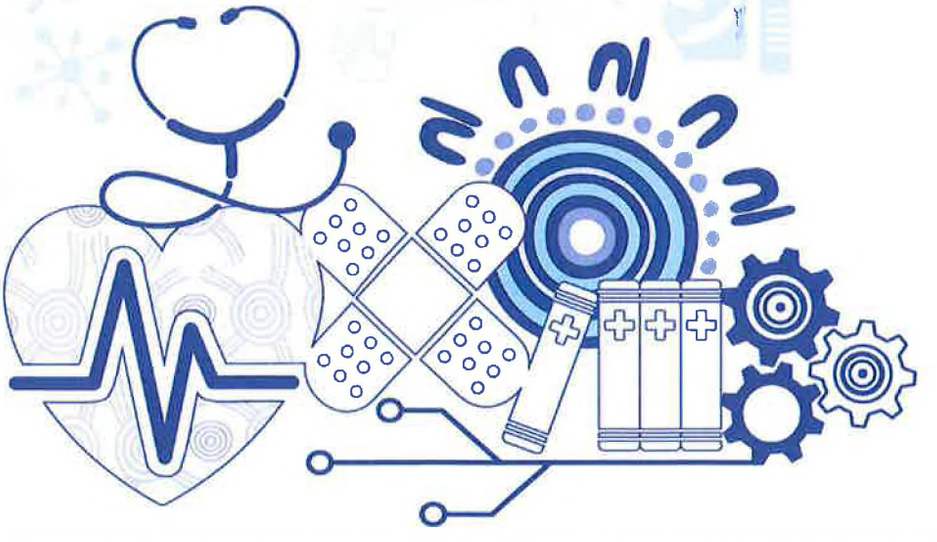
Service Agreement 2023-2028

An agreement between the Northern Sydney Local Health District

and

HammondCare Affiliated Health Organisation

For the period 1 July 2023 - 30 June 2026 with two optional 12-month extension periods available.



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NSW Health Service Agreement – 2023-28

Principal purpose

Service Agreements support partnerships between Local Health Districts and Affiliated Health Organisations. The principal purpose of the Service Agreement is to set out the service and performance expectations for funding and other support provided to HammondCare Affiliated Health Organisation (AHO) (the Organisation), to ensure the provision of equitable, safe, high quality and human-centred healthcare services in respect of its services recognised under the *Health Services Act 1997* supported by the District. It facilitates accountability to Government and the community for service delivery and funding.

The agreement articulates direction, responsibility, and accountability across the NSW Health system for the delivery of high quality, effective healthcare services that promote, protect, and maintain the health of the community, in keeping with NSW Government and NSW Health priorities. Additionally, it specifies the service delivery and performance requirements expected of the Organisation that will be monitored in line with the *NSW Health Performance Framework*.

The Agreement recognises and respects the health care philosophy of the AHO. In some instances, there may be a Memorandum of Understanding or other agreement that operates within the context of this Agreement.

HammondCare AHO agrees to meet the service obligations and performance requirements outlined in this Agreement. Northern Sydney Local Health District agrees to provide the funding and other support to HammondCare AHO outlined in this Agreement.

Parties to the agreement

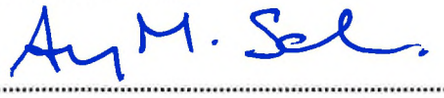
Affiliated Health Organisation
Kok Kong Chan
Chair
On behalf of the
HammondCare Affiliated Health Organisation Board

Date 12 February 2024 Signed 

Mike Baird
Chief Executive
HammondCare Affiliated Health Organisation

Date 23 January 2024.....Signed 

Northern Sydney Local Health District
Adjunct Prof. Anthony M. Schembri AM
Chief Executive
On behalf of the Northern Sydney Local Health District

Date 12 Feb 24 Signed 

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1. Legislation, governance and performance framework

1.1 Legislation

1.1.1 Preamble

The *Health Services Act 1997* (the "Act") provides the framework for the NSW public health system. Section 7 of the Act provides that the public health system constitutes, inter alia, Local Health Districts and Affiliated Health Organisations in respect of their recognised services and recognises establishments (s.6). The Act defines Local Health Districts and Affiliated Health Organisations as public health organisations (s.7).

A Local Health District is a public health organisation that facilitates the conduct of public hospitals and health institutions in a specific geographical area for the provision of public health services for that specific area.

The principal reason for recognising services and establishments or organisations as Affiliated Health Organisations is to enable certain non-profit, religious, charitable, or other non-government organisations and institutions to be treated as part of the public health system where they control hospitals, health institutions, health services or health support services that significantly contribute to the operation of the system (s.13).

1.1.2 Service Agreements between Local Health Districts and Affiliated Health Organisations

This Service Agreement constitutes the performance agreement under section 130 of the Act. Section 130 provides for Local Health Districts exercising the delegated function of determining subsidies for Affiliated Health Organisations to enter into performance agreements with Affiliated Health Organisations in respect of recognised establishments and established services and may detail performance targets and provide for evaluation and review of results in relation to those targets.

Section 130 of the Act addresses performance agreements between local health districts and affiliated health organisations:

(1) A Local Health District exercising a function delegated under section 129 in respect of an affiliated health organisation may enter into a performance agreement with the Affiliated Health Organisation in respect of its recognised establishments and recognised services.

(2) A performance agreement:

(a) may set operational performance targets for the Affiliated Health Organisation in the exercise of specified functions in relation to the health services concerned during a specified period, and

(b) may provide for the evaluation and review of results in relation to those targets.

(3) The Affiliated Health Organisation must, as far as practicable, exercise its functions in accordance with the performance agreement.

(4) The Affiliated Health Organisation is to report the results of the organisation's performance under a performance agreement during a financial year to the local health district at the quarterly performance meetings.

(5) The Local Health District is to evaluate and review the results of the organisation's performance for each financial year under the performance agreement and to report those results to the Secretary, NSW Health.

(6) The Secretary, NSW Health may make such recommendations to the Minister concerning the results reported to the Secretary, NSW Health under subsection (5) as the Secretary, NSW Health thinks fit.

While the Act requires a formal annual report, effective performance management will require more frequent reviews of progress against agreed priorities and service performance measures by the parties to the Service Agreement.

1.2 Term and variation of the agreement

The term of this agreement is:

Commencement Date	Date of signature
Initial Term Period - End date	30th June 2026
First Optional Extension Period - End date	30th June 2027
Second Optional Extension Period - End date	30th June 2028

The Agreement may be amended at any time by agreement in writing by all the parties. The optional extension periods will automatically roll on except in the circumstance where the agreement is terminated with at least 180 days' notice prior to the end of term period. The Agreement may also be varied by the Secretary, or the Minister as provided in the Health Services Act 1997. Any updates to finance or activity information further to the original contents of the Agreement will be provided through separate documents that may be issued during the term of agreement.

The parties are to agree on an appropriate local dispute resolution process. Should a dispute be unable to be resolved by the relevant officers the matter should be escalated, in the first instance to the relevant Chief Executives and, if not resolved, subsequently to the Secretary, NSW Health.

Local Dispute Resolution

NSLHD meets quarterly with the Chief Executive (or their delegate) and senior management team of the AHO through the performance review meetings. Where a performance issue is identified, this is directed to the relevant Operations meeting for review and resolution. The frequency of the performance meetings may be increased until the issue is resolved.

1.3 Governance

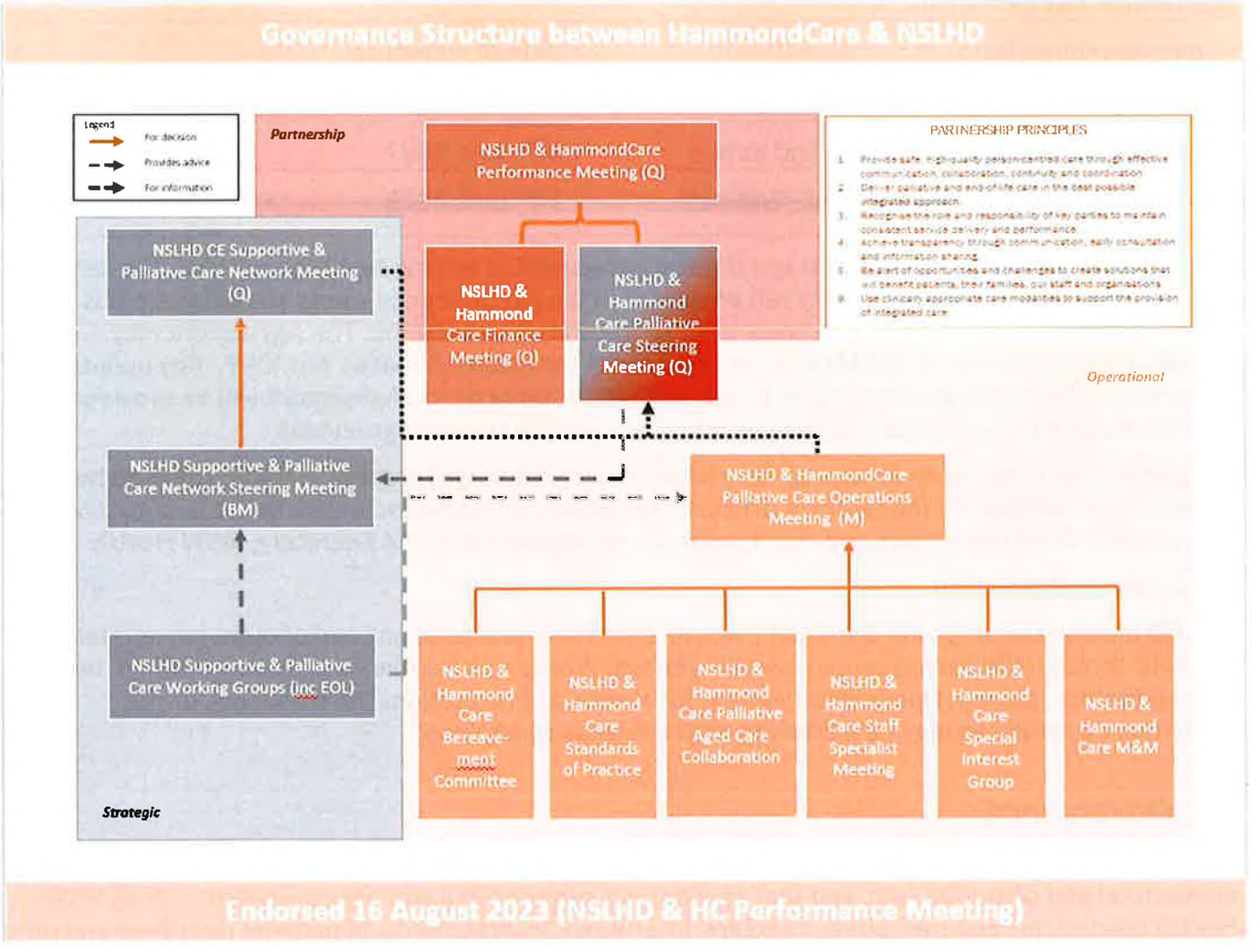
The Organisation must ensure that all applicable duties, obligations, and accountabilities are understood and complied with, and that services are provided in a manner consistent with all NSW Health policies, procedures, plans, circulars, inter-agency agreements, Ministerial directives and other instruments and statutory obligations.

The overarching framework for governance comprises:

- Service Agreements with AHOs, include clearly stated performance requirements including Strategic Priorities and governance requirements.
- the roles and responsibilities of AHOs and NSLHD.
- KPIs and their performance thresholds that, if not met, may raise a performance concern and the process through which these concerns are identified and raised.
- transparent monitoring and reporting processes both internally to boards and externally to government.
- expectations of responses to unsatisfactory performance or significant clinical issues or sentinel events.
- robust governance processes through which escalation or de-escalation of responses is determined.

To govern all three services within the Service Agreement, there are a series of committees. All these committee ultimately reporting into the NSLHD & HammondCare Performance Meeting. These are outlined below.

Palliative Care Governance



Older Peoples Mental Health Services (OPMHS)

There is an overarching OPMHS operations committee between HammondCare and OPMHS called "MHDA and HammondCare Tri Monthly Meetings". These are held quarterly.

Additional committees reporting into the quarterly operations meeting include:

- Macquarie Hospital & HammondCare Electro Convulsive Therapy Liaison Committee
- Mental Health Drug & Alcohol Skin Integrity and Falls Prevention Committee

Rehabilitation Services

There is an overarching Rehabilitation operation meeting held quarterly.

2. NSW Health services and networks

Affiliated Health Organisations and Districts are to collaborate in short, medium and long term planning processes relevant to the Organisation, including consideration of any capital and procurement.

Each NSW Health service including AHOs are part of integrated networks of clinical services that aim to ensure timely access to appropriate care for all eligible patients. The Organisation must ensure effective contribution, where applicable, to the operation of statewide and local networks of retrieval, specialty service transfer and inter-district networked specialty clinical services as agreed.

2.1 District responsibilities to AHOs

In keeping with the AHO's recognised establishments and recognised services, Districts must negotiate on the same basis as other facilities within the District, access to the following:

- Continuity of (non-inpatient) acute care services.
- Specialised services (e.g., orthotics, specialised seating, bio-medical engineering, pathology, patient transport).
- Training programs, particularly mandatory training, run by the Health Education and Training Institute.
- NSW support programs offered by pillar organisations.
- eMR, eRecruitment, IMS+ (RiskMan) and other NSW Health systems conducive to the fulfilment of the AHO's service, quality and safety and clinical training obligations.
- Agreed and clearly articulated information management support for IT hardware, software and systems support and integration.
- Engagement and participation of AHO Chief Executive Officer (or their delegate) in District budget planning and negotiations.
- Access to capital support and the Asset Replacement and Refurbishment Plan where services are situated on NSW Health property.
- Engagement and participation of AHO Chief Executive Officer (or their delegate) in District senior leadership committees and with pillar and support organisations as required.
- Access to District Training and Development Services & courses.

3. Budget

Local Health Districts have responsibility for funding AHO service delivery across district borders where an organisation has statewide or cross-border sites listed in Schedule 3 of the *Health Services Act 1997*. The Budget includes an indicative split based on service delivery.

The Local Health District also undertakes to advise the AHO of opportunities for additional funding as they arise at any time, through the life of this Agreement.

Annual Financial statements are issued by the Executive Director Finance and Corporate Services. These are found in TRIM.

Note: The AHO and LHD are to agree the content, taking into consideration that Budget information should be sufficient for the AHO to readily understand the budget allocation. Negotiations are to specifically include obligation to share and make transparent all opportunities for application, negotiation and/or disbursement of growth/expansion/enhancement funding.

4. Purchased volumes and services

4.1 Activity

4.1.1 Rehabilitation Service Specifications

This service specification outlines the purpose, scope, and key functions of the NSLHD purchased HammondCare Rehabilitation services, the target group for these services and the associated service components. The key performance indicators are matched to the expected services to be delivered.

The services purchased from HammondCare under this agreement are as follows:

4.1.1.1 Outpatient multidisciplinary rehabilitation.
4.1.1.2 Home based multidisciplinary rehabilitation.

*HammondCare Day Hospital is out of scope of this Service Agreement. All references to centre-based rehabilitation in this service agreement exclude HammondCare Day Hospital and are in relation to outpatients.

Policy Context

The following are policies, standards, and guidelines relevant to rehabilitation service delivery outlined in this agreement:

- NSLHD Clinical Services Plan (2024-2029 - DRAFT)
- NSLHD Rehabilitation Model of Care (2023)
- ACI Principles to Support Rehabilitation Care (2019)
- Outpatient Rehabilitation in NSLHD (NSHD0207408 v1.0)

Purpose

The outpatient and home-based rehabilitation services are to provide early supported rehabilitation discharge from NSLHD hospitals for patients with recent onset of significant disability.

These services will provide comprehensive, high quality multi-disciplinary rehabilitation for the attainment of optimal independence for clients who have loss of function or ability due to injury or illness.

Outpatient rehabilitation services are defined as coordinated single discipline or multidisciplinary services provided at the health service.

Home-based rehabilitation services are defined as coordinated single discipline or multidisciplinary services provided in the home.

Service Specifications

4.1.1.1 Outpatient multidisciplinary rehabilitation.
4.1.1.2 Home based multidisciplinary rehabilitation.

Scope

Patients discharged from hospitals (NSLHD or other LHD), and those experiencing a period of functional decline (not following initial acquisition of the impairment) who reside in the NSLHD are in scope for Greenwich outpatient or home-based rehabilitation services.

Key Functions

Referral & access management

- Referral criteria for the outpatient and home-based rehabilitation service are essentially the same. The treating clinical team will determine appropriate streaming for the patient. Home based rehabilitation is indicated where a context specific service is required, or where access issues are prohibitive to attending a centre. It can be beneficial for stroke and other neurological impairments.
- HammondCare will maintain communication with referring acute care and subacute rehabilitation services to ensure that referrals are appropriate and program commencement is timely.
- HammondCare will have a referral and handover procedure between referring NSLHD acute care and subacute rehabilitation units and HammondCare services.
- HammondCare will operate an effective and efficient system to receive and prioritise all referrals into the service. This will include a central point of intake for referrals.
- Eligibility criteria is:
  - 18 years and above
  - Reside within the stated geographical catchment area (Lane Cove, Willoughby, Mosman, and North Sydney LGAs). Those residing in Northern Beaches LGAs may also be able to access services if Mona Vale Hospital outpatient rehabilitation service is unable to accept referral.
  - Must have "SMART" rehabilitation goals: specific, measurable, attainable, realistic, and targeted which a multidisciplinary rehabilitation team can reasonably address through a focused period of intervention (time-limited), supported by currently available evidence. Attainment of these goals should have a significant impact on the person and/or their carer's quality of life.
  - Individuals with (but not limited to) the following conditions and impairments:
    - Orthopaedic conditions (primary cohort)
    - Neurological conditions, stroke, and non-stroke (secondary cohort)
    - Patients requiring reconditioning (secondary cohort)
- Exclusion criteria is:
  - Those with psychological, psychiatric and/or cognitive impairment that has been assessed as precluding the individual from participation in a rehabilitation program.
  - Severe traumatic brain injury and spinal cord injury.
  - Patients that are unable to be supported by 1:1 therapy due to high care needs without carer support.

Service Delivery

- Provide multidisciplinary rehabilitation in the most appropriate setting for the client. In the case of Outpatient Services, this will be at the health service. In the case of home-based services, this will be in the home. Clinical practice recommendation for allocation to home-based therapy is most indicated for stroke and hip fracture clients.
- Provide a programme that includes comprehensive assessment, client goal setting, case management, clinical care coordination, progress evaluation and discharge planning.

- Ensure the focus of care is on optimal achievement of realistic functional and lifestyle goals. Focus includes the client and family/carer.
- Develop a goal-orientated plan agreed between the client, family/caregiver and the multi-disciplinary team that is linked to timeframes.
- Adjust the rehabilitation programme to maximise positive outcomes and in accordance with the client's response and achievement of clinical or functional benefit. Ensure that the client and their caregiver or family understand the way the rehabilitation plan will be delivered.
- Provide an appropriately qualified multi-disciplinary workforce, including:
    - Allied health professionals (including Physiotherapists, Occupational Therapists, Speech Pathologists, Social Workers, Exercise Physiologists, Dietitians and Clinical Psychologists)
    - Rehabilitation Specialists
    - Access to the following when clinically indicated:
    - Neuropsychologist
- Provide an appropriate mechanism to ensure continuity and coordination of care regardless of entry point to the system e.g., case manager, key liaison person.
- Ensure early and comprehensive planning for the end of the episode of care is undertaken in consultation with the patient's General Practitioner if required.
- Where 2 or more therapists are involved in a patient's rehabilitation, hold multidisciplinary case conferences at appropriate intervals.
- A Rehabilitation physician should provide clinical leadership and support for complex care, with the option to include General Practitioners in MDT care planning discussions.
- Incorporate virtual care services (phone or telehealth) as another service delivery mode.
- An episode of activity-based therapy and coaching is generally for a period of up to 12 weeks for stroke and neurological impairments, and up to 6 weeks for other impairment groups.
- A short series of home-based rehabilitation sessions may be provided in the context of a person's outpatient rehabilitation program.
- Commence discharge planning during goal planning processes to promote a smooth transition into resumption of life roles after discharge from the ambulatory rehabilitation program.
- Plan discharge in consultation with the client, carer/family and agencies as appropriate.
- Discharge the client from the service when the client has achieved identified goals and outcomes, or they are not receiving clinical or functional benefit as assessed by an appropriate tool or outcome measure.
- Provide timely referrals to a locally defined range of programs and community services as appropriate.
- Ensure that transition of responsibility for the client management to other providers has been confirmed, prior to discharge.
- Provide multi-disciplinary discharge information to general practitioners and other post discharge service providers.
- Provide consultation and advice to secondary care facilities, general practitioners, community allied health professionals and residential care facilities, community support teams, family/ carers etc. as it relates to individual client needs.
- Outreach to RACF as an alternative to admitted rehabilitation should be available for eligible patients with a volume expected to be minimal (I.e., Approximately up to 5 per year).

4.1.2 Older People's Mental Health Service Specifications

This service specification outlines the purpose, scope, and key functions of the Older People's Mental Health Services (OPMHS) Riverglen Acute Inpatient Unit (AIU), the target group for these services and the associated service components.

The services purchased from HammondCare under this agreement are as follows:

4.1.2.1 Inpatient OPMHS unit – 20 beds
4.1.2.2 ECT Services

OPMHS will be provided in line with specified volumes as outlined in the Service Agreement. No change will be made to specified volumes in the absence of approval by Northern Sydney Local Health District (NSLHD).

Policy Context

The principles outlined in this service specification are based on the following key policy initiatives:

- NSW Older People's Mental Health Services Service Plan 2017 – 2027
- NSW Older People's Mental Health (OPMH) Acute Inpatient Unit Model of Care Guideline GL2022_003
- National Mental Health & Suicide Prevention Plan 2021
- NSW review of seclusion, restraint, and observation of consumers with a mental illness in NSW Health facilities
- PR 2009_286 Admission to Acute Adult Mental Health Inpatient Units – MHDA
- PR 2009_050 Bed Capacity Management with Mental Health Services – MHDA
- PD2020_004 Seclusion & Restraint in NSW Health Settings

In addition, the following quality standards and requirements also apply:

- The Riverglen AIU will maintain accreditation through Australian Council on Health Care Standards as per the NSQHS 2nd Ed Standards. If there are challenges/changes in relation to the accreditation status, then Riverglen Unit will provide an immediate update to the Director NSLHD MHDA.
- NSW Mental Health Act 2007
- Mental Health National Standards
- NSW Mental Health Drug and Alcohol MH-OAT reporting
- NSW Mental Health and Cognitive Impairment Forensic Provisions Act 2020
- NSW Guardianship Act

Furthermore, key HammondCare operational policies, procedures and guidelines guiding Riverglen OPMHS AIU service delivery are outlined below:

- Medical Clinical Handover
- Patient Special

- Recognition and Management of the Deteriorating Patient
- Safe Medication Administration
- Patient and Family R.E.A.C.H.
- Unauthorised Leave (absconding) Management
- HCH Riverglen admission policy
- HCH Riverglen ECT Admission Discharge procedure

Purpose

- Multi-disciplinary assessment of older consumers and their supports with appropriate collaborative comprehensive care planning.
- Involvement of family and carers as an integral part of the care planning process and provision of service.
- Promotion of personal and clinical recovery and the prevention or concurrent management of secondary morbidity.
- Provision of care plans that aim to achieve a reduction in acute mental health symptomatology and associated behaviours.
- Assessment and management of acute risk including the risk of suicide and deliberate self- harm.
- Clinical review and handover processes that are multi-disciplinary and in line with NSLHD MHDA policies, procedures and guidelines (PPG).
- Inpatient treatment that reflects compliance with and the least restrictive means of care as defined in the NSW Mental Health Act (2007).
- Transfer of care as soon a clinically indicated and to be coordinated in a safe and person-centred way.

Service Specifications

4.1.2.1 Inpatient OPMHS unit – 20 beds

Scope

The OPMHS target population is outlined clearly in the NSW OPMH Acute Inpatient Unit Model of Care Guideline GL2022_003 but may be defined broadly as people over the age of 65 years with mental illness (including people with or without dementia and BPSD) and those people under the age of 65 years (50 + years for Aboriginal people) with issues of ageing resulting in significant functional disability.

Philosophy of Care

- The Riverglen OPMHS AIU will adopt a person-centred, biopsychosocial and trauma informed philosophy of care and ensure that care environments, processes and practices reflect this philosophy.
- Consumers and their families and carers can expect to be provided with care that is consistent with the National Mental Health Statement of Rights and Responsibilities.
- Provision of recovery oriented, person centred and trauma informed care and practice, and clinicians who work in partnership with families and carers.

- The Riverglen OPMHS AIU is accessible to the target population and provides an equitable and transparent admissions process.
- Consumers receive effective and evidenced based care and this is reviewed regularly.
- The functional health needs, including physical health, of consumers are identified and addressed by the inpatient multi-disciplinary team/s.

Key Functions

Referral & access management

Entry Criteria
The following criteria must be met for admission to Riverglen Unit:

- Criteria outlined above under "target population" and
- Any concurrent medical problem is currently stable, with medical review prior to admission.
- Admission to Riverglen may be as a voluntary or involuntary patient, as determined by the NSW Mental Health Act 2007 and the Mental Health and Cognitive Impairment Forensic Provisions Act 2020

Access

- The Riverglen AIU will provide services to consumers who reside within the NSLHD boundaries and meet the criteria for admission.
- The Riverglen AIU Consultant Psychiatrist and NUM will agree to the transfer of a consumer who meets the criteria.
- A Clinical Handover must occur between the referring psychiatric team and the Riverglen AIU Medical team as well as between the Nurse Manager from the referring unit to the NUM (or delegate) at Riverglen AIU.
- Accept appropriate referrals from community OPMHS within NSLHD.
- Accept referrals from NSLHD inpatient services via NSLHD Patient Flow and Transport Unit (PATU)
- Comply with NSLHD MHDA procedures in relation to consumer flow & bed management as per PR2013_105 Acute Patient Flow Communication & Capacity Planning – MHDA.
- Accept admissions 24 hours per day from emergency department and/or out of business hours admissions , seven days per week following consultation between MHDA CADM, PATU, Consultant Psychiatrist and NUM of Riverglen AIU, to ensure it is safe and appropriate to do so.
- The Patient Flow Portal Inter-Hospital Transfers list will be the system used to fill bed vacancies and maintain waitlists.
- The Riverglen AIU NUM, in consultation with the unit's Clinical Director will ensure that a process is developed and implemented to identify consumers who are appropriate for discharge when urgent admission is required.
- The Riverglen AIU NUM or delegate will participate in the MHDA Friday Bed status teleconference at 12 midday.
- The electronic medical record (eMR) is used as the main system for documenting all clinical information regarding consumer care.

Exclusions

- Consumers who are assessed as acutely medically unwell and require a period of acute hospitalisation prior to transfer to the OPMHS AIU.
- Consumers who have a primary diagnosis of drug and alcohol disorder or delirium without a mental illness and/or an age related functional or cognitive disability.
- Consumers who have an acquired brain injury without comorbid mental illness.
- Consumers who are under 65 years who have no significant issues of ageing and /or are not experiencing behavioural and psychological symptoms of dementia (BPSD).

Note: *Whilst acute behavioural disturbance is not an exclusion criterion, additional consideration should be considered given to the afterhours staffing and the fact there is no onsite security support available to the AIU. In these instances, a discussion with the Nursing Unit Manager (NUM) is required prior to admission.*

Service Delivery

- The following components of assessment will be considered:
  - A comprehensive biopsychosocial assessment process that involves the needs and wishes of the consumer and their family & carers & GP where agreed.
  - All consumers must have a full physical examination on admission including cognitive testing.
  - Where consumers are not able to provide consent, assessment must be undertaken in a manner consistent with the NSW Guardianship Act and/or the NSW Mental Health Act (2007).
  - Assessments are conducted by appropriately qualified staff and are timely, multi-disciplinary, comprehensive, and consistent with relevant professional and policy standards.
  - Provision of specialist psychiatric coverage out of hours.
  - Inclusive of risk assessments which incorporate the risk of harm to self and others, the risk to reputation and the risk of falls and pressure injuries through completion of the Risk screening and Assessment pathway within eMR.
  - The use of interpreters as indicated and for all consumers where English is identified as a second language.
  - Riverglen AIU will utilise MH-OAT documentation as per PD2010_018 Mental Health Clinical Documentation NSW Ministry of Health (MoH) Policy Directive.
- The following components of provision of care will be followed:
  - Care from appropriately qualified allied health professionals is provided at a minimum Monday to Friday between 9am -5pm as outlined below.
  - Riverglen AIU will work with NSLHD OPMHS to continue to implement the NSW Ministry of Health OPMH AIU Model of Care 2022.
  - Riverglen will collaborate with NSLHD MHDA OPMHS to initiate and maintain an extended length of stay review process for consumers with lengths of stay more than 35 days and 70 days respectively. The Riverglen Medical Director or delegate will seek an internal second opinion at 35 days if HONOS is not improving.
  - Where the consumer remains in an acute phase of care at 70 days, then the NSLHD OPMHS Clinical Director or delegate will review the patient at 35-day intervals until the discharge is completed.
  - From 2024, for consumers who are no longer in the acute phase of their illness, consideration will be given to transferring the consumer to a sub-acute unit on the Macquarie Hospital Campus to continue their care and discharge planning. See the algorithm for long stay/admissions at Riverglen for more information.
  - The Riverglen Unit will notify the Director NSLHD MHDA or delegate of all critical incidents (Harm score 1 or Harm score 2) e.g., patient death, attempted suicide, all Category 1 and 2 consumers/high risk consumers absent without leave in a timely manner sufficient to enable NSLHD MHDA to advise the MoH within the mandated 24-hour reporting period. Appropriate documentation will be completed as soon as practicable and within the NSW Health guidelines and will be submitted via NSLHD-MHDARIB@health.nsw.gov.au.
  - Riverglen AIU will comply with all NSW Health Policy PD 2020_047 Incident Management Policy and NSLHD Procedures such as:
    - Aggression, Seclusion & Restraint in Mental Health Facilities - Guideline Focused Upon Older People GL2012_005 and Seclusion & Restraint in NSW Health Settings PD2020_004
    - Engagement & Observation in Mental Health Inpatient Units PD2017_025 NSW Health

        - The Riverglen Unit will escalate to NSLHD OPMHS Program Manager significant issues that have been raised by the NSW Official Visitors Program as soon as practicable. Where possible a collaborative approach to resolving these will be taken.
    - Service provision includes:
        - Onsite and off-site functional assessment by allied health professionals
        - Specialist mental health assessment
        - Specialist geriatrician medical cover
        - Specialist behavioural assessment and interventions
        - Clinical psychology services
        - ECT Services
        - Neuropsychological assessment via the RNS Aged Care team.
    - A phone call within 7 days of discharge together with documentation on the eMR must be completed and documented in eMR for patients who do not reside within NSLHD. Patients residing within NSLHD will be followed up by the respective community OPMHS team.

- The Riverglen Unit will ensure that transfer of care planning is undertaken in line with the following policies and guidelines:
    - Discharge Planning and Transfer of Care for Consumers of NSW Mental Health Services. PD 2019_045
    - Acute Patient Flow Capacity Planning – MHDA PR 2013_105
    - The Riverglen Unit will comply with and achieve or exceed NSW Health targets as per the Mental Health Clinical Documentation – Redesigned Guideline (GL2008_016),
    - The Physical Examination module also supported by Physical Health Care with Mental Health Services Policy (PD2017_033) and the Screening for Domestic Violence supported by Domestic Violence - Identifying and Responding policy (PD2006_084).

Support Services

- The Service provider will ensure that consumers have access to clinical support services including:
    - Radiology services,
    - pathology,
    - pharmacy and allied health.
    - Onsite – pharmacy,
    - catering,
    - speech therapy,
    - psychology,
    - physiotherapy,
    - occupational therapy and
    - social work.

4.1.2.2 ECT Services

Scope

- Riverglen will provide 230 sessions of ECT per annum +/- 5% to Macquarie Hospital consumers and follow on for Riverglen inpatient units within the current funding arrangements.
- A formal review of funding will be considered by the NSLHD Director MHDA, if ECT treatments consistently fall below 230 per annum for two consecutive financial years by 10X %.
- If required, a set of business rules on the financial arrangements around billing for all ECT services over and above 230 will be developed in conjunction with HammondCare and NSLHD MHDA.

Governance

- The Riverglen NUM and Medical Director will ensure that appropriate training processes are developed, implemented and reviewed / evaluated to allow for the training of nursing, medical and psychiatry students and staff of Macquarie Hospital.

- HammondCare are required to maintain the appropriate credentialing for ECT clinicians (psychiatrist and psychiatry registrars) as per PR2012_035 Credentialing of Senior Medical staff for Electroconvulsive Therapy (ECT) – MHDA and PR2012_037 v2 Credentialing of Junior Medical staff for Electroconvulsive Therapy (ECT) – MHDA and maintain volumes at or above the minimum level as per PD2011_003 Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW, section 10.4. I thought these had been updated
- Appropriate communication and formal processes will be documented and implemented between Riverglen and Macquarie Hospital to ensure that the role and responsibilities of Macquarie Hospital nursing staff are clearly defined in accordance with best practice.
- A quarterly ECT meeting between senior and relevant staff of the Riverglen Unit and Macquarie Hospital is maintained to ensure the monitoring of agreed processes and timely identification and rectification of any issues. A copy of the minutes of this committee meeting will be made available to the chair MHDA ECT Committee for tabling.
- Riverglen OPMHS AIU will ensure that monthly reports are provided to the Quarterly NSLHD OPMHS Operations Meeting, documenting:
  - the number of ECT sessions performed for that quarter,
  - the de-identified names of the individual consumers, and
  - the date of service provision.

Key Functions

Referral & access management

- The following patients are eligible for the service:
  - Inpatients of Macquarie Hospital.
  - Inpatients of Riverglen Unit.
  - Follow-on community patients from a Riverglen admission who require maintenance therapy.

Service Delivery

- Will be administered according to the GE2015_005 Electroconvulsive Therapy (ECT) Service Delivery in NSLHD and GE2013_022 Electroconvulsive Therapy (ECT) Services: Monitoring & Auditing – MHDA in association with the MHDA ECT Review Committee, current RANZCP guidelines are followed, and the requirements of the NSW Mental Health Act 2007 are met.
- A formal procedure documenting the processes involved in the delivery of ECT for patients of Macquarie Hospital has been developed conjointly by Greenwich Hospital and Macquarie Hospital Electroconvulsive Therapy (ECT) Mental Health Drug & Alcohol – Macquarie Hospital PR2009_267). This includes but is not limited to transport of consumers, responsibilities for care of consumers throughout the process, prioritisation, and scheduling arrangements etc. These processes are monitored by the quarterly Macquarie Hospital and Riverglen ECT liaison committee.
- Appropriate communication processes and procedures will be in place between medical staff of Riverglen and Macquarie Hospital to ensure there is the proper prescription, monitoring and review of ECT treatment, dosing, and number of treatments. This will be accurately documented at all stages of the ECT preparation and treatment process.
- The Department of Anaesthesia, Royal North Shore Hospital (RNSH) provides anaesthetic services to the Riverglen Unit for ECT. Services are provided 3 days/week for 52 weeks of the year. Services are not provided on weekends and public holidays. RNSH will invoice the Riverglen AIU for the anaesthetic services provided on a quarterly basis. Average session times are 3 hours (inclusive of travel time) and the hourly rate charged will be the Visiting Medical Officer (VMO) rate.
- Macquarie Hospital will provide nurse escort/s that have been risk assessed to meet the needs of consumers of Macquarie Hospital.

Workforce & Staffing

- The Riverglen AIU will maintain staffing levels and skill mix at levels sufficient to provide appropriate care for the consumers and to provide a safe and healthy workplace for staff.
- The Clinical Director of Riverglen will ensure medical staff cover is always adequate and appropriate to the needs of the consumers.
- The Operations Manager – Director of Nursing Greenwich Hospital will ensure that nursing staff are appropriately skilled and are provided in sufficient numbers per shift to ensure that the nursing care needs of the consumers are met.
- The Operations Manager – Director of Nursing Greenwich Hospital will ensure that allied health and support staff are appropriately skilled and are provided in sufficient numbers per shift to ensure that the allied health and support care needs of the consumers are met.
- Psychiatry Registrars
    - Two FTE Psychiatry Registrars, who are NSW Health employees, are seconded to the Riverglen Unit through the HETI Network B Training Scheme, which is auspiced by Northern Sydney LHD Mental Health Drug and Alcohol.
    - All psychiatry registrars working at the North Shore Ryde Mental Health Service and Riverglen are part of a shared on-call roster to cover after hours registrar on call services for Ryde Community Mental Health Services and Riverglen Unit.
    - The after-hours on-call roster for psychiatry registrar cover for Ryde Community Mental Health Service and Riverglen is prepared by the North Shore Ryde Mental Health Service. The facility requiring the call out is invoiced for overtime costs of the psychiatry registrar call outs.
    - Relief psychiatric registrar cover for Riverglen registrars required to do a week of night shift cover for NSRMHS is billed to Riverglen as agreed.
- Consultant Psychiatrists
    - A shared on-call roster for Consultant Psychiatrists will involve all Consultant Psychiatrists working at Macquarie Hospital and Riverglen. This roster provides on call cover for both services.
- Anaesthesia Support for Electro-Convulsive Therapy (ECT) Services
    - The Department of Anaesthesia, Royal North Shore Hospital (RNSH) provides anaesthetic services to the Riverglen Unit for ECT. Services are provided 3 days/week for 52 weeks of the year. Services are not provided on weekends and public holidays. RNSH will invoice the Riverglen AIU for the anaesthetic services provided on a quarterly basis. Average session times are 3 hours (inclusive of travel time) and the hourly rate charged will be the Visiting Medical Officer (VMO) rate.
- Nursing Unit Manager and Clinical Nurse Educator
    - The Riverglen Nursing Unit Manager (NUM) and the Clinical Nurse Educator (CNE) will develop and maintain professional linkages via participation in NSLHD OPMHS initiatives. Clinical / professional support can be accessed through participation in the NSLHD MHDA CNC / CNE /CNS network.
    - The NUM & CNE will support implementation of evidence-based nursing practice within Riverglen AIU. The NUM & CNE will work in close collaboration with the NSLHD OPMHS CNC 3 to promote consistency of service provision and continuity of care for consumers.
    - The Riverglen CNE will support the ongoing maintenance of the OPMHS Core Competency program within Riverglen AIU and will participate in the NSLHD MHDA Professional Development Program
    - The Riverglen NUM & CNE will work collaboratively with the NSLHD OPMHS Program Manager on the implementation of state wide OPMHS strategies and initiatives.
- The NSLHD Consumer Peer Worker is a permanent role with ongoing placement at Riverglen subject to routine review.
- Temporary Positions:

- Temporary funding may, at times, become available for time-limited clinical workforce opportunities within OPMHS.
- NSLHD MHD&A may liaise with HammondCare on these occasions to discuss options to further support the model of care.

Support Services

- The Service provider will ensure that consumers have access to clinical support services including:
  - Radiology services,
  - pathology,
  - pharmacy and allied health.
  - Onsite – pharmacy,
  - catering,
  - speech therapy,
  - psychology,
  - physiotherapy,
  - occupational therapy,
  - recreational activities officer and
  - social work.

Education

- That all staff undertake all mandatory education as determined by NSLHD MHDA.
- Maintenance of staff education records for mandatory and non-mandatory education.
- That medical, nursing allied health staff have access to education through Greenwich Hospital, Macquarie Hospital, NSLHD ODAC and the MHDA Learning and Capacity Development team.
- Education and information sessions are provided to consumers and their families / carers.
- Maintenance of records demonstrating evaluation of education for consumers and families /carers.

Continuous Improvement

- Riverglen OPMHS AIU will implement the Your Experience of Service (YES) and the Carer Experience of Service (CES) survey for all inpatients and participate in the benchmarking of this KPI against NSW State cohorts. Riverglen will celebrate good consumer feedback and systemically action feedback that is falling short of the expected standard via the prescribed methodology.
- Riverglen AIU will participate in the NSLHD MHDA Falls Prevention Committee and ensure compliance with PR2014_032 Falls Risk Management: Mental Health and Drug & Alcohol.
- Riverglen will participate in the NSLHD MHDA Skin Integrity Committee.
- Riverglen AIU will ensure compliance with NSLHD Pressure Injury Prevention and Management PD2021_023 and with NSLHD MHDA GE 2017_027 Advance Care Planning.
- Documentation Audits will be completed 6 monthly in line with NSLHD MHDA Documentation Audit schedule.
- Variance to documentation audits should be reported using an Action Plan template as per Documentation Audit Schedule.

4.1.3 Palliative Care Service Specifications

This service specification outlines the purpose, scope, and key functions of the NSLHD purchased HammondCare Palliative Care services, the target group for these services and the associated service components. The key performance indicators are matched to the expected services to be delivered. No change will be made to specific volumes (including bed numbers) in the absence of approval by NSLHD.

The services purchased from HammondCare under this agreement are as follows:

4.1.3.1 Inpatient Palliative care (Neringah & Greenwich – 15 beds each)
4.1.3.2 Specialist Palliative Care Community Services (RACF in-reach, palliative care clinics and home-based services)
4.1.3.3 Acute Hospital Consultation (RNS, Ryde)
4.1.3.4 On-call Roster (all palliative care units – Greenwich, Neringah, and Mona Vale)
4.1.3.5 Bereavement Services for those known to Palliative Care Services

Definitions

Specialist Palliative Care - is care provided by those health professionals who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals. Specialist palliative care may be provided in palliative care units, hospital-based consultative services, community, RACFs, supportive care and outpatient teams. NSLHD specialist palliative care services will provide high quality care that meets national standards by providers who are formally trained in palliative care. Specialist palliative care practice builds on the palliative care provided by generalist providers and reflects a higher level of expertise in complex symptom management, spiritual support, psychosocial support, cultural support, and bereavement support.

Policy Context

The following are policies, standards, and guidelines relevant to rehabilitation service delivery outlined in this agreement:

- National Palliative Care Standards 2018
- NSW End of Life and Palliative Care Framework 2019-2024
- NSW Health Guide to the Role Delineation of Clinical Services (Level 5 Palliative Care Services)

NSLHD-HammondCare Palliative Care Partnership Principles

These provide the basis for any service planning, delivery, and evaluation.

1. Provide safe, high-quality person-centred care through effective communication, collaboration, continuity, and coordination.
2. Deliver palliative and end-of-life care in the best possible integrated approach.
3. Recognise the role and responsibility of key parties to maintain consistent service delivery and performance.
4. Achieve transparency through communication, early consultation, and information sharing.
5. Be alert of opportunities and challenges to create solutions that will benefit patients, their families, our staff, and organisations.
6. Use clinically appropriate care modalities to support the provision of integrated care.

Purpose

All residents of Northern Sydney who require supportive and/or palliative care will have access to seamless high quality, integrated palliative care that is adaptive and responsive to their needs and those of their families, carers, and other health professionals.

Linked by agreed approaches to care and consistent with National Palliative Care Standards 2018 and NSW End of Life and Palliative Care Framework 2019-2024, supportive and palliative care services across NSLHD will provide specialised holistic, multidisciplinary advice, intervention, and care to patients with life limiting illness, their carers and their primary health care providers accompanied by general health promotion and community capacity building activities.

Supportive and palliative care services in NSLHD will be provided under a three-hub model. Hubs service the geographic areas of Hornsby Ku-ring-gai; Lower North Shore, Ryde, and Hunters Hill; and Northern Beaches LGAs. Each hub encompasses in-reach to acute care, access to sub-acute beds, non-admitted and home-based care including RACF.

Where possible and appropriate, services will be delivered in the patient's place of residence in partnership with the person's General Practitioner and primary health care providers. This will be enhanced by the development of a primary nurse model supported by nurse specialists and community registrars, allied health, pastoral care and when necessary medical support using telemedicine, and clinic visits or home visits if clinically indicated. An area wide emphasis will be placed on forward care planning to anticipate and manage symptoms and issues throughout the disease trajectory with use of telehealth where possible.

NSLHD's aim is to support existing palliative care services to engage as cohesively to provide five key components of the patient journey including referral, access, and initial contact; assessment; service delivery; transfer of care; and family/bereavement. The principles underpinning this are patient, carer, and family centered care; needs based care; access to local and networked services; evidence based, safe and effective care; integrated and coordinated care; equitable care; and a skilled and supportive workforce.

Objectives

- Provision of clinical services that align with the NSLHD strategic vision for supportive and palliative care which are responsive to those with complex needs, by:
  - Utilising best practice in clinical assessment, care and service delivery
  - Delivering care in an environment and cultural context of the person's choice wherever possible
  - Providing some specialist services which are available 24 hours 7 days a week.
- Collaboration in the development of a primary nurse model supported by nurse specialists, allied health, pastoral care and community registrars and when necessary, senior medical support using telemedicine and clinic visits or home visits if clinically indicated.
- Community services delivered in the patient's place of residence, where appropriate, in partnership with the person's general practitioner and other primary health care providers.
- Promoting and supporting the provision of collaborative and integrated models of care with generalist providers by:
  - Implementing mechanisms for integrating and coordinating care, for generalist clinical and support services, including referral criteria and out of hours cover.
  - Coordinating the development of integrated models/frameworks of palliative care provision, which recognise the roles of specialist and generalist clinical and support services.
  - Providing education programs, advice and support for generalist clinical and support services, in order to help build their capacity and capability to respond to palliative care need.

- Commitment to quality improvement principles in clinical and management practice by:
  - Participation in professional development, audit, credentialing/benchmarking and research/evaluation.
  - Engagement with the Palliative Care Outcome Collaboration (PCOC) to submit local data from inpatient, outpatient and community services.
  - Promoting excellence in palliative care clinical practice, through the collaborative development and dissemination of agreed and auditable evidence-based clinical guidelines.
  - Contributing to supporting the development and maintenance of an appropriately skilled and resourced specialist palliative care workforce.

Service Specifications

4.1.3.1 Inpatient Palliative care (Neringah & Greenwich – 15 beds each)

Scope

- Greenwich Hospital (15 beds) and Neringah Hospital (15 beds) are the palliative care inpatient units that support the lower north shore and Hornsby Ku-Ring-Gai areas respectively.
- Provide short-term holistic care for patients and their families/carers, living with life-limiting illnesses at various times in their illness trajectories within an inpatient palliative care unit setting.
- Provide comprehensive medical, nursing, allied health and pastoral care based on the unique needs of the patients, carer and family when facing a life-limiting prognosis including:
  - Symptom management
  - Emotional and psychosocial support
- High quality care for patients and their families/carers at end of life.
- Planning for discharge from hospital to home or RACF.

Key Functions

Referral and access management

- Admission criteria includes:
  - Patients with active, progressive, life limiting illness and complex physical, psychosocial, or spiritual needs*.
  - Patients who are approaching or have clearly entered the terminal phase of their illness.
- Refer to HammondCare Health Inpatient Admission Criteria Greenwich and Neringah Palliative Care Units document.

Service Delivery

- Medical staff on site business hours during weekdays. Weekends' medical staff are on duty and on-site part of business hours. Staff specialists and registrars are on call 24 hours. The medical on call includes weekend reviews, admissions of in-patients, phone support and afterhours call out.
- Specialised nursing care 24 hours per day.
- Allied health is available 5 days per week between 0830 and 1700. Allied health services provided include:
  - pharmacy,
  - physiotherapy,

- occupational therapy,
- psychology,
- speech pathology,
- dietetics,
- social work,
- Pastoral care and massage therapy are also available.

4.3.1.2 Specialist Palliative Care Community Services (RACF in-reach, palliative care clinics and home based)

Scope

- HammondCare community services will continue to work in conjunction with NSLHD providers to ensure community-based services are available in accordance with the needs of the NSLHD population, with an increasing focus on care in place of choice.
- Includes palliative care outpatient clinics, RACFs and community (at-home) services for the NSLHD region.
- Services are based out of Greenwich Hospital, Neringah Hospital, and the Northern Beaches Community Palliative Care Service at the Mona Vale Hospital site.
- Nurse-led model with qualified Nurse Practitioners, Clinical Nurse Consultants, Clinical Nurse Specialists and Registered nurses, Multidisciplinary Team consisting of Social Work, Physiotherapy, Occupational therapy, Pastoral care, volunteers and bereavement counsellors. Specialist medical advice for complex patients available where clinically appropriate by phone / telehealth or clinic / home visit if clinically indicated by Registrars and Staff Specialists
- Additional service components include:
  - Training and support for GP's and community nursing staff.
  - Multidisciplinary case conferences.
  - 24-hour contact number.
  - Equipment provision excluding hospital beds (loan).
  - Bereavement services.

Key Functions

Referral and access management

- The criterion for admission includes:
  - The patient has a progressive, life limiting illness.
  - The patient has complex symptom management issues that cannot be addressed by current caring team.
  - The patient and/or family/carer require psychosocial and spiritual support.
  - The patient or their decision maker is aware of and agrees to palliative care referral.
  - The primary goals for CPC services are to control symptoms, maximise function, offer psychosocial support and maintain quality of life and provide advice and support for patients wishing to die at home.
- The process for referral is:
  - Referrals can be made by general practitioners (GPs) and Specialist Medical officers. A medical referral is not a mandatory requirement for access.

- Specialist Palliative & Supportive Care Service Referral Form North - CR 11.1 is completed by referring clinician and faxed or emailed to service.
- Provide further medical information via fax, which includes:
  - Letter of referral if specific needs or requests not identified in online referral.
  - Copies of relevant specialist letters (e.g., Oncologist letters).
  - Hospital Discharge Summary.
  - GP Health summary.
  - Copy of relevant scans and pathology results.
  - Relevant medication list/orders.
- Referral is followed up with phone call from the referring clinician to the Palliative care team if referral is urgent.
- A phone call may be required to the referrer and/or patient to determine the appropriate time frame that a visit is required. The priority criterion includes aspects of symptom management, family supports in place and emotional or spiritual care needs.
- The referrer will be contacted if all the required medical information has not been supplied and advised that admission to the service will be delayed until all relevant information has been provided.
- Contact with patient and/or family/carer is attempted 3 times before the referrer being notified of inability to contact and referral reviewed.

Service Delivery

Community Services

- Provide multidisciplinary palliative care in the most appropriate setting for the client. Settings include:
  - Private home
  - Residential Aged Care
  - Outpatient Clinics
  - Telehealth
- Proactive model of community palliative care which enables care to be provided by the right person, in the right place, at the right time and avoids preventable hospital admissions.
- Ongoing case management through regular contact and assessment, care planning and review, in addition to collaboration with services delivering care across the district.
- Use of PCOC phasing and assessment to prioritise and respond to patient and family needs in a timely manner.
- Ensure care is patient and family centred, and holistically addresses care needs, including symptom management (physical, psychosocial, and spiritual), advanced care-planning and high-quality end of life care, in location of choice.
- Provide an appropriately qualified multi-disciplinary workforce, including:
  - Medical
  - Specialist Nursing
  - Allied Health
    - Social Work
    - Physiotherapy
    - Occupational Therapy
  - Bereavement
- After Hours phone service operated by a Specialist Palliative Care Nurse who provides support, advice, coordination of external services and escalation to/from on call medical specialist where appropriate.
- Delivery of relationship-based care supported by:
  - HammondCare volunteers, which may include legacy making through 'Life Stories Program' and social support to address isolation.
- Pastoral Care Coordinators, providing carers and family members with emotional and spiritual support.

- In-person/ Telehealth/ Phone response Monday to Friday for new referrals and consultations with 24/7hour phone support.
- After hours phone services
- The multidisciplinary team to consider discharge if:
  - The patient has been in stable phase for a period of at least 6 months (as per Palliative Care Outcomes Collaboration phase definition).
  - Deterioration soon due to progressive disease is unlikely.
  - The patient is being regularly reviewed by a general practitioner with involvement from a medical specialist where appropriate.
  - Patient care needs are being met by family/carers, care packages and/or private services.
  - Patient needs may be better met by other services i.e., aged care services.
  - The patient and family/carers, once informed of the role of HammondCare Specialist Community Palliative Care Services, decline the service.
  - The patient requests to be discharged from the service.
  - The patient moves out of the Northern Sydney Local Health District. Referral to local services will be recommended as required.
  - The patient repeatedly declines offers of assessment, whether assessment is offered face to face or over the phone.
  - The patient would be automatically discharged if:
    - The patient is deceased during the episode of care provided by the Specialist Community Palliative Care Service.

RACF In-Reach

- Provides in-reach to Residential Aged-Care Facilities (RACF) with referrals being received from General practitioners (GPs) and directly from RACFs.
- Provision of patient and family centred care which includes initial assessment, care planning and review. Advice to GPs on medication prescription.
- Escalation and access to staff specialist for complex needs
- Family and carer support, education, and referrals to external services.
- Provision of education and advice to RACF staff
- Discharge when clinically stable, as determined by PCOC phase.
- Collaborative case management with the Palliative Aged Care Collaboration Service (PACCS), to ensure care to be provided by the right person, in the right place, at the right time and avoids preventable hospital admissions.

4.3.1.3 Acute Hospital Consultation (RNS, Ryde)

Scope

- Acute consultation services will be provided by HammondCare to NSLHD under a 'secondment model' whereby HammondCare staff will be employed as non-contingent workers by the LHD allowing these staff to be managed onsite by the appropriate clinical manager within the hospital.
- Acute consultation service to inpatient acute facilities within NSLHD to assess palliative care needs, provide appropriate recommendations and determine appropriate referrals for transfer to a designated inpatient palliative care facility or community service.
- Staffing consists of 1.2 FTE Staff Specialist to cover RNSH & Ryde Hospitals, 1.0FTE Registrar covers RNSH, 1 FTE CNC covers Ryde Hospital and 0.1 FTE Staff Specialist to cover Mona Vale Palliative Care Unit.

- The staff specialist time is expected to be distributed evenly across the working week to ensure good clinical cover. The staff specialist is expected to participate fully in the clinical service providing timely and responsive care and support to the whole team including junior medical officers, nursing, and allied team members.
- The advanced training registrar will work according to agreed position description and in discussion with the Head of Department RNSH Palliative Care services. Further, the director (or proxy) will provide supervision to ensure training needs are met.

Note: NBH acute consults is managed through a separate arrangement between NBH and HammondCare.

Key Functions

Access & Referral

- All referrals for inpatient acute consult are to be made via an e-order in eMR.
- The CNC is responsible for monitoring the census task list to confirm appropriateness of referrals and the whole team will prioritise.
- All referrals are initially seen by the CNC and registrar.

Service Delivery

- Timely and responsive service to inpatients at acute facilities to support appropriate palliative care in the most appropriate environment for the patient and their families.
- Thorough assessment of the patient's and family/carer's needs.
- Psychosocial, emotional, physical support and care planning for patients and families and carers using a holistic person and family/carer centred approach.
- Provision of Palliative care education to medical, nursing and allied health staff at Ryde.
- Support discharge planning as appropriate to the needs of the patient.
- Interim leave cover arrangements for the CNC includes:
    - Under 2 weeks – NSLHD CNCs will provide telephone consult and adhoc face to face as required.
    - Over 2 weeks - HammondCare CNCs will provide like for like cover.

4.3.1.4 On-call Roster (all palliative care units – Greenwich, Neringah, Mona Vale and)

Scope

- The staff specialists will jointly provide afterhours support to acute facilities in the LHD including RNSH, Ryde Hospital, Hornsby Ku-ring-gai Hospital palliative care inpatient units including Greenwich, Neringah and Mona Vale Hospitals. The staff specialists will also provide support to community patients both in their own homes or RACF who are known to palliative care services. This will include weekend ward rounds as required by need.
- The on-call roster is divided into three teams and the roster covers after hours Monday to Friday and all weekend.

- Team A – covers Greenwich Palliative Care Inpatient Unit, Neringah Palliative Care Inpatient Unit, Ryde, Hornsby and RNS hospitals.
- Team B – covers Mona Vale Palliative Care Inpatient Unit, Community patients including RACF. Note: this includes NBH and Southern NSW as per separate accreditation and contracts with HammondCare.
- Team C – covers the AYAH only and is not covered by HammondCare Staff Specialists.

Key Functions

Referral and access management

- Any new admissions will be reviewed within 24 hours.

Service Delivery

- The palliative care advanced training registrars will provide 24/7 out of hours' medical support to Greenwich and Neringah hospitals in conjunction with the on-call staff specialist. This will include weekend ward rounds. Regardless of whether the registrars are employed by HammondCare or NSLHD, they all participate in an on-call roster.
- The exception is the registrar employed by the MVPCU who participate in the MVPCU/AYAH roster and this registrar along with residents employed by MVPCU and the AYAH do ward rounds on the weekend but do not take calls after hours.
- The other registrars take calls but only from Greenwich and Neringah Hospitals PCUs. They are expected to round both Saturday and Sunday.

4.3.1.5 Bereavement Services

Scope

- Bereavement services will be provided in line with 'NSLHD Bereavement Services Model of Care' (which to be finalised). Until then, Bereavement services will be provided to families and carers of patients known to palliatiev care services.
- Bereavement services in NSLHD will include strategies to:
  - Ensure bereavement services are available to the family members and carers across all settings. This includes access to specialised bereavement counsellors, chaplains, volunteers, and memorial service.
  - Ensure bereavement services are provided by the appropriately qualified person depending on the level/ type of service required. Bereavement services will be provided by an appropriately qualified counsellor, a registered social worker with specific training in bereavement support, a spiritual support person with specific training in grief and loss support, or a trained and supervised volunteer.
  - Ensure that all bereavement support volunteers undertake appropriate training and supervision.
  - Ensure patients are provided the option of face to face or telehealth appointments.

Key Functions

Referral and access management

- Counselling, walking groups and online grief counselling groups: anyone who has experienced the death of a family member, carer or friend and was linked to a palliative care service in Northern Sydney.

- Grief and Loss online information sessions: anyone who has experience the death of a family member, carer or friend in Northern Sydney
- It is a self-referral model via the HammondCare Bereavement Services Website or phone 1800 427 255 or email bereavement@hammond.com.au.

Service Delivery

- Bereavement services will be provided to families and carers of patients known to palliatiev care services
- Public Health model of Bereavement care recommends bereavement services should provide a universal level of care for all bereaved people, focused on normalisation of the grieving process. For those identified as having more complex needs, additional support opportunities would be provided. These would include the grief info sessions, volunteer support and support groups as well as individual counselling where indicated. Part of the public health approach and as reflected in palliative care standards, is that all bereaved families have equitable and timely access to bereavement care. Until capacity across NSLHD is reviewed, HammondCare is expected to provide bereavement services to any family or carer of a patient who was known to the palliative care services.
- Service delivery modes include:
  - Specialist counselling in person, online or on the phone (one on one, couples and family counselling)
  - Grief and Loss online information sessions
  - Grief Information Presentations in Languages other than English
  - Online Grief Counselling Groups
  - Bereavement Walking Groups
- Staffing consists of:
  - 1FTE Bereavement Counsellor
  - 0.6FTE Bereavement Counsellor
  - 0.6FTE Bereavement Coordinator/Clinical Psychologist.

Access to Equipment

- Specialist palliative care providers will have explicit and agreed processes for obtaining equipment in a timely manner in order to enable a person if possible, to stay in their own home.
- These explicit and agreed processes will ensure that those with specialist palliative care needs will have access to or knowledge of how to access the following equipment: home oxygen, beds, stomal supplies, continence, IV, enteral and parenteral supplies, lymphedema bandages and hosiery, general aids and equipment and dressings either through HammondCare or Northern Sydney Home Nursing Services.
- HammondCare will participate in District-wide initiatives to improve equity and access to equipment to support patients in the home e.g., the sharing of equipment pools across the NSLHD health services.

Information Management

- HammondCare will participate in District wide initiatives to improve information management to enable the collection of a uniform set of data across SPCS to support service evaluation, planning

and benchmarking via the eMR End of Life Platform. This will include a mechanism to ensure the standardisation of data that is entered into systems.

- Non-Admitted Patient Occasions of Service
- PCOC data collection
- any National Data Collection initiatives.
- Telehealth to be provided using the NSW Health endorsed platform of myVirtualCare.

HammondCare Workforce

- The skill set within the SPCS will include at a minimum expertise in the following areas, with access to other services as required:
  - End of life decision making/ advanced care planning
  - Pain and symptom control
  - Complex discharge planning
  - Community referral and provision of information
  - Counselling for existential and psychological distress
  - Bereavement support
  - Functional and mobility assessments and intervention
  - Home modification/ equipment prescription.
- The SPCS will provide access to volunteers, art and diversional therapy where possible.

4.1.4 Pain Service Specifications

Policy Context

- Service specifics are outlined in a separate Service Agreement and Service Plan developed between all parties (NSLHD/22/1178).

Service Specifications

Scope

Greenwich Hospital Pain Management Service will:

- Build Capacity and enhance the skills of Far West LHD and primary care clinicians.
- Deliver specialist outreach pain management services to patients meeting specific criteria within Far West LHD through a telehealth model.

Purpose

The HammondCare pain service agreement outlines provision of outreach pain management education and services to Far West NSW Local Health District. This partnership includes HammondCare, Far West NSW Local Health District, Northern Sydney Local Health District, Western NSW Primary Health network and Maari Ma Health Aboriginal Corporation.

The funding provided will be used for salaries, travel and expenses relating to the delivery of pain management training, education and capacity building conducted by Greenwich Hospital Pain Management Service for Far West Local Health District staff and Maari Ma Aboriginal Corporation primary care providers.

Northern Sydney Local Health District agrees to:

- Oversee the execution of the Service Plan by Greenwich Hospital Pain Management Service.
- Arrange transfer of all funding received by NSW Health under this agreement to HammondCare Health & Hospitals for the use of the Greenwich Hospital Pain Management Service to enable them to meet the terms of the agreement.
- Meet with the Project Lead at Greenwich Hospital Pain Management Service as needed to help ensure satisfactory delivery of the service.

Greenwich Hospital Pain Management Service HammondCare agrees to be responsible for the appointment of staff to carry out the clinical and corporate functions of the outreach services, including the following:

- To lead the processes for development and review of the SLA and Service Plan in close collaboration with the partnerships identified in the SLA.
- To provide training, education and multidisciplinary support for the PHN and primary care clinicians as agreed in the Service Plan.
- To provide clinical services by telehealth as agreed in the Service Plan.

- To provide the administrative support for processing referrals, organizing telehealth consultations and training and education activities as agreed in the Service Plan.
- To ensure that all stakeholders have access to the required IT capabilities within the clinic space to facilitate telehealth support.
- To ensure that all participating general practitioners have appropriate professional indemnity insurance and that all participating primary health care organisations have appropriate public liability insurance.

Service Delivery

The Service Provider will:

- Develop a Service Plan in partnership with Far West LHD and Maari Ma Aboriginal Corporation with identification of partnerships, local needs and priorities.
- Develop a Service Level Agreement in partnership with Far West LHD, Maari Ma Aboriginal Corporation and primary care to clarify:
  - A detailed budget for the funds allocated.
    - Following discussions between HammondCare Health and NSLHD in February 2022 the budget will be increased for HammondCare Health to $196,300 commencing FY22/23, under a 5-year contract. The additional $96,300 will be added by NSLHD to the already established election commitment of $100,000 per annum, recurrent funding plus CPI.
    - The outreach support will include telehealth, multi-disciplinary support, and outreach site visits to provide clinical service delivery for clients and training and education for LHD and primary care clinicians to build local capacity.
    - This SLA covers the period from 1 July 2022 until 30 June 2027. A new agreement may be entered into in 2027. The parties may agree, in writing, to extend the term of the SLA beyond that date and/or to vary the terms of the SLA at that time. However, the initial election commitment to recurrent funding remains a part of an ongoing SLA.
  - Governance arrangements for the service.
  - The services provided to Far West LHD, Maari Ma Aboriginal Corporation and primary care by Greenwich Hospital Pain Management Service.
  - Public Liability arrangements.
  - Credentialing arrangements.
- Appoint appropriate staff.
- Support the implementation of VideoCall at the Greenwich Hospital Pain Management Services in collaboration with the ACI Telehealth Manager.
- Provide a monthly telehealth clinic to Far West LHD and/or primary care services with access to the following minimum staffing: physiotherapist, medical specialist in pain management, psychologist and registered nurse.
- Allocate financial support for travel expenses to facilitate three outreach visits by multi-disciplinary team per annum according to local need by December each year.
- Provide expert clinical telephone or telehealth support to meet local needs.
- Participate in the electronic persistent pain outcome collaboration (ePPOC) or equivalent outcome reporting.
- Participate in the evaluation of the pain management model of care led by the ACI.
- Establish and maintain links with the ACI Pain Management Network.
- Provide annual reports to the ACI.

The Agency for Clinical Innovation will monitor the service establishment and ongoing deliverables with support from NSLHD.

5. Performance against strategies and objectives

5.1 Key performance indicators

The performance of the Organisation is assessed in terms of whether it is meeting key performance indicator targets for NSW Health strategic priorities.

Detailed specifications for the key performance indicators are provided in the Service Agreement Data Supplement. See:
http://internal4.health.nsw.gov.au/hird/view_data_resource_description.cfm?ItemID=47648

Outcome Indicators: These key performance indicators are reported to NSW Treasury under the *NSW Health Outcome and Business Plan*.

5.2 Performance deliverables

Key deliverables will also be monitored, noting that process indicators and milestones are held in the detailed operational plans developed by the Organisation.

If a performance issue/s is identified, Northern Sydney Local Health District will request the AHO to undertake an in-depth assessment of the problem, identify options to address the problem and provide a plan and timetable for resolution. The issue/s will also be referred to the Operations Meeting for notation and relevant action. The AHO may need to provide additional reporting to the District.

Service	Service Type	KPI Type	Measure	Target
Rehabilitation – Outpatient and Home Based	Referral and access management	Efficiency and Effectiveness	90% in identified Patient LGA of residence.	90%
			80% of referrals from Public hospitals.	80%
			7 days Waiting time from date of discharge to program commencement date.	100%
		Clinician Experience of Providing Care	Waiting times provided regularly to NSLHD Clinical Network Admin officer to maintain currency on intranet.	N/A
			Feedback to NSLHD clinicians on patients referred post discharge from hospital to ensure optimal timing of care.	N/A
	Service Delivery	Efficiency and Effectiveness	Patient OOS & Service Events, Patient OOS: Service Events Total OOS	N/A
			MOH Service Agreement KPI with all LHDs - Increase of 5 percentage points year-on-year from the activity baseline until 30% of non-admitted patient service events are performed virtually.	TBC
			Average duration of the program (days) - Up to 42 days total (impairment groups other than stroke or other neurological) - Up to 84 days (stroke or other neurological impairments)	N/A
			5% of total OOS are MDT case conference as modality of care	5%
		Patient Health Outcomes	ACI Rehab KPI - Assessment of Quality of Life – 6 Dimensions (AQoL-6D)	TBC
		Clinician Experience of Providing Care	HC Staff satisfaction "Voice" survey – annually (highlights)	TBC
		Patient Experience of Care	The ACI Outpatient PREM	TBC

Service	Service Type	KPI Type	Measure	Target
OPMHS – Inpatient Unit & ECT	Referral and access management	Efficiency and Effectiveness	90% occupancy rate (noting D=20 beds)	90%
			Time from acceptance to bed	2 weeks
		Clinician Experience of Providing Care	Waiting times - Waiting list report	N/A
	Service Delivery	Efficiency and Effectiveness	Average bed occupancy - Total number of bed days / Total number of discharges	42 days
			Number of ECT performed	230 +/- 5%
			Consumers residing outside of NSLHD receive a phone call within 7 days of discharge must be completed and documented in eMR.	100%
		Patient Health Outcomes	Health of the Nation Outcome Scale (HONOS) – benchmarking of acuity as rated by HONOS. Annual benchmark by Inform. Number of completed or ongoing episodes of mental health care with completed outcome measures, partitioned by setting, where significant improvement/significant deterioration/no significant change was identified between baseline and follow-up within the reference period/ Number of completed or ongoing episodes of mental health care with completed outcome measures, partitioned by setting within the reference period.	
			≥80% Standard measures complete on admission, review, and discharge as per NSW Health MH-OAT data collection reporting requirements.	
			HAC – HAI (Rate of hospital acquired respiratory complications per 10,000 episodes of care), Falls (A fall occurring in health service area resulting in intracranial injury, fractured neck of femur or other fracture as a rate per 10,000 episodes of care), PI (The rate of completed inpatient episodes with stage 3 or 4, or unspecified, or unstageable, or deep tissue hospital acquired pressure injuries per 10,000 episodes of care), unplanned transfers, medication complications (The rate of completed inpatient episodes within the reporting period where a medication complication has occurred in a public hospital per 10,000 episodes of care).	

			Harm score 1 and 2 – total count	
		Clinician Experience of Providing Care	Clinical Reviews are completed and documented in the patient medical record at day 35 in line with MHOAT protocol. indicating no significant change in baseline. At 70 days, this is repeated and escalated to a MDT review.	90%
			HC Staff satisfaction "Voice" survey – annually (highlights)	TBC
		Patient Experience of Care	YES Survey	75% report very good or excellent
			CES Survey	75% report very good or excellent

Service	Service Type	KPI Type	Measure	Target
Palliative Care – Inpatient Units	Referral and access management	Efficiency and Effectiveness	90% occupancy rate	90%
		Patient Health Outcomes	90% of patients have their episode commence on the day of, or the day after ready for care (note this measuring receiving care within a specialised sub-acute palliative care unit)	N/A
			Responsiveness to urgent needs - 90% of unstable phases last for three days or less	90%
	Service Delivery	Efficiency and Effectiveness	Average LOS (Bed days per patient)	14 days
			Inpatient Unit occupancy rate (bed days per patient)	95%
		Patient Health Outcomes	90 % of patients with absent or mild pain (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild pain at the end of the phase.	90%
			60% of patients with moderate or severe pain (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild pain at the end of the phase.	60%
			90% of patients with absent or mild distress from pain (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from pain at the end of the phase.	90%
			60 % of patients with moderate or severe distress from pain (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from pain at the end of the phase.	60%
			90% of patients with absent or mild distress from fatigue (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from fatigue at the end of the phase.	90%
			60% of patients with moderate or severe distress from fatigue (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from fatigue at the end of the phase.	60%
			90% of patients with absent or mild distress from breathing problems (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from breathing problems at the end of the phase.	90%
			60% of patients with moderate or severe distress from breathing problems (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from breathing problems at the end of the phase.	60%
			90% of patients with absent or mild family/Carer problems (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild family/carer problems at the end of the phase.	90%
			60% of patients with moderate or severe family/Carer problems (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild family/carer problems at the end of the phase.	60%

			HAC – HAI (Rate of hospital acquired respiratory complications per 10,000 episodes of care), Falls (A fall occurring in health service area resulting in intracranial injury, fractured neck of femur or other fracture as a rate per 10,000 episodes of care), PI (The rate of completed inpatient episodes with stage 3 or 4, or unspecified, or unstageable, or deep tissue hospital acquired pressure injuries per 10,000 episodes of care), unplanned transfers, medication complications (The rate of completed inpatient episodes within the reporting period where a medication complication has occurred in a public hospital per 10,000 episodes of care).	
			Harm score 1 and 2 – total count	N/A
		Patient Experience of Care	Inpatient experience tool – paused as being revised	TBC

Service	Service Type	KPI Type	Measure	Target
Palliative Care – Community & RACF	Referral and access management	Efficiency and Effectiveness	95% of community patients are contacted by phone within two working days of receipt of the referral	95%
		Patient Health Outcomes	90% of patients have their episode commence on the day of, or the day after ready for care (PCOC)	90%
			Responsiveness to urgent needs - 90% of unstable phases last for three days or less	90%
	Service Delivery	Efficiency and Effectiveness	95% of patients receive one case conferences	95%
			MOH KPI - Increase of 5 percentage points year-on-year from the activity baseline until 30% of non-admitted patient service events are performed virtually.	TBC
			Patient OOS & Service Events (community vs RACF) Patient OOS: Service Events (community vs RACF) Total OOS (community vs RACF)	N/A
		Patient Health Outcomes	90% of patients with absent or mild pain (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild pain at the end of the phase.	90%
			60% of patients with moderate or severe pain (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild pain at the end of the phase.	60%
			90% of patients with absent or mild distress from pain (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from pain at the end of the phase.	90%
			60% of patients with moderate or severe distress from pain (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from pain at the end of the phase.	60%
			90% of patients with absent or mild distress from fatigue (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from fatigue at the end of the phase.	90%
			60% of patients with moderate or severe distress from fatigue (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from fatigue at the end of the phase.	60%
			90% of patients with absent or mild distress from breathing problems (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from breathing problems at the end of the phase.	90%
			60% of patients with moderate or severe distress from breathing problems (as measured by the SAS tool) at the beginning of their phase of palliative care have absent or mild distress from breathing problems at the end of the phase.	60%
			90% of patients with absent or mild family/Carer problems (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild family/carer problems at the end of the phase.	90%

			60% of patients with moderate or severe family/Carer problems (as measured by the PCPSS tool) at the beginning of their phase of palliative care have absent or mild family/carer problems at the end of the phase.	60%
		Patient Experience of Care	Inpatient experience tool – pause- 2 months - as being revised	TBC

Service	Service Type	KPI Type	Measure	Target
Palliative Care – Acute, On-call & Bereavement	Referral and access management	Efficiency and Effectiveness	Bereavement - Current waiting time for counselling	TBC
			Bereavement - Number of people on waitlist	N/A
			Bereavement - Number of new referrals	N/A
			On-Call - patients are reviewed within 24 hours	100%
			Acute Consult - TAT – Patients referred to Palliative care for an acute consult are seen within 24 hours referral	80%
	Service Delivery	Efficiency and Effectiveness	Total Occasions of Service (OOS) – modality of care (education, support groups and individual)	N/A
			# Non-registered groups	N/A
			# counselling sessions - 4 x one hour counselling sessions per day per counsellor x 48 weeks	1344

6. Appendices

6.1 Supra LHD services

Under the *NSW Framework for New Health Technologies and Specialised Services* (GL2018_023), Supra LHD services are provided across District and Network boundaries to provide equitable access for everyone in NSW.

The following information is included in all Service Agreements to provide an overview of recognised Supra LHD services and Nationally Funded Centres in NSW.

Supra LHD Services	Measurement Unit	Locations	Service requirement
State Spinal Cord Injury Service (adult and paediatric)	Access	Prince of Wales Royal North Shore Royal Rehabilitation Centre, Sydney SCHN – Westmead and Randwick	Services to be provided in accordance with *Critical Care Tertiary Referral Networks & Transfer of Care (Adults)* and *Critical Care Tertiary Referral Networks (Paediatrics)* policies. Participation in the annual reporting process.

6.2 Strategic Priorities

The delivery of NSW Health strategies and priorities is the responsibility of the Ministry of Health, health services and support organisations. These are to be reflected in the strategic, operational, and business plans of these entities.

It is recognised that the Organisation will identify and implement local priorities to meet the needs of their respective populations taking into consideration the needs of their diverse communities. In doing so they will:

work together with clinical staff about key decisions, such as resource allocation and service planning

engage in appropriate consultation with patients, carers and communities in the design and delivery of health services.

6.3 Future Health: Strategic Framework

The Future Health Strategic Framework is the roadmap for the health system to achieve NSW Health's vision. It will guide the next decade of care in NSW 2022-32, while adapting to and addressing the demands and challenges facing our system. The framework is also a reflection of the aspirations of the community, our patients, workforce, and partners in care for how they envisage our health system by 2031.

Strategic outcomes		Key objectives
	**Patients and carers have positive experiences and outcomes that matter:** People have more control over their own health, enabling them to make decisions about their care that will achieve the outcomes that matter most to them.	1.1 Partner with patients and communities to make decisions about their own care 1.2 Bring kindness and compassion into the delivery of personalised and culturally safe care 1.3 Drive greater health literacy and access to information 1.4 Partner with consumers in co-design and implementation of models of care
	**Safe care is delivered across all settings:** Safe, high quality reliable care is delivered by us and our partners in a sustainable and personalised way,	2.1 Deliver safe, high quality reliable care for patients in hospital and other settings 2.2 Deliver more services in the home, community, and virtual settings 2.3 Connect with partners to deliver integrated care services 2.4 Strengthen equitable outcomes and access for rural, regional and priority populations 2.5 Align infrastructure and service planning around the future care needs

	within our hospitals, in communities, at home and virtually.	
	**People are healthy and well:** Investment is made in keeping people healthy to prevent ill health and tackle health inequality in our communities.	3.1 Prevent, prepare for, respond to, and recover from pandemic and other threats to population health 3.2 Get the best start in life from conception through to age five 3.3 Make progress towards zero suicides recognising the devastating impact on society 3.4 Support healthy ageing ensuring people can live more years in full health and independently at home 3.5 Close the gap by prioritising care and programs for Aboriginal people 3.6 Support mental health and wellbeing for our whole community 3.7 Partner to address the social determinants of ill health in our communities
	**Our staff are engaged and well supported:** Staff are supported to deliver safe, reliable person-centred care driving the best outcomes and experiences.	4.1 Build positive work environments that bring out the best in everyone 4.2 Strengthen diversity in our workforce and decision-making 4.3 Empower staff to work to their full potential around the future care needs 4.4 Equip our people with the skills and capabilities to be an agile, responsive workforce 4.5 Attract and retain skilled people who put patients first 4.6 Unlock the ingenuity of our staff to build work practices for the future
	**Research and innovation, and digital advances inform service delivery:** Clinical service delivery continues to transform through health and medical research, digital technologies, and data analytics.	5.1 Advance and translate research and innovation with institutions, industry partners and patients 5.2 Ensure health data and information is high quality, integrated, accessible and utilised 5.3 Enable targeted evidence-based healthcare through precision medicine 5.4 Accelerate digital investments in systems, infrastructure, security, and intelligence
	**The health system is managed sustainably:** The health system is managed with an outcomes-focused lens to deliver a financially and environmentally sustainable future.	6.1 Drive value based healthcare that prioritises outcomes and collaboration 6.2 Commit to an environmentally sustainable footprint for future healthcare 6.3 Adapt performance measurement and funding models to targeted outcomes 6.4 Align our governance and leaders to support the system and deliver the outcomes of Future Health

6.4 NSW Premier's Priorities

In June 2019, the NSW Premier set new social priorities to tackle tough community challenges, lift the quality of life for everyone in NSW and put people at the heart of everything the Government does.

NSW Health is leading three priorities for improving the health system:

Improving outpatient and community care

Reduce preventable hospital visits by 5% through to 2023 by caring for people in the community.

Improving service levels in hospitals

100% of all triage category 1, 95% of triage category 2, and 85% of triage category 3 patients commencing treatment on time by 2023

Towards zero suicides

Reduce the rate of suicide deaths in NSW by 20% by 2023.

NSW Health staff will continue to work together to deliver a sustainable health system that delivers outcomes that matter to patients and the community, is personalised, invests in wellness, and is digitally enabled.

6.5 NSW Health Outcome and Business Plan

The NSW Health Outcome and Business Plan is an agreement between the Minister for Health, the Secretary, NSW Health, and the NSW Government setting out the outcomes and objectives that will be the focus for the current period.

NSW Health has identified five state outcomes that it will achieve for the people of NSW:

1. Keeping people healthy through prevention and health promotion
2. People can access care in out of hospital settings to manage their health and wellbeing
3. People receive timely emergency care
4. People receive high-quality, safe care in our hospitals

5. Our people and systems are continuously improving to deliver the best health outcomes and experiences

To achieve these outcomes, NSW Health has set a series of ambitious targets and has a comprehensive program of change initiatives in place. These targets have been built into key performance indicators in the Service Agreement, the *NSW Health Performance Framework*, the *NSW Health Purchasing Framework,* and the funding model.