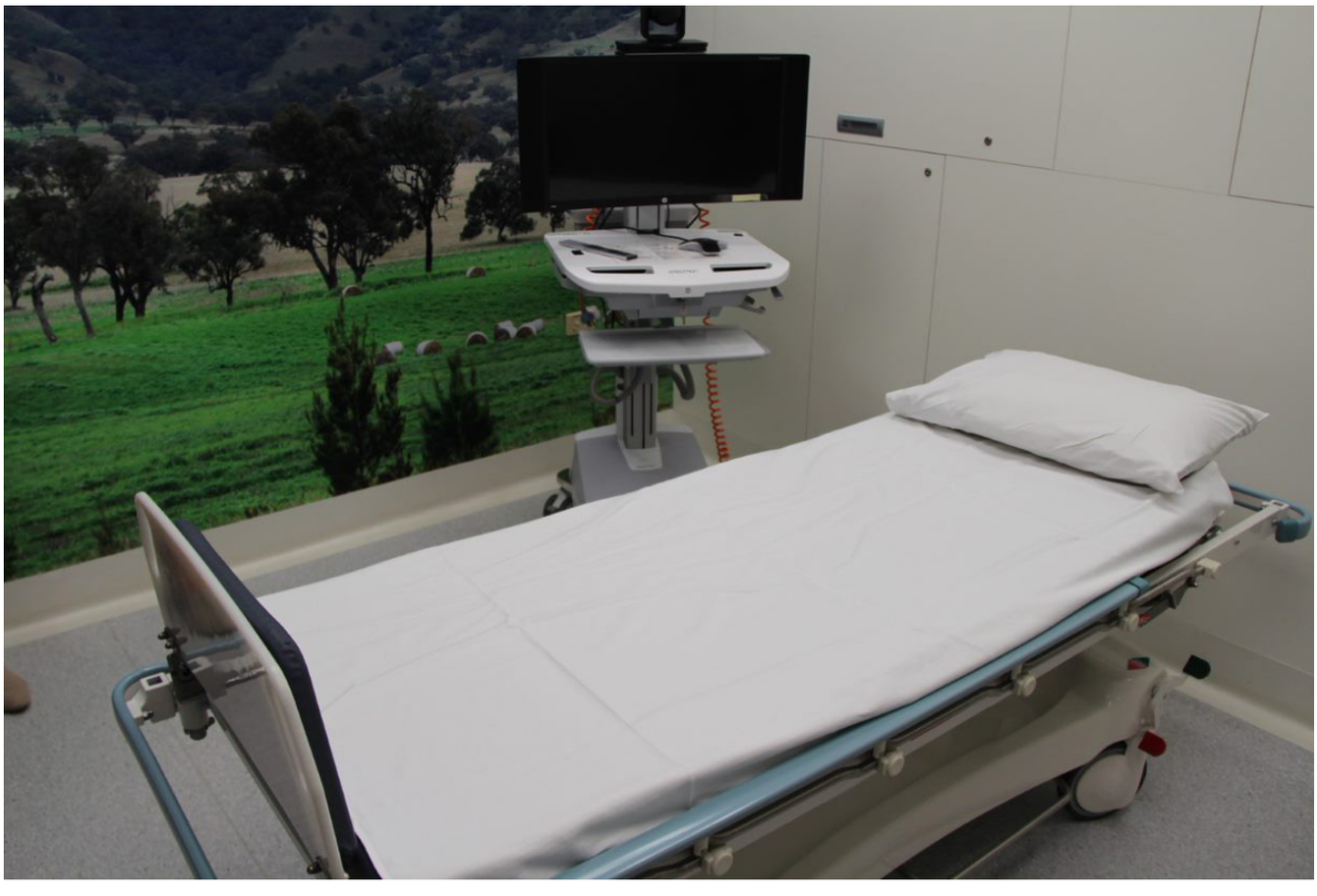
Service

NMHEC-RAP can be accessed by ED teams requiring specialist mental health assessment 24 hours a day. The service design and experience are broken into three processes:

1. Triage at ED site.
2. Virtual assessment completed by NMHEC-RAP staff.
3. Clinical recommendations communicated from NMHEC-RAP to ED staff.

Triage – at ED site

All patients presenting to EDs are triaged in accordance with NSW Health Triage of Patients in NSW Emergency Departments Policy**. If someone presents with significant mental health symptoms and is within scope, they will be informed about the NMHEC-RAP assessment. Once a patient has been cleared of any physical issues and provided verbal consent to be assessed, ED clinicians will commence the process for referral.



Muswellbrook ED safe room, HNELHD

**See NSW Health Triage of Patients in NSW Emergency Departments Policy in supporting documents list

Table 2 – patient cohort

In scope	Out of scope
• Mental Health condition cannot be managed by existing ED resources	• Patient is physically unwell
• In-person mental health assessment is not available	• Patient unable to engage or refuses assessment; or • Patient agitated, medium to high risk to self/others
• Patient can conduct a rational conversation; and • Is not drowsy, intoxicated or delirious; and • has verbally given informed consent for assessment by videoconference	• Patient has been scheduled under Mental Health Act and has presented at a non-declared ED
• Patient has been scheduled under Mental Health Act and has presented to declared mental health facility.	

The NMHEC-RAP service does not specify age limits. Children are considered within scope and assessments for children have been completed in the past.

If a patient is out of scope, they may either require transport to a declared mental health facility or support from other ED services, such as an on-call psychiatrist.

If patient is scheduled under the Mental Health Act and is in a non-declared facility, the patient must be transported to a declared facility by NSW Ambulance.

The treating ED clinicians make a verbal referral to NMHEC-RAP over the phone and provide:

- patient demographics
- observations from the current presentation to ED – including any physical or mental trauma;
- relevant medical history obtained from a phone call to local GP or mental health service if possible; and
- further background information sought from patient's family or support people, where possible.

Following the verbal referral, the details of the videoconference device to dial and an approximate time for assessment will be provided by the NMHEC-RAP team.

Where possible, patients will be relocated within the ED to wait for their assessment. It is preferable for people to be assessed in a private room where they can have a confidential conversation, accompanied by a support person.

In rural and remote EDs this can be challenging. If a private room is not available, the patient should be situated in a location easily observable by ED staff (and should be checked according to the assessed level of observation required). ED staff will attempt to contact a support person if the patient chooses.

Initial Steps – at James Fletcher Hub

NMHEC-RAP clinicians complete the following steps:

- Collect the referral information and enter it in CHIME (Community Health Information Management Enterprise)
- Review background information in CHIME and CAP (Clinical Applications Portal) eMRs
- Prioritise referrals according to clinical need
- Provide an approximate time for assessment and the details of the videoconference device to dial.

On rare occasions when service demands may lead to an extended delay, NMHEC-RAP clinicians advise EDs to consider alternatives to avoid compromising the consumer's welfare.

NMHEC-RAP Assessment and Recommendation – at James Fletcher Hub

NMHEC- RAP clinicians (including nurses, social workers and occupational therapists) conduct assessments by videoconference from NMHEC-RAP assessment rooms. One of the following assessments is completed in collaboration with the person's family or carers, where possible:

- Mental Health Assessment: for a new patient, or a patient assessed more than 28 days previously.
- Mental Health Assessment Review: for a returning patient assessed within the previous 28 days
- Mental Health Act 2007 assessments – Section 19, Section 27 or Section 33, in conjunction with one or more of the above assessments.

Should the clinician require further advice, they will consult with the NMHEC-RAP psychiatrist, registrar or the LHD on-call psychiatrist.

The NMHEC-RAP clinician will make one of the following recommendations based on the assessment findings:

- Discharge home with appropriate follow-up.
- Admission into ED or ward (where capacity exists) for observation, under the care of a medical officer, with a view to discharge home when clinically appropriate.
- Transfer for admission to the nearest mental health facility.

A copy of the completed assessment, including the recommendation, is documented in CHIME and faxed to the ED. It can also be viewed by the ED through the web-based portal CAP.

For NNSW and MNC LHDs, the assessment and recommendations are directly documented in the LHD eMR.

Data indicates that 70% of recommendations are for patients to be discharged with follow up arrangements. The remainder are transferred to a declared mental health facility.

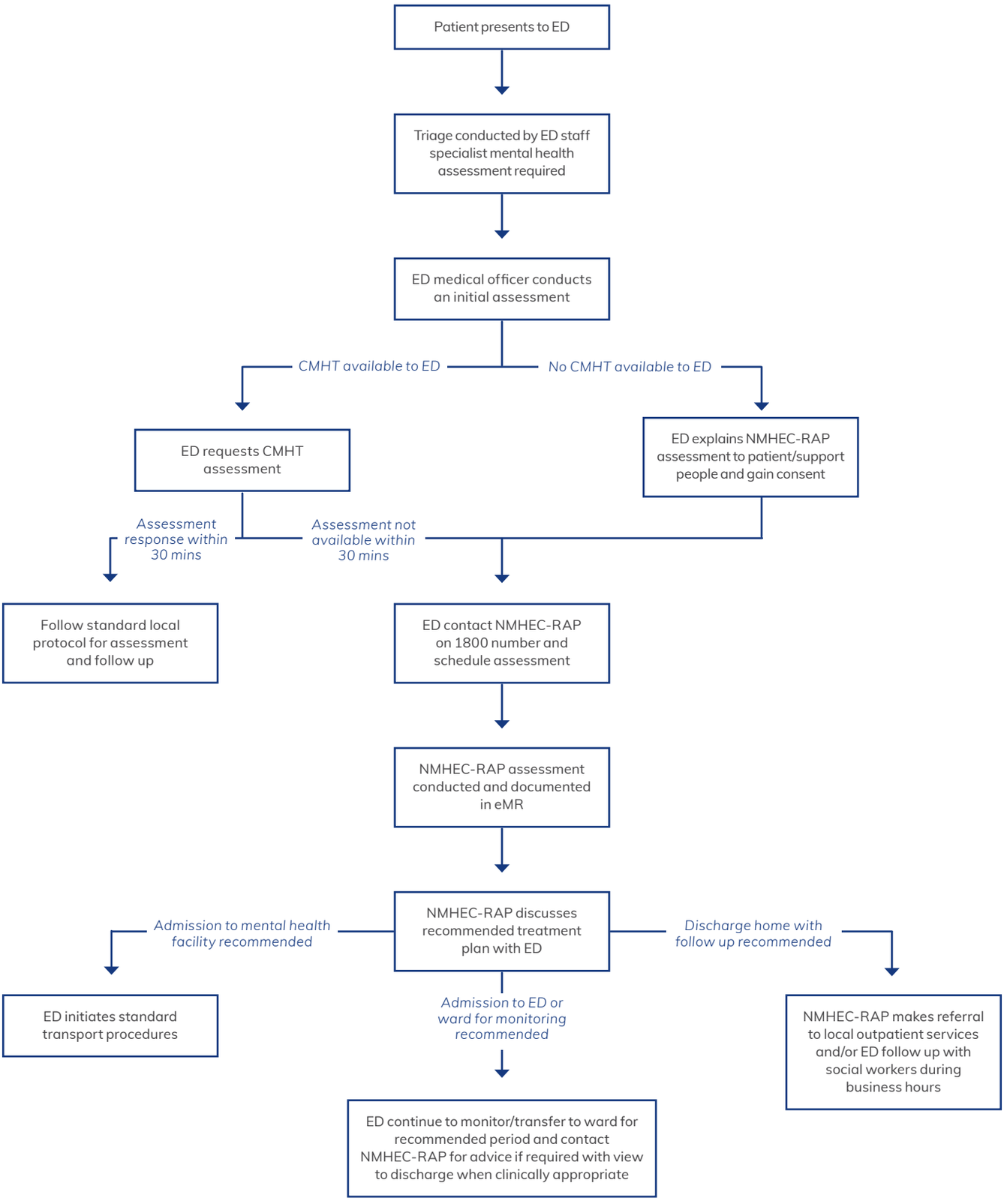
Recommendation – at ED site

The ED can request further clarification if needed from the NMHEC-RAP team by calling the dedicated 1800 number.

While the ED medical officer ultimately decides whether a person requires an admission or is discharged with a follow up referral, almost all NMHEC-RAP recommendations are followed.

Workflow diagram

Figure 1: NMHEC-RAP Workflow diagram



Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the supporting documents section at the end of this report also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

The NMHEC-RAP model is underpinned by a formal service agreement signed by the Chief Executive of each participating LHD. This is further supported by the following governance structures.

NMHEC-RAP hub governance

- The NMHEC-RAP clinician faxes daily summaries of assessments and interventions done in the ED for the preceding 24 hours to the respective local community mental health team (CMHT). A NMHEC-RAP team member telephones the receiving CMHT the next day to ensure receipt of this information and offers the opportunity to discuss any concerns.
- The NMHEC-RAP psychiatrist is responsible for clinical governance at the NMHEC-RAP hub and conducts audits of all after-hours assessments.

Regional ED governance

- Participating EDs are divided into three regionally based groups for ongoing review and engagement meetings with the NMHEC-RAP team.
- Meetings are held every three months for each regional group and offer the opportunity for ED staff to escalate any clinical or operational concerns and for the NMHEC-RAP team to provide advice or Continuous Quality Improvement (CQI) updates.
- Outside of formal meetings, ED teams can always raise urgent concerns with the NMHEC-RAP team through the dedicated 1800 number.

Executive governance

- Inter-LHD steering group meetings occur approximately every three months, aligning to the regional ED meetings. The focus on strategic goals and offer an escalation pathway for issues raised within regional meetings.
- A comprehensive model of care document underpins the operations of NMHEC-RAP and incorporates standard NSW and district mental health policy guidelines and directives e.g. documentation, assessment, risk assessment, clinical handover, discharge from ED, transfer of care, etc.
- The model is aligned to the strategic focus of the LHD. This attracts clinicians interested in innovative modalities of care and results in effective local clinical leadership and a self-selected, technologically savvy and enthusiastic team.
- Technical and practical integration across districts is coordinated by HNELHD via:
  - extensive consultation with rural and remote EDs and mental health services regarding roll-out and implementation
  - credentialing of the medical clinical team members across districts
  - ensuring accredited persons are certified within each district they service
  - ICT support for the videoconferencing
  - cross-LHD access to eMRs.

Key strategic challenges include:

- the complexity of the service, with multiple interfaces across specialist services and catchment boundaries. Many difficulties only became apparent after the service became operational
- the model was kept flexible so that it could be adapted to local environments and demands. This has led to scope creep with existing workloads and pathways being re-directed to NMHEC-RAP.
- misalignment between site eMRs and hybrid paper/eMRs within and across LHDs. Clinicians' time can often be taken up with manually documenting and recording information or communicating on multiple platforms.
- limited resources and the small size of some remote communities can make it difficult to maintain privacy.
- ensuring the Mental Health Act is interpreted correctly and uniformly across sites can be challenging. It is essential that there is clear understanding of declared and non-declared facilities, which staff members are accredited clinicians and when delivery by virtual care aligns to the Act.

'We offer a genuine enhancement to small hospitals, enabling a mental health clinician to meet someone rather than have them transferred. It feels like we are offering a good service - comprehensive assessments are something people would line up for in a metro hospital and that would probably be a longer wait than what is required for a for NMHEC-RAP assessment.'

EXECUTIVE SPONSOR, BRENDAN FLYNN - DIRECTOR OF MEDICAL SERVICES, MENTAL HEALTH – HNELHD

Building engagement

Engagement with local community providers

Local Community Mental Health Teams (CMHTs) and general practices (GPs) are significant stakeholders in the NMHEC-RAP model:

- In most cases, where people are discharged with follow up arrangements, referrals will be made to CMHTs and GPs providing the assessment findings.
- NMHEC-RAP clinicians provide recommendations to ED medical officers when they are available, and often medical officers are local GPs.
- To support engagement with local providers, the NMHEC-RAP team provides education and communication into communities. Local awareness of the service and thorough understanding of what is provided through the model was flagged by both the NMHEC-RAP clinical team and rural ED staff as a key enabler.

This is achieved by:

- Providing education about the NMHEC-RAP service in onboarding materials for local GPs and mental health clinicians.
- Clear communication to referrers about what constitutes a mental health emergency. This avoids referrals for people who are not in crisis and should be treated with a mental health plan.
- A NMHEC-RAP fact sheet and other materials are provided to all LHD staff as part of the onboarding of new services prior to 'going live'.

Engagement across LHDs

Design of the NMHEC-RAP telepsychiatry model involved HNELHD, NNSWLHD, MNCLHD, and the MoH. A collaborative approach has ensured the needs of all stakeholders are considered and fosters positive and productive working relationships.

Key steps included:

- Stakeholder consultations facilitated with multiple rural and remote EDs and CMHTs to plan and design the model. Considering the ED contexts in which assessments would be offered was essential.
- Ensuring cross-district credentialing requirements are met and defining scope of practice for medical staff. This was coordinated by the clinical lead and required significant investment to manage across three LHDs.
- Certifying accredited persons within in each district in which they provide care.
- Orientation and information sessions were provided by the NMHEC-RAP team to receiving sites both before and after roll-out. The included site visits to support set up of videoconferencing, and to provide orientation and training for ED staff (detailed further in workforce section).
- The operation of NMHEC-RAP is enabled by the following mechanisms to foster engagement between HNELHD, NNSWLHD and MNCLHD:
- Ongoing support – offered by the NMHEC-RAP team to ED clinicians across the 3 districts including guidance on providing mental health care for people in crisis and videoconferencing technology support.
- Cross-district service agreements, which define clinical protocols, responsibility and escalation procedures
- A train the trainer education model to ensure ED staff and local stakeholders have a thorough understanding of the service and can navigate consumer care.
- Defined clinical governance structures that foster engagement between clinical staff within EDs the NMHEC-RAP team and LHD executive (described in governance section).

'This is a very person-centred model and that is what is important. We are giving patients the option very early on to be involved in their assessment and the ability to make decisions, rather than forcing them to be transported, which is taking the decision away from them. Then, once they are reviewed and discharged, they are stranded. This model very much focuses on the person.'

NURSE UNIT MANAGER, MUSWELLBROOK ED, SHARON ERIKKSON

Workforce and resourcing

Technology

The equipment used at the NMHEC-RAP hub and ED sites is very similar. All portable videoconferencing systems include a webcam, microphone, speaker and videoconferencing-enabled screen. This technology is being upgraded to the statewide myVirtualCare platform.

The ad-hoc and urgent nature of emergency mental health care requires videoconferencing equipment to be solely dedicated to the NMHEC-RAP service. This equipment was procured through MoH establishment funding. Minimal ongoing maintenance costs are absorbed by block funding.

Each ED has at least one videoconferencing cart and a system for storing and charging the cart when not in use.

The HNELHD virtual care team provide the following support to all sites:

Reviewing of the operational status of the ED videoconferencing carts and referral of issues to the IT team for troubleshooting.

Troubleshooting connectivity issues and improving connectivity by educating ED staff on the best locations and setups within EDs to enhance the network.

Having a business continuity plan in the event of technology failure, including an alternative contact number to support the ED if needed.

Providing ad hoc videoconferencing training to new NMHEC-RAP team members and ED clinical staff

Workforce:

The multi-disciplinary mental health team is fully dedicated to the three HNE mental health services (NMHEC-RAP, Mental Health Line and the Mental Health First Responders). Table 3 lists the team members.

Table 3 – HNELHD multi-disciplinary mental health team

Medical coverage during working hours:	
Psychiatrist (0.6 FTE)	Psychiatric registrar (1 FTE)
Allied health and/or nursing coverage 24/7:	
Registered nurses (14.8 FTE)	Social workers (7.4 FTE)
Occupational therapists (3.2 FTE)	Psychologist (1 FTE)

Benefits

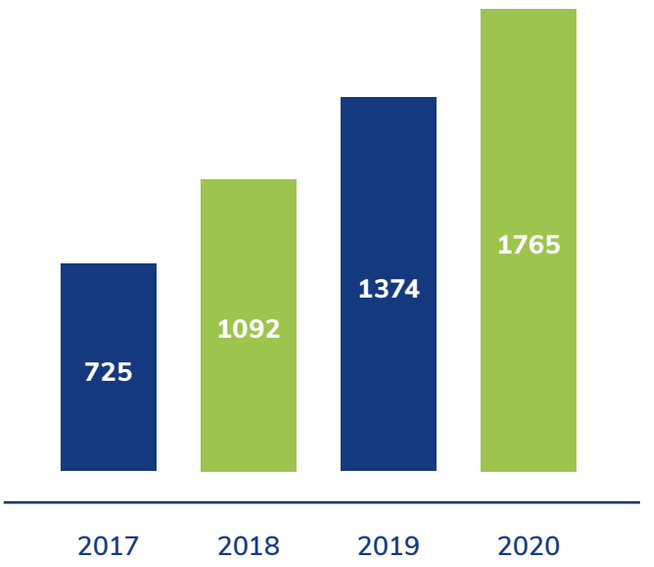
Results

More than 1,200 of the people assessed avoided admission or transfer to a declared mental health facility.

There has been overwhelmingly positive feedback from ED clinicians and consumers about the value of the virtual assessments, especially the ability to avoid unnecessary travel.

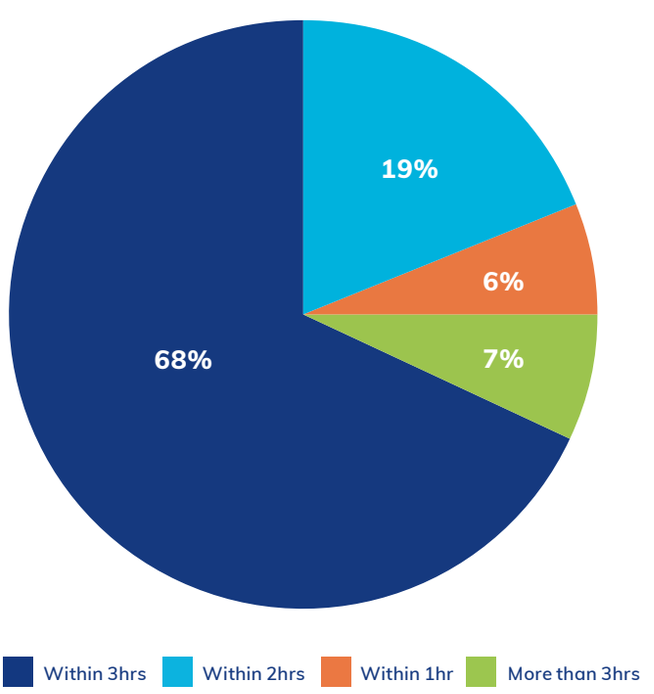
The NMHEC-RAP Telepsychiatry service was a finalist for the Don Walker Award at the 2018 Health Informatics Conference, which recognises pioneering applications of technology in healthcare.

NMHEC-RAP request per year



The NMHEC – RAP team are able to respond in a timely manner to almost all referrals. Data collected since 2017 shows that assessments are provided in a timely manner.

Time to commence assessment from receipt to referral:



Monitoring and evaluation

Descriptive quantitative data has been collected since the service commenced. This is derived from referral information collected locally and operations statistics collected routinely. The summary is presented annually to HNE and MoH executives.

There has not been a formal evaluation of the service. However, smaller pilot evaluations have been done. The feedback from EDs is positive and there is a high level of acceptance of virtually enabled care from both consumers and staff.

A comprehensive evaluation of the service has been proposed, formal research and study grants have been applied for. The planned evaluation will include a dedicated research team and funding to explore the consumer and system level outcomes as well as an economic evaluation of the model.

Evaluation of specific sites has found:

- In 2019-20, transfers of 39 patients from Moree to Tamworth were avoided, representing an average cost savings of $4,500 per patient
- In 2018-19, patients assessed by NMHEC-RAP at Muswellbrook ED and subsequently transferred to the Maitland Hospital were evaluated showing:
    - no significant difference in the waiting times at Muswellbrook ED but significantly less wait time at Maitland ED
    - a reduction in patient transfers (from 24% to 15%)
    - most patients transferred were subsequently admitted to mental health units, demonstrating the validity of the clinical MHEC-RAP assessments.
- Descriptive data has been collected since the service commenced. This is derived from referral information and operations statistics and is presented annually to HNE and MoH executives:
    - 55% of patients assessed by the service are female
    - 25% of patients identify as Aboriginal or Torres Strait Islander
    - 68% of patients are assessed within one hour of referral.

Opportunities

Components of the NMHEC-RAP service could be adapted for implementation at other sites or for different services:

- Specialist mental health assessments could be offered across a variety of settings outside of EDs, including community inpatient and outpatient facilities.
- Other specialist medical services could be provided via in-reach to EDs using the NMEC-RAP clinical model.
- The NMHEC-RAP clinical service could be provided to other rural LHDs that do not have access to emergency mental health assessments.

The Mental Health First Responder service provided by the HNELHD mental health team (highlighted below) also represents a future opportunity. This demonstrates the adaptability of the model to enhance service provision outside of EDs through interagency collaboration with police and ambulance.

Mental Health First Responders

Police and ambulance are often the first responder to emergencies involving mental health crisis. Without guidance from mental health professionals, emergency services are often required to transport patients to the nearest declared mental health facility for assessment. Should admission not be required, consumers are then responsible for making their own way home, which may be hundreds of kilometres away.

Helping emergency services to access specialist mental health triage to determine the most appropriate care pathway for the individual ensures people are receiving the correct care and reduces unnecessary transport.

By providing mental health triage through videoconferencing direct to police and ambulance, the Mental Health First Responder model:

- ensures patients are receiving timely, safe and appropriate care - reducing the trauma of emergencies
- avoids taking emergency workers out of their communities for extended periods to conduct unnecessary transportation
- reduces potentially preventable presentations to Emergency Departments.

The Mental Health First Responder initiative is being implemented at multiple sites across the HNE. The Mental Health First Responder approach is based on the successful Police and Ambulance Early Access to Mental Health Assessment via Telehealth (PAEAMHATH) initiative, which was piloted in the Port Stephens area in 2017. PAEAMHATH had a 98% satisfaction rate, from patient experience measures and saw 75% of eligible patients avoid transport to hospital while providing timely and safe care. Not only does this service save resources and time for the police and ambulance, it also empowers emergency services to provide more targeted care for vulnerable people in crisis situations. Feedback from some emergency services staff indicates that the post-triage feedback phone call with the Mental Health First Responder clinician offers support for decision making and builds confidence in responding to situations that can be confronting and challenging for emergency services.

Technology

The Mental Health First Responder model is enabled by the following technology:

- iPads with access to the myVirtual Care telehealth platform
- A dedicated phone line at NMHEC-RAP hub
- Videoconferencing devices at NMHEC-RAP hub.

Part 3
Western NSW Local Health District (WNSWLHD) Mental Health Emergency Care (MHEC)

Overview

The WNSWLHD mental health team facilitate virtual mental health services with the goal of providing access to high quality specialist mental health care for the people of Western and Far Western NSW.

The WNSWLHD mental health team based at the Bloomfield Hospital in Orange provides a range of service through virtual modalities. All interactions with the service are initiated via phone calls to a dedicated single point of access, the 1800 mental health line. The team provide MHEC assessments, mental health triaging and clinical advice to WNSWLHD and the Far West Local Health District (FWLHD).

WNSWLHD began providing MHEC assessments in 2006 to respond to high numbers of unnecessary mental health admissions. The MHEC model offered a solution for local EDs, General Practitioners (GPs) and Community Mental Health Teams (CMHTs) by providing support to make timely and clinically appropriate decisions about mental health care needs.

Today, only 25% of people who receive MHEC assessments are admitted to mental health facilities. This represents a significant reduction in inappropriate admissions, delivering improvements in system resource capacity, wait times in local EDs and supporting appropriate mental health care to be delivered closer to home.

MHEC assessments are now available to 47 EDs across WNSWLHD and FWLHD, 24 hours a day. While focussing on the MHEC service, this section will also explore the interrelationship of this service with the wider WNSWLHD mental health service, including the mental health line, mobile MHEC triaging and consultation liaison service.

A single point of entry approach to service design has been extremely successful across WNSWLHD and FWLHD, with consumers and clinicians citing the practicality and value of this approach.

'The best thing from our point of view is the expert opinion. The MHEC clinicians are usually very experienced clinicians. Community workers can feel a little bit isolated and need to debrief about certain situations having this 24/7 service with experienced clinicians as an advice line for clinicians is invaluable.'
ALEXANDER SCHMICH, TEAM LEADER, VIRTUAL MENTAL HEALTH TEAM WNSWLHD

Services

Many calls to the mental health line are received from consumers, carers, GPs, CMHTs, or emergency workers for patients who require support services but are not in mental health crisis.

The service provision and patient journey is tailored for each call. Each consumer is provided one of the following three services:

- Mental health triage
- MHEC assessment
- Clinical advice.

An overview of these three services is provided below and a more detailed overview of the MHEC assessment service is provided in figure 4. Generally, mental health assessments are not offered to children under 10 years old, unless they have been referred by a paediatrician. When this is not appropriate and no other alternative is available, advice to parents on managing acute behavioural disturbance in younger children may be offered through mental health triage.

Mental health triage

- MHEC clinicians provide consumers with appropriate help and advice about their mental health concerns. In addition to conducting a review and addressing immediate mental health concerns, the MHEC clinician will also match and refer the caller to the appropriate local service to support them with follow up care.
- This process relies heavily on the knowledge of the MHEC clinical team of locally available services across the Western NSW and Far West districts, including intake processes, clinic availability and physical locations.
- Some referrals may not require triage to mental health services, and services such as drug and alcohol, domestic violence or trauma specific services may be recommended.

Clinical advice

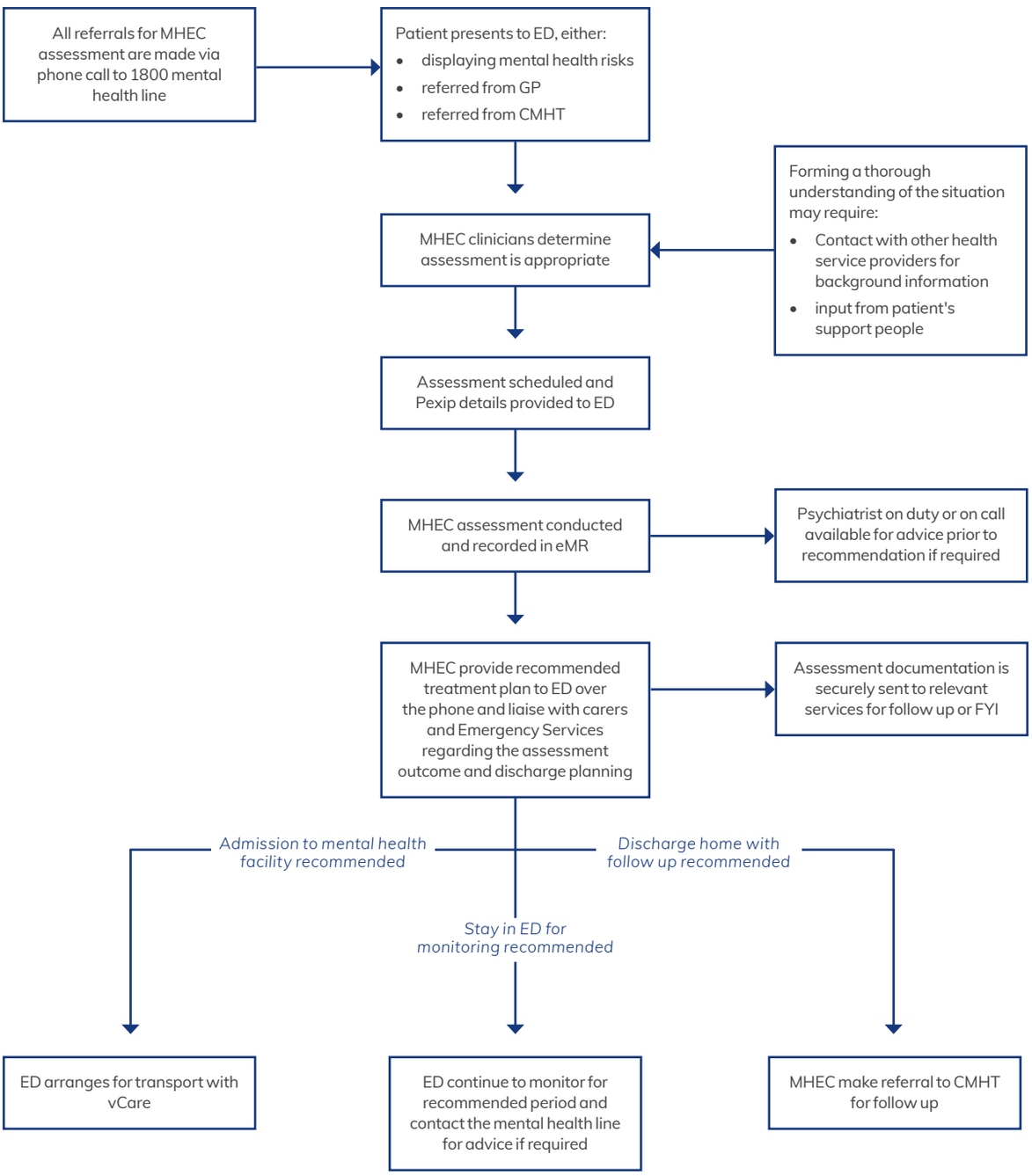
- The expert clinical MHEC team also offer in-reach clinical advice for all LHD and other mental health clinicians within the Western NSW and Far West districts.
- Calls received from clinicians seeking advice are managed by all team members and advice is sought from a psychiatrist if required.
- As this is not direct service delivery, the documentation of any clinical advice impacting diagnosis or treatment is the responsibility of the clinician caring for the patient. Typically, no clinical notes or eMR documentation is recorded for these discussions.
- The call statistics (duration, MHEC team receiver and location) are recorded on touchpoint software to track service utilisation.

Mobile MHEC:

- A mobile MHEC service is currently being trialled in Cowra. Police and ambulance services can access triage and mental health assessments when responding to mental health emergencies.
- A first responder can dial the mental health line providing details of the situation in which a consumer needs mental health support.
- The MHEC clinician provides a link for a video consultation hosted at MHEC in Orange and accessed either on:
  - police or ambulance iPads within patients' homes; or
  - videoconferencing machines set up in police station cells.

Workflow diagram

Figure 2: MHEC Assessment Service flow diagram



MHEC Assessments

The MHEC assessment service operates 24/7 across WNSWLHD and FWLHD. EDs without CMHTs can access the service 24/7, and for those with CMHTs the service is accessible outside of business hours.

Consumers can be referred for a MHEC assessment through their GP, CMHT or via self-referral by presenting to their local ED. After an initial referral telephone call to the 1800 mental health line, specialist mental health assessments are provided using videoconferencing from Orange to local EDs.

MHEC staff will recommend that a consumer is either discharged home with CMHT follow up, stays in ED temporarily with MHEC support, or is transferred to a declared mental health facility following the assessment.

Patient story

Elena* has post-traumatic stress disorder (PTSD), a mental disorder that can develop after exposure to a traumatic event. People experiencing PTSD can experience feelings of panic or extreme fear and symptoms may include flashbacks, nightmares and extreme anxiety.

Elena had attended panorama clinic in Bathurst and was given the mental health line card by the team. People experiencing PTSD can experience symptoms at any time and Elena felt having the mental health line number to call on was very important.

Elena needed support late one night, rang the Mental Health line and spoke to the MHEC team.

The benefit of virtual care for Elena was that accessing it is as simple as picking up the phone.

'I like talking, you just pick up the phone – that's all I am capable of doing sometimes. With the mental health issues, it makes it difficult to talk – the nurse knew how to deal with it, they were very experienced, waiting for me to do that, working with me, helping me to help myself.

I recently had to ring and mentioned that I had developed asthma, which is a flag for my mental health. They referred me to a doctor on call who called me back straight away and talked to me. This was a perfect coordinated effort that stopped me from having to go in an ambulance to get help.'

The team were able to access Elena's previous clinical notes, which ensured she didn't need to repeat information she had provided before. This proved invaluable for continuity of care.

* Name changed to protect patient privacy and confidentiality.

Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the supporting documents section at the end of this report also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

All telephone and videoconferencing services offered by the WNSWLHD MHEC team are clinically led from the Orange hub.

MHEC hub governance

- The MHEC team perform a daily check to ensure all recommendations and referrals have been received and followed up. If receipt of referral is not acknowledged the MHEC team follows up by phone or email to the team that received the referral.
- Three times a week the team hold case review meetings. These are led by the psychiatrist and review the previous days referrals, assessments and outcomes. This offers a mechanism for continuous quality improvement and escalation pathway for any issues arising.
- Mental health meetings are hosted daily by the Dubbo mental health team and are attended remotely by at least one member of the MHEC team. As a significant number of referrals are received from Dubbo region, this meeting offers the opportunity to discuss handover of any people with complex needs. It also allows clinical team to be notified of staffing changes and any ad hoc issues to be escalated.

Regional governance

- CMHTs from Orange and Bathurst Hubs meet with the lead psychiatrist from MHEC weekly to discuss key issues arising in recent referrals, review recent complex presentations and discuss lessons learnt or issues for escalation. These discussions act as a mechanism for continuous quality improvement and support continuity of care between the CMHTs across both districts and the MHEC team.
- MHEC offers district wide education, to enhance the mental health clinical expertise of stakeholders across the districts, this is detailed further in the building engagement section.

Executive governance

- Clinical leads of the MHEC team have regular meetings with executive sponsors from both WNSWLHD and FWLHD.
- Support from executives has been identified as a key enabler of the growth and success of the MHEC model. Having executive sponsorship aligned with the goal of enabling access to high quality mental health care for everyone across WNSW and FWNSW has allowed the model to continually adapt and improve equity of access through technological advancements.

'The service has experienced a huge amount of technological change in a short space a time. The district is always very receptive of innovative ideas, which has been an enabler for this model of care.'

HELEN MCFARLANE - INNOVATION AND PERFORMANCE MANAGER MENTAL HEALTH DRUG AND ALCOHOL WNSWLHD, EXECUTIVE SPONSOR

Building engagement

Consumer and community engagement

- There is a strong focus on raising community awareness of the 1800 mental health line to ensure people receive the most appropriate care for their individual need.
- Consumer feedback has highlighted the empowerment and positive mental health outcomes resulting from consumers and carers having the knowledge and ability to engage with the mental health line.
- Flyers providing an overview of the mental health line and business cards with the number and short description are available in community mental health facilities, general practices and other health care facilities across the districts.

Mental Health Line card and information brochure available in community facilities across Western and Far West NSW.

'I would like to get the cards to everyone, I have no shame anymore because of the healthcare I have received. I used to keep it a secret but if these cards were all over the community where people could access them discreetly, this would encourage them to access these services in private.'

MHEC PATIENT WNSWLHD

Engagement through education

The WNSWLHD MHEC team have developed virtual training programs that leverage the district-wide online training calendar. Through this training they regularly engage with referring clinicians, as well as clinicians and consumers across the district who are interested in mental health care.

- The training programs ensure that mental health workers across the district can upskill, build confidence in caring for consumers in mental health crisis and only need to contact the central line when extra support is needed.
- Monthly virtual outreach education sessions are hosted by the MHEC team. They cover a broad range of practical topics related to mental health and are presented by MHEC team members and guest clinical experts. Sessions are attended by ED and CMHT members as well as staff from GPs, Aboriginal Community Controlled Health Services (ACCHSs) and NGOs across the district.

- Fortnightly virtual education sessions hosted by the MHEC CNC are provided to referring EDs. Nurses are surveyed to identify key areas for focus, which is provided in practical 20-minute sessions. ED staff training aims to improve triage processes and management of mental health presentations.
- Community education has been identified as an opportunity for further engagement by the team. When consumers and carers are well informed, they can meet their own service needs better. This includes understanding when to use MHEC or GPs for mental health plans, CMHFs for outpatient care, or calling the central mental health line or presenting at ED for emergencies. Further development of community education is planned to enhance mental health care across the system.

Orange MHEC Hub, Jeff Bull MHEC Nurse Unit Manager

'If MHEC didn't exist these patients will all have to be transported. This really has been a blessing for us and so valuable for clients. The education sessions for clinicians have also been very useful.'

ALEX SCHMICH, VIRTUAL MENTAL HEALTH TEAM LEADER, WNSWLHD

Engagement with other service providers

- The single point of access offered by the WNSWLHD mental health line means that a broad range of providers are referring into the mental health services. This helps to build networks that the MHEC team can refer to.
- Across the WNSW and FW health districts, many services providers interact with the MHEC team including ACCHCs, The Royal Flying Doctor Service, Beyond Blue, Live better, Mission Australia and others.
- Stakeholders from all these organisations are encouraged to take part in the monthly education sessions hosted by the MHEC team.
- The success of the model relies on the MHEC team's thorough understanding of local services, including availability and referral processes and mental health funding to assist consumers and referrers to navigate services.
- The MHEC team works closely with vCare who support patient flow and patient transport arrangements when a transfer is required.
- MHEC also works alongside the Virtual Rural Generalist Service (VRGS), which provides support to facilities without a doctor on site. VRGS doctors maintain medical responsibility for patients and MHEC provide advice.

Workforce and resourcing

Technology

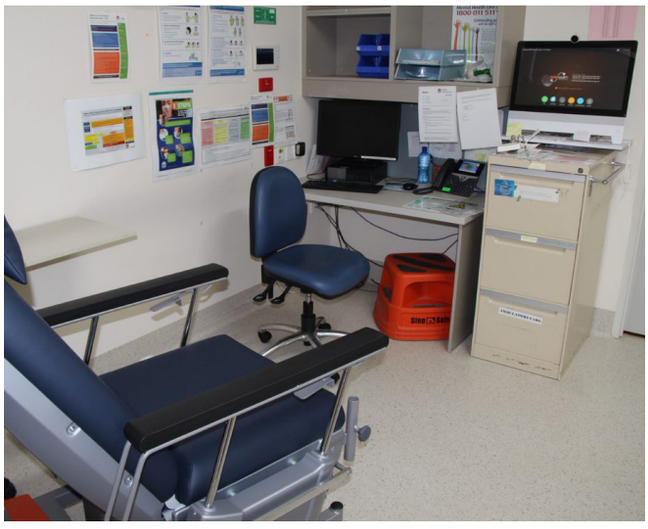
Orange Hub

Technology within the Orange Hub supports the agility of the mental health line, allowing the team to triage and action telephone calls and move smoothly between telephone and video assessment consultations. This set up includes the following elements:

- A phone system on each desktop workstation within the office to receive incoming calls to the1800 mental health line.
- Pexip enabled videoconferencing machines are set up in five private rooms for MHEC assessments.
- Direct links to portable videoconferencing machines in EDs enables video connections to patients.
- A shared eMR across WNSWLHD and FWLHD streamlines assessments providing seamless access to clinical notes records that provide context for mental health presentations.
- Mobile MHEC assessments are facilitated using police or ambulance tablets with videoconferencing software installed, or police stations videoconferencing machines.

Receiving EDs

- Workstations on wheels ('Wallies') or fixed videoconferencing machines are available in each ED with:
  - two-way audio-visual conferencing
  - videoconferencing enabled screen.
- Access to MHEC services from a smaller ED occurs using the same procedures and technology as these other virtual services. This is an important for the model's implementation, as it ensures streamlined access to services and improves the experience of staff on the referring end.



Blayney ED, WNSWLHD

Workforce

WNSWLHD hosts a team dedicated to the mental health line, MHEC, mobile MHEC and clinician advice services. Two clinicians are on shift 24 hours a day and a third is rostered between 4pm and 4am, when there is higher service demand. Table 4 lists team members.

Workforce recruitment

- Recruiting a workforce to provide mental health specialist care entirely virtually from a regional hub is both a key challenge and an enabler for MHEC. Whilst attracting clinicians to regional centres can be challenging, those interested and enthusiastic about virtualised care delivery tend to self-select and be passionate about improving access to care. Clinical leaders have emphasised the importance of recruiting clinicians that are experienced or wanting and willing to learn.

Recruitment challenges have been overcome using the following strategies:

- Support is provided to new starters by the lead psychiatrist. Psychiatrists review the triages and assessments completed by new staff regularly to offer advice and improvements to build their confidence.
- There is always a 24/7 option to call upon the consultant psychiatrist to seek guidance for complex assessments. This helps to build the experience and clinical knowledge of new starters whilst maintaining professional support.

A culture of open communication, a flat hierarchy and a broad willingness to help team members and mental health staff across the district with the goal of enhancing patient outcomes has contributed greatly to the success of the MHEC model in WNSWLHD.

Table 4 – WNSWLHD multi-disciplinary mental health team

Medical coverage during business hours:	
Psychiatrist (0.4 FTE)	Psychiatric registrar (1 FTE)
Allied health and/or nursing coverage 24/7:	
Nurse unit manager (1.0 FTE)	Allied health clinician (3.0 FTE)
Registered nurses (9.5 FTE)	Clinical nurse consultant (1.0 FTE)
Administration officer - 1.0 FTE during business hours	

Benefits

Results

Approximately **22,000 calls are received per year** through the 1800 mental health line in Orange.

Telephonic data shows that **90% of calls to the 1800 number are answered within 30 seconds** and almost all others are answered within two minutes.

Approximately **10% of calls** result in a videoconferencing MHEC assessment.

Significant **reduction in unnecessary transportation** and avoidable admissions.

Monitoring and evaluation

Evaluating a model that is delivered across a diverse range of settings is challenging. However patient experience and outcome data are collected, and anecdotal feedback is regularly received from CHMTs.

- All call participants are invited to complete the 'Your Experience Survey' (YES survey) following contact with the MHEC team. The take up rate for feedback could be improved, and the team have identified a more targeted and user-friendly approach as an opportunity.
- Regular positive feedback from stakeholders across all levels in the districts is received through the governance and engagement structures, including feedback from education sessions, local, regional and executive governance meetings, and through community engagement.

Opportunities

There are opportunities for the MHEC service to collaborate with other community mental health services or be adapted to enable new ways of providing care.

- As 100% of service offerings from the WNSWLHD MHEC team are provided virtually, it would be possible to recruit clinicians who are based remotely across the districts. This could provide a mechanism to strengthen stakeholder relationships across the region, especially in remote areas.
- The expansion of the mobile MHEC service to new police and ambulance zones would increase access to timely and appropriate care and reduce unnecessary transport.
- Collaboration with existing mental health care initiatives offers an opportunity to enhance community follow up by fostering information sharing and education.
    - The planned trial of the 'Project Air Gold Card Clinic' initiative for MHEC clinicians aims to support the team's ability to provide a brief mental health intervention directly into people's homes.
    - The recently developed SafeHaven service spaces across the state, may represent an opportunity for referrals and support options for the MHEC patient cohort.

References and links

Spotlight on virtual care: vCare (WNSWLHD)

Spotlight on virtual care: Virtual Allied Health Service (WNSWLHD)

Spotlight on virtual care: Virtual Rural Generalist Service (WNSWLHD)

National Safety and Quality Health Services Standards

Supporting documents

Mental Health Assessment

Mental Health Assessment Review

PD2019_056 – Credentialing and Delineating Clinical Privileges for Senior Medical Practitioners and Senior Dentists

PD2016_026 – Staff Specialist employment Arrangements across more than one Public Health Organisation

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Kate Simpson	Clinical Coordinator, Intake Services
Peter Kemp	Service Manager, Intake Services
Brendan Flynn	Executive Sponsor – Executive Director, Mental Health

WNSWLHD

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Heather Gant	CNC Orange MHEC
Dr Rodney Juratowitch	Head psychiatrist
Helen McFarlane	Executive Sponsor – Innovation & Performance Manager, Mental Health Drug & Alcohol Services

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The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

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