NORTHERN SYDNEY CENTRAL COAST NSW HEALTH

File No: NSCC/09/9660

Performance Agreement

Between

Northern Sydney Central Coast Area Health Service

And

Royal Rehabilitation Centre Sydney

Royal Rehabilitation Centre Sydney, as the service provider, agrees to provide the Services and to all obligations as outlined in this Agreement. Northern Sydney Central Coast Area Health Service (NSCCAHS) as the purchaser of services agrees to all obligations as outlined in this Agreement.

Signed for and on behalf of
Northern Sydney Central Coast Area Health Service

Authorised Signatory

Name: .....

Position: .....

Date: 19.10.10

End Date: 30 June 2012

Witness

Name: Janine Bell

Date: 19.10.10

Signed for and on behalf of
Royal Rehabilitation Centre Sydney

Authorised Signatory

Name: STEPHEN LOUNDES

Position: CEO, RAYAL REHABILITATION CENTRE SYDNEY.

Start Date: 1/6/2009

End Date : 30 June 2012

Signed 17/11/11

Witness

Name: Lynette Mason

Date: 17/11/11

PART 1 - HEAD AGREEMENT – SERVICE SCHEDULE SUMMARY TABLE

This section lists all documents included in the Performance Agreement between Northern Sydney Central Coast Area Health Service and Royal Rehabilitation Centre Sydney, which comes into effect from the commencement date identified in Part 1 below.
The following summary table will be updated in an agreement variation, whenever there is a change to this list.

Part 1 – The Head Agreement

Document	Commencement Date	End Date
Head Agreement – Version 2	1 July 2009	25 September 2009
Head Agreement – Version 3	26 September 2009	30 June 2010
Head Agreement – Version 4	1 July 2010	30 June 2012

Part 2 – The Service Schedules

Service Schedule	Version Number	Commencement Date	End Date
Sub Acute Aged Care and Rehabilitation Service Schedule	2.0	1 July 2009	30 June 2010
	4.0	1 July 2010	30 June 2012
Brain Injury Rehabilitation Service Schedule	2.0	1 July 2009	30 June 2010
	3.0	1 July 2010	30 June 2012
Spinal Injury Rehabilitation Service Schedule	3.0	1 July 2009	30 June 2010
	3.0	1 July 2010	30 June 2012
Weemala Extended Care Service Schedule	2.0	1 July 2009	30 June 2010
	3.0	1 July 2010	30 June 2012

The End Date above refers to the date at which the content of the Service Schedules (specifically the Service Specifications) must be reviewed, if a review has not taken place prior to this date.

Please note that the service units/ volume and service price outlined in Section B of each Service Schedule will be renegotiated annually. Details of the Service units/volume and price will then form the Funding Agreement each year, which will be attached to the Head Agreement and located in Appendix 3.

PART 1 – HEAD AGREEMENT – FUNDING AGREEMENT

The table below contains details the level of funding/price to be paid for each Service as well as the funding period for each Service type/setting (where the funding period is over 12 months the level of funding will be renegotiated annually).

SERVICE UNIT	Start Date	End Date	VOLUME	UNIT PRICE	TOTAL SERVICE PRICE 2009-2010
Inpatient Aged Care Rehabilitation (Dixon unit) 18 beds	1 July 2009	30 June 2011	277 (cost weights)	$11,203	$3,103,231
Inpatient Working Aged Rehabilitation (CARS Unit) 14 beds	1 July 2009	30 June 2011	256	$11,203	$2,867,968
Non Inpatient Working Age Rehabilitation including hydrotherapy	1 July 2009	30 June 2011	To be determined (TBD)	Negotiated Price	$310,905
Community Home Based Rehabilitation	1 July 2009	30 June 2011	TBD	Negotiated Price	$650,825
Total General Rehabilitation (Aged and Working Age)					**$6,932,929**
Inpatient Brain Injury Rehabilitation	1 July 2009	30 June 2012	337 (cost weights)	$11,203	$3,775,411
			Adjustment	Negotiated top up funds	$896,046
Community Brain Injury Rehabilitation Community Team	1 July 2009	30 June 2012	TBD	GMTT determined	$652,427

Part 1 – Head Agreement

SERVICE UNIT	Start Date	End Date	VOLUME	UNIT PRICE	TOTAL SERVICE PRICE 2009-2010
(BIRCT). **GMCT funded**[1]					
Community BIRCT			TBD	Negotiated top up	$529,635
Total Brain Injury Rehabilitation					**$5,853,519**
Inpatient Spinal Injury Rehabilitation Community Team	1 July 2009	1 July 2012	432 (Cost weights)	$11,203	$4,839,696
				Negotiated top up funds	$777,975
				GMTT determined	$185,085
Community Spinal Outreach Service	1 July 2009	30 June 2012	TBD	GMTT determined	$844,453
Community Rural Spinal Cord Injury Service	1 July 2009	30 June 2012	TBD	GMTT determined	$687,593
Total Spinal Cord Injury Rehabilitation					**$7,334,802**
Extended Care Services (Weemala)	1 July 2009	30 June 2012 (dependent on Weemala population)[2]			2,750,000
Total Extended Care Services					**2,750,000**
				Escalation 2009/10	**2,169,743**
				Sub-total	**$25,040,993**
				Revenue	**$4,009,000**
				Escalation 2009/10 (Revenue)	**$1,545,742**
				Total price	**$19,486,251**

[1] The Greater Metropolitan Transition Taskforce (GMTT) component of funding in the table above refers to State-wide funding for Brain and Spinal Injury Services. 'GMTT determined' funding is the only identifiable State-wide funding for Services provided by RRCS. All other funding identified in the table above is sourced from NSCCAHS General Funds.
[2] See Service Schedule – Weemala Extended Care Services. Funding is provided for a specific client group only 'grand parent funding'. The funding period is therefore dependent upon client numbers.

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PART 1 HEAD AGREEMENT

SECTION 1 PREAMBLE

1.1 GENERAL

Royal Rehabilitation Centre Sydney (the Company) is listed in Schedule 3 of the Health Services Act 1997 (the Act) and is a Schedule 3 facility (Affiliate Health Organisation) in respect to all of its "recognised establishment and services".

An Affiliated Health Organisation is a non-government, not for profit religious or charitable organisation or institution whose establishments or services are recognised as public health services. These services include a range of acute and sub-acute health care and may be provided on a local (i.e. to populations within the boundaries of an Area Health Service) or State-wide basis.

The above hospitals are "recognised establishments" within the meaning of the Act and under section 7 of the Act the Company is a Public Health Organisation in respect of the Hospitals.

Under section 127 of the Act a public health organisation may be paid a subsidy from the Consolidated Fund in an amount and on such conditions as may be determined by the Minister.

Under section 129 of the Act the Minister may delegate to an Area Health Service the function of determining the subsidy to be received by an Affiliated Health Organisation for its recognised establishments and recognised services, and the conditions attaching to that subsidy.

Under section 130 of the Health Services Act 1997 an Area Health Service may enter into a Performance Agreement with an Affiliated Health Organisation in respect of its recognised establishments and recognised services.

Northern Sydney Central Coast Area Health Service (NSCCAHS) and Royal Rehabilitation Centre Sydney will enter into a Performance Agreement for a three year period. The Performance Agreement sets out the responsibilities and accountabilities of both parties in providing health services that meet Government priorities, community needs and NSW Health strategic directions.

NSCCAHS values the contribution of Royal Rehabilitation Centre Sydney to the service network and the achievement of good health outcomes within the Area. Royal Rehabilitation Centre Sydney acknowledges its obligations to implement the strategic and operational requirements of the Performance Agreement. NSCCAHS recognises Royal Rehabilitation Centre Sydney's role in providing State-wide services as part of Health's State wide service networks.

In good faith, both parties will work collaboratively and in partnership to ensure that all requirements of the Performance Agreement are met.

1.2 PURPOSE OF THE PERFORMANCE AGREEMENT

The Performance Agreement is part of an ongoing effort to improve the operations and outcomes of the health services provided within the context of the health care requirements of NSCCAHS and state-wide priorities for health in NSW.

Part 1 – Head Agreement

The purpose of this Performance Agreement is to set out the mutual understanding of the respective obligations and expectations of the parties; to define the scope and nature of the Services which will be funded through NSCCAHS; and to define the performance deliverables for which Royal Rehabilitation Centre Sydney is responsible.

The strategic priorities and performance measures stated in this agreement reflect the NSW Government's directions for the NSW Health System as outlined in the NSW State Plan, *A New Direction for NSW*; the *NSW State Health Plan: Towards 2010* and *Fit for the Future: Future Directions for Health in NSW: Towards 2025.*

They are also consistent with the Area Health Service's strategic objectives as outlined in:
- A New Direction for Northern Sydney Central Coast Health Service Strategic Plan – towards 2010.
- Northern Sydney Central Coast Area Health Clinical Services Strategic Plan.
- NSCCAHS Annual Performance Agreement with the Director-General, of NSW Health.

1.3 STRATEGIC OBJECTIVES AND PERFORMANCE CONTEXT

Vision and Goals of NSW Health

NSW Health and NSCCAHS will focus their efforts on delivering high quality health services that are responsive to the needs of health consumers and the community and will ensure that services can adapt to meet future challenges.

The vision, "Healthy People – Now and in the Future", reflects this focus and is supported by the four goals common to the NSW Health system.

Our goals:
- To keep people healthy
- To provide the health care that people need
- To deliver high quality services
- To manage health services well

The seven strategic directions for NSW Health underpin the vision.

Seven Strategic Directions:
1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health and continuing care in the community
4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of health services
6. Build a sustainable health workforce
7. Be ready for new risks and opportunities.

Australian Health Care Agreement (AHCA)
NSW Health is required to comply with the provisions of the AHCA, through which the Commonwealth and New South Wales jointly commit to improving the health of the Australian population. Royal Rehabilitation Centre Sydney contributes to achieving this goal.

1.4 RESPONSIBILITIES UNDER THE HEALTH SERVICES ACT

Under section 9 of the *Health Services Act 1997 (NSW)* the primary purpose of an Area Health Service is:

(a) To provide relief to sick and injured persons through the provision of care and treatment,
(b) To promote, protect and maintain the health of the community.

NSCCAHS undertakes strategic and service planning; provides health services and meets population health functions within a risk management framework; provides the infrastructure to support the delivery of health services and monitors performance in a continuous improvement cycle with relevant stakeholder involvement.

Under section 10 of the *Health Services Act 1997* the functions of an Area Health Service include, inter alia:

(k) to administer funding for recognised establishments and recognised services of affiliated health organisations where that function has been delegated to it by the Minister under section 129.

Royal Rehabilitation Centre Sydney is an affiliated health organisation under section 62 and Schedule Three of the *Health Services Act 1997*. Section 14 of the Act defines the functions and responsibilities of affiliated health organisations as inter alia:

(a) achieve and maintain an adequate standard in the conduct of its recognised establishments and the provision of its recognised services,
(b) to ensure the efficient and economic operation of those establishments and services,
(c) to carry out such other functions as are conferred or imposed on it by or under this or any other Act or as may be prescribed by the regulations.

SECTION 2 GENERAL TERMS AND CONDITIONS

2.1 AGREEMENT

The Performance Agreement consists of Part 1 (this document, to be referred to as the Head Agreement), together with Part 2 (the documents listed in the Agreement Summary on page 2).

The documents that form Part 2 are Service Schedules for the major clinical services provided by Royal Rehabilitation Centre Sydney that are funded through NSCCAHS.

The Service Schedules contain information relating to the level of funding that will be provided and specifications that describe the service, and set out quality and information reporting requirements additional to those specified in this document (Part 1).

Where Service Schedules are not finalised at the date of Commencement of this Agreement the aspects requiring finalisation will be noted in the Head Agreement and Service Schedule Summary Table and a work plan established to finalise the Schedules. .

If there is any conflict in the terms of Part 1 and Part 2, the terms of Part 2 will prevail.

Both parties expect that Part 1 – Head Agreement will not normally be amended and that any such amendment will usually be expressly provided for in Part 2.

The Agreement will commence on the Commencement Date and, subject to any rights or review (section 2.8), amendment, variation (section 2.9) or termination, will apply until the End Date. Funding for some services as defined in the Service Schedules which form part of the Head Agreement maybe subject to Commencement and End Dates that differ from the Head Agreement. The Funding Agreement contains details of funding periods specific to each service.

Where a new Agreement has not been signed beyond the End Date then the Terms and Conditions as outlined in Part 1 and Part 2 will be extended and apply until the parties have signed a new Performance Agreement.

2.2 RELATIONSHIP – RECIPROCAL RESPONSIBILITIES

Both parties acknowledge that the relationship between each of us is fundamental in achieving the above mentioned strategic objectives (section 1.3). Relationship principles that will guide our dealings with each other in the operation of this Agreement have been developed. These principles are outlined in **Section 5 – Appendix 1**.

2.3 SERVICE PROVISION

It is recognised that it is NSCCAHS's ultimate right to determine the types of services in consultation with Royal Rehabilitation Centre Sydney, to be funded from NSW public funds, and how such services provided by Royal Rehabilitation Centre Sydney should be integrated with those delivered by other hospitals and health care providers in the NSCCAHS. This clause is not intended to impede the day to day operational decision making on the part of Royal Rehabilitation Centre Sydney.

This Agreement recognises the clinical expertise and operational efficiency of Royal Rehabilitation Centre Sydney to deliver subacute services to NSCCAHS. Therefore Royal Rehabilitation Centre Sydney expects both parties to this Agreement to participate in the development of service enhancement proposals consistent with the State Health Plan and Clinical Services Plan of the Area Health Service.

Services will be provided by Royal Rehabilitation Centre Sydney:

- in a prompt, efficient, professional and ethical manner; and
- in accordance with all relevant legislation;
- in accordance with relevant NSCCAHS and State: Strategic Objectives; relevant planning and policy documents; and
- In accordance with the Service Specifications that form Part 2 of this Agreement.

NSCCAHS will exercise its stewardship functions to support Royal Rehabilitation Centre Sydney to attain the agreed strategic priorities of NSCCAHS and NSW Health.

2.4 CONSULTATION AND COMMUNICATION

- NSCCAHS will actively involve Royal Rehabilitation Centre Sydney in the development of NSCCAHS corporate, service and clinical plans.
- NSCCAHS will communicate and provide, in a timely manner, information and advice needed for the management of Royal Rehabilitation Centre Sydney programs and services as outlined in the Service Schedules.
- Royal Rehabilitation Centre Sydney will consult with NSCCAHS on any proposed significant service developments or changes in the delivery of services and obtain approval from NSCCAHS before instigating any such significant service changes, for those services funded by NSCCAHS.
- NSCCAHS will consider the mission and values of the organisation and consult with Royal Rehabilitation Centre Sydney in regard to any proposed changes in its role. No changes in its role will be effected without the approval of Royal Rehabilitation Centre Sydney.
- NSCCAHS and Royal Rehabilitation Centre Sydney will meet regularly to discuss progress and ensure the requirements of this Performance Agreement are being met.
- All communication between NSCCAHS and Royal Rehabilitation Centre Sydney will be underpinned by the relationship principles outlined in Section 5 – appendix 1.

2.5 QUALITY

(See Section 3 for indicators relating to corporate and clinical governance.)

Both parties commit to ensuring care meets industry standards of quality and safety, and to ensuring ongoing improvement. The parties will support each other in their interface with certifying and regulatory bodies, including the Health Care Complaints Commission, the Australian Council of Healthcare Standards (ACHS) and the Department of Health. The Royal Rehabilitation Centre Sydney will seek to maintain ACHS accreditation, or other such accreditation status.

Royal Rehabilitation Centre Sydney will actively monitor and report on the quality of its services, including relevant elements of the NSW Health/ NSCCAHS annual performance agreement. The parties will collaborate to develop specific quality and safety performance indicators relevant to the services delivered by the Royal Rehabilitation Centre Sydney.

Royal Rehabilitation Centre Sydney will advise NSCCAHS of any major adverse events (Severity Assessment Code 1 or 2), consistent with NSW Health policy. NSCCAHS will provide

technical support for the investigation and management of major incidents, as requested by Royal Rehabilitation Centre Sydney.

2.6 INSURANCE

It is recognised that Royal Rehabilitation Centre Sydney is a Public Health Organisation covered by the Treasury Managed Fund (TMF) Under the TMF, coverage does extend to other employees of Royal Rehabilitation Centre Sydney even if they are funded from other sources such as grants.

2.7 FINANCIAL MANAGEMENT

NSCCAHS Performance Unit in consultation with Royal Rehabilitation Centre Sydney are moving from historical incremental funding models to the implementation of output based methods of funding. The Service Schedules in Part 2 detail the funding for each service.

A transition period to be negotiated will apply in respect of the financial impact of output based funding.

NSCCAHS RESPONSIBILITIES:

- Provide Royal Rehabilitation Centre Sydney with an annual budget allocation before 31 July. Movement to output based funding methods will increase the transparency of information contained with the budget allocation.
- Provide weekly cash subsidy to Royal Rehabilitation Centre Sydney on each Monday on the basis of 1/52 of annual cash subsidy outlined in the allocation letter provided to Royal Rehabilitation Centre Sydney annually from NSCCAHS.
- Make adjustments for approved pay award increases and other agreed increments through the output based funding mechanism, as soon as funds are received from NSW Department of Health. NSCCAHS does not underwrite award increases not funded or not fully funded by NSW Health.

Royal Rehabilitation Centre Sydney RESPONSIBILITIES

Royal Rehabilitation Centre Sydney:

- Will operate sound financial management systems and procedures.
- Has full responsibility for leave liabilities and termination payments occurring in the normal course of operation. Royal Rehabilitation's liability for the payment of leave upon winding up cannot be quantified at this time, the ultimate funding level would be determined upon winding up based on
    - Any contractual relationship which may be formulated between the administering bodies of the hospitals administered and the Area Health Service/ Department;
    - The nature of the winding up , e.g. closure or privatisation; and
    - The level of cash already transferred under the Department's leave mobility provisions.
- Will be responsible for covering 50% of any deficit in Treasury Managed Fund, annual deposit premiums and will retain 50% of any annual surplus premium. Note: 100% of any hindsight adjustment, surplus or deficit will be applied.
- Is solely responsible for the full amount of any cash net deficit and will retain any net cash surplus. Any net surplus will not be deducted from subsequent funding levels.
- Will comply with the financial reporting requirements outlined in SECTION 3 in each of the Service Schedules as they relate to finance issues.
- Provide information as required to enable NSCCAHS to complete episode based clinical costing for sub-acute services. It is recognised that there is no currently accepted

episode based clinical costing methodology to cost sub-acute **non inpatient services** for palliative care and rehabilitation. These services are defined as "out of scope" of the Rehabilitation and Extended Care Funding Model. These services will be block funded based on a price negotiated between both parties for a 12 month period only (2009/10). Funding for future years will be based on an output based methodology to be determined.

- Provide information as agreed between NSCCAHS and the Royal Rehabilitation Centre Sydney and as stipulated in the Service Schedules to support episode based costing for **non inpatient services,** in the absence of a recognised State model for funding of these services.

NSCCAHS does not underwrite annual revenue targets for specific services with Royal Rehabilitation Centre Sydney. Revenue targets will be negotiated with Royal Rehabilitation Centre Sydney each year and will be determined by efficiency targets and activity.

Where NSCCAHS has serious concerns (based on reasonable grounds) that Royal Rehabilitation Centre Sydney is not operating sound financial management systems and procedures, NSCCAHS may in consultation with Royal Rehabilitation Centre Sydney request and arrange for an independent audit, to audit accounts, processes and systems, at the cost of NSCCAHS.

2.8 REVIEW OF THE AGREEMENT

This Agreement will be entered into for a period extending from 1 July 2009 to 30 June 2012.

Either Party may request a review of:

1. The whole or any part of the Agreement six months from the Commencement Date of the Agreement; and/or
2. The whole or any part of a Service Schedule that forms part of this Agreement before the End Date;

Initiation of a review will generally be to reflect the progressive policy priorities of the NSW Health System and NSCCAHS, or to address and remedy any provisions of the Agreement which are found to be hampering the objectives of the Agreement. However, a review may be requested for any other reason as long as the reasons are provided in writing as per below.

Written notice is required to request the review (minimum 10 working days) which must describe the purpose for the review, issues to be addressed and any proposals in existence at the time of the notice.

Following a review initiated under this clause, amendments/variations to a whole or part of the Agreement or Services Schedules may be proposed. Both parties will, in good faith, seek to agree on what amendments, if any, will be made to the Agreement or relevant Service Schedule.

Any amendments to the Agreement or a Service Schedule that are specific to Royal Rehabilitation Centre Sydney are to be made by agreement from both parties. This does not apply to amendments that may impact on another Affiliate Health Organisation. For the purposes of this clause "amendments" include, without limitation, the addition of a new provision or service schedule to this agreement or the deletion of an existing provision or Service Schedule to this Agreement.

Any amendments agreed under this clause will take effect under this Agreement from a date agreed to by both parties, but not less than three months from the amendment being supported, wherever practicable.

2.9 VARIATIONS

This Performance Agreement may be varied at any time by agreement between both parties following a review in line with Section 2.8 above.

Either Party will provide a minimum of six months notice of any changes to Royal Rehabilitation Centre Sydney's provision of services, unless an alternative, service-specific minimum notice period has been outlined in Part 2 –Service Schedules, for those services funded by NSCCAHS.

Items in the Agreement can be varied in the following ways:

1. HEAD AGREEMENT – the exchange of letters, with letters noting agreed variations and signed by the Chief Executive (or delegate) of NSCCAHS and the Chief Executive Officer (or delegate) Royal Rehabilitation Centre Sydney.
2. SERVICE SCHEDULES – the exchange of letters, with letters noting agreed variations and signed by the Chief Executive (or delegate) of NSCCAHS and the Chief Executive Officer (or delegate) Royal Rehabilitation Centre Sydney.

   Following agreement via the exchange of letters the relevant section of Part 2 – Service Schedule, and HEAD AGREEMENT SUMMARY should be updated accordingly. Update of the Summary table includes the assignment of a new version number, commencement Date and End Date.

2.10 NOTICE OF INTENTIONS

Before the end date of any Service Schedule if:

a) Either party does not wish to enter into a new Service Schedule for those Services when the Service Schedule ends; or
b) One of the parties wishes to enter into a new Service Schedule for those Services when the Service Schedule ends but on materially different terms.

The party must give a minimum of six months written notice.

More minor variations should be dealt as per clause 2.8 and 2.9.

2.11 DISPUTE RESOLUTION

This process excludes breaches of the Agreement.

Where a dispute arises between the parties to the agreement to following steps are to be followed to resolve the dispute.

Notice of dispute

If the parties are unable to agree on any matter under this Performance Agreement either of them may give written notice to the other stating details of the matter in dispute and requiring that the matter be resolved by a meeting between the parties.

Representatives of the parties

The parties agree that the representatives of the parties for such meetings will be the Chief Executive of NSCCAHS (or his or her nominee) and the Chief Executive of Royal Rehabilitation Centre Sydney (or his or her nominee).

Process of dispute resolution

(a) The parties must meet in good faith to seek to resolve any area of dispute. The parties must meet together within seven days of the serving of notice of a dispute under this Performance Agreement. Both parties are committed to conciliation as the principle means of dispute resolution and will act in good faith to ensure that conciliation is conducted in a manner which is consistent with this principle.

(b) If the parties cannot resolve the dispute within seven days of the initial meeting as set out in clause 2.11 (a), the parties agree to refer the dispute to mediation. An independent person as agreed to by the parties will be appointed to mediate. The mediator is to be informed in writing of the conciliation process which has been unsuccessful and provided with the terms of reference for the mediation. The terms of reference will have been supported by both parities.

(c) If such mediation as outlined under clause 12.1.3(b) does not result in a satisfactory resolution between the parties, the parties agree to arbitration by an arbitrator agreed by both parties, this may be the Australian Commercial Dispute Centre Limited. The mediator must not be the arbitrator.

(d) The parties to the dispute are entitled to be represented by a qualified legal practitioner at any such arbitration.

(e) The arbitrators decision will be final and binding.

(f) The parties agree to meet the costs of their own representation and to share equally in the costs incurred by the arbitration being conducted.

Continuing performance

Pending determination of any dispute under this Performance Agreement the parties agree to continue to perform all their obligations under this Performance Agreement.

Summary or urgent relief

Nothing in this clause 2.11 prevents either party from instituting court proceedings to seek urgent injunctive relief, interlocutory or declaratory relief in respect of a dispute under this Performance Agreement.

Court proceedings not precluded

Subject to the obligation to meet in good faith to seek to resolve any area of dispute as set out in clause 2.11 (a), either party may institute court proceedings to determine a matter of law arising in connection with this Performance Agreement.

Liaison with NSW Health

Nothing in this Agreement prevents Royal Rehabilitation Centre Sydney liaising with NSW Health at any time of its choosing.

2.12 TERMINATION OF A SERVICE

In the event that either party wishes to terminate a complete clinical service that is outlined in Part 2 – Service Schedules, of this Performance Agreement, written notice with a minimum notice period of at least twelve months is required.

Where a Service Schedule is terminated the Head Agreement Summary Table in Part 1 should be updated accordingly.

SECTION 3 GENERAL REPORTING REQUIREMENTS

Royal Rehabilitation Centre Sydney will:

- Provide comprehensive, accurate, timely reporting to NSCCAHS in relation to operational and clinical performance and emerging issues. Financial reports will be provided where it is a statutory requirement of the Affiliate Health Organisation.
- Report all incidents to NSCCAHS through the Incident Information Management System (IIMS) and meet patient safety and clinical quality standards.
- Collect, monitor and review data and information to meet the planning and reporting needs of the organisation, the NSCCAHS and NSW Health, in achieving the priorities in the NSW State Plan and State Health Plan.
- Operate according to the requirements of legislation (including obligations under the Health Services Act 1997), and comply with all relevant standards, policies and guidelines of NSW Health.
- Report against the key performance indicators outlined below. These indicators represent NSW Health dashboard indicators. These KPIs are indicative but agreed in principle.
- Report against the performance indicators outlined in the Service Specifications that form Part 2 of this Agreement.

3.1 STRATEGIC DIRECTION 2 – CREATE BETTER EXPERIENCES FOR PEOPLE USING THE PUBLIC HEALTH SYSTEM

Royal Rehabilitation Centre Sydney will undertake to achieve health system objectives and results as required by the performance indicators below.

NSCCAHS will provide definitions as per the NSW Health format for the indicators below. These will be reviewed, refined and agreed to ensure that only those applicable to Royal Rehabilitation Centre Sydney are required for reporting.

Hospital and Community Patient Management (organisation wide indicators)	**Target**	**Actual**	**Reporting Frequency mechanism**
Available Beds	As per hospital		
Bed utilisation	> 85%		
Average length of Stay			
Achievement of service schedule KPIs within 3% of agreed targets			
All relevant data requirements completed and submitted within agreed timeframes (i.e. quarterly, monthly) (Refer to Appendix2 – Section 5)	100% complete within timeframe		

Customers satisfied with services	**Target**	**Actual**	**Reporting Frequency mechanism**

Standardised measures of patient experience following treatment			Collation by Royal Rehabilitation Centre Sydney and provision of reports to Area Performance unit annually
Complaints resolved in 35 days	100(%)		
Consumers rating healthcare as excellent, very good or good. (%). - Community Health - Hospital inpatient			

High quality clinic treatment/ control of incidents	**Target**	**Actual**	**Reporting/ Frequency mechanism**
(%) Unplanned/unexpected readmissions within 28 days of separation – all admissions	< baseline		
Medication errors	< baseline		
Falls in hospital (%)	50% reduction		
Deaths as a result of a fall in hospital (number)	50% reduction		
RCAs completed on time (%)			
Implementation of National inpatient Medical Chart	100%		
Australian Council of Healthcare Standards (ACHS) accreditation.	Accreditation maintained.		

3.2 STRATEGIC DIRECTION 3: STRENGTHEN PRIMARY HEALTH AND CONTINUING CARE IN THE COMMUNITY

Integration of care	**Target ***	**Actual**	**Reporting frequency/mechanism**
Discharge summaries sent to GPs (%)			Collation by Royal Rehabilitation Centre Sydney and provision of reports to Area Performance unit annually
Utilisation of ComPacks packages (%)			
Utilisation of CAPACs packages (%)			
Utilisation of TACP packages (%)			

3.3 STRATEGIC DIRECTION 5 – MAKE SMART CHOICES ABOUT THE COSTS AND BENEFITS OF HEALTH SERVICES.

Sound financial management #	**Target ***	**Actual**	**Reporting frequency/mechanism**
Provision of financial statement audit and audit report provided	Copy forward annually.		Collation by Royal Rehabilitation Centre Sydney and provision of reports to Area Performance unit annually Annually
Copy of the Internal Audit plan	Copy forward annually		

Revenue Performance	**Target**	**Actual**	**Reporting frequency/mechanism**

Total Operating Income (excluding Grants and Subsidies	+4% 2007/08 acutal		

3.4 STRATEGIC DIRECTION 6 – BUILD A SUSTAINABLE HEALTH WORKFORCE

Right People, right place	**Target**	**Actual**	**Reporting frequency/mechanism**
FTEs/ budgeted FTEs			Collation by Royal Rehabilitation Centre Sydney and provision of reports to Area Performance unit annually
Clinical Staff as a proportion of total staff (%)	> baseline		
Aboriginal staff as proportion of total staff (5)	>baseline		
Agency nurse staff (%)			
Overtime (%)			
Ratio EN/RN (targeted at 20:80)			

Employer of choice			
Staff turnover – Permanent staff separation (%)			Collation by Royal Rehabilitation Centre Sydney and provision of reports to Area Performance unit annually
Workplace injuries (%)			
Staff > 55 years staying on (%)			
Staff salary packaged (%)			
Sick leave – annual average per FTE (hours)			
Smoke Free work Place implemented.			

3.5 STRATEGIC DIRECTION 7 – BE READY FOR NEW RISKS AND OPPORTUNITIES

Strong clinical governance	**Target**	**Actual**	**Reporting frequency/mechanism**
SAC 1 incidents that have RCA (%)			
RCA recommendations completed on time (%)			
Pandemic Influenza Plan in place			
Participation in counter disaster exercises program			

Strong Corporate Governance	**Target**	**Actual**	**Reporting frequency/mechanism**
Disaster recovery plans in place			
Risk audits completed			
Risk audit recommendations implemented			
Data collection and information management and reporting – quality and timeliness			

SECTION 4 PERFORMANCE MANAGEMENT FRAMEWORK

- The nominated officer for monitoring the Performance Agreement will be the Director, Clinical Operations, NSCCAHS and the Chief Executive Officer, Royal Rehabilitation Centre Sydney.

- NSCCAHS and Royal Rehabilitation Centre Sydney will meet quarterly to review the progress of the implementation of this agreement, and particularly to review the performance against relevant performance indicators or more frequently as requested by either party.

- Royal Rehabilitation Centre Sydney and NSCCAHS agree to provide progress reports one week prior to each review meeting. Reports will outline progress against identified performance indicators.

- Royal Rehabilitation Centre Sydney and NSCCAHS will each nominate a responsible officer/s from each of the clinical streams for which there are service specifications. Responsibilities of the nominated officer will be:

    a. Ensuring that services are provided in line with the service specifications,

    b. Developing and implementing processes to work towards the alignment of services with the Service Specification and reporting on progress

    c. The provision of clinical stream support to ensure requirements of the performance agreement are met

    d. To facilitate the development and implementation of data collection processes to ensure reliable reporting on the agreed data set for each clinical stream.

    e. Provision of advice, feedback in relation to the assessment against KPIs for each clinical stream and the achieved of health outcomes.

SECTION 5 APPENDICES

APPENDIX 1 – PRINCIPLES FOR THE WORKING RELATIONSHIP

The principles outlined below (sourced from the New South Wales Government - Department of Premier and Cabinet) have been adopted and adapted to apply the relationship between Northern Sydney Central Coast and the Royal Rehabilitation Centre Sydney.

Principles for the funding relationship

Value for money: Obtaining the best mix of services to meet the community's needs within available funding and selecting the mix of resources that delivers the best possible outcomes to clients.

Fairness, Integrity and Transparency: Both parties agree to maintain regular, open communications on all matters related to the funding of services under this agreement. This will include regular meetings of key position holders about funding and conditions of subsidy. It will also include consultation and collaboration on an ongoing basis about funding of services how that best meet the needs of each party.

Cooperation: NSCCAHS and Royal Rehabilitation Centre Sydney will work to promote a relationship based on reciprocity.

Coordination: Outcomes for people and communities can be improved through better alignment of planning, program design and service delivery within and across both Government, non government organisations and local government.

Probity: The provision of funding/subsidy to Royal Rehabilitation Centre Sydney must be conducted in an environment of integrity, honesty and scrutiny.

Principles for the working relationship

Partnership: Both NSCCAHS and Royal Rehabilitation Centre Sydney will work in partnership in the delivery of specific health services (that are included in this agreement) within the local government area covered by NSCCAHS.

Evidence-based approach: Policy and program development and service delivery should be based on reliable evidence.

Outcomes: Decisions should be informed by a focus on real outcomes for people and communities.

Accountability: Both NSCCAHS and Royal Rehabilitation Centre Sydney are accountable and transparent in the way in which they spend public funds, in a manner appropriate to the level of expenditure.

Respect: Both NSCCAHS and Royal Rehabilitation Centre Sydney respect each other's roles and acknowledge that these roles may lead to differences of opinion around particular issues. Where differences occur, the parties agree to collaborate respectfully to reach a mutual understanding and agreement.

NSW Health and NSCCAHS will respect the stated mission and ethos of Royal Rehabilitation Centre Sydney, as fundamental to the character of that organisation, and will not impose any

activity or restrict any activity that will conflict with or prevent the AHO from giving effect to its stated mission or ethos.

Communication: Wherever possible, open communication and consultation is a priority, particularly where changes to policies, programs or services are being considered or advocated. Regular meetings will be held with key position holders of both parties to maintain open communications on matters related to this agreement.

Independence: Royal Rehabilitation Centre Sydney is an independent agency that is responsible and accountable for its own performance and management. Royal Rehabilitation Centre Sydney is accountable to its Board in the operation of the organisation, and is subject to the Corporations Act. Where Royal Rehabilitation Centre Sydney receives funding from NSW Health via NSCCAHS it is also accountable to NSCCAHS (NSW Health) for its performance in relation to the service or initiative being funded.

NSW Health and NSCCAHS will not cause the Directors or Senior Management of Royal Rehabilitation Centre Sydney to be placed in a situation where they are unable to meet their statutory obligations under the Health Services Act and any other State or Commonwealth Act.

Inclusiveness: NSCCAHS is obliged to balance the interest of all citizens residing within the boundaries of the Area Health Service and has a responsibility to allocate resources accordingly. This may involve changes to policies, administrative and funding arrangements.

Service Development: NSCCAHS will promote the development and enhancement of services provided by Royal Rehabilitation Centre Sydney consistent with the NSCCAHS Clinical Services Strategic Plan and in keeping with the mission and ethos of the Royal Rehabilitation Centre Sydney.

APPENDIX 2 – DATA AND REPORTING REQUIREMENTS

Data Submission required	Service Units included	Reporting mechanism/ timeframe	Rationale
Available bed reporting	All inpatient units	Monthly To be submitted to the Area Performance Unit (APU) Activity Information Coordinator by the first Wednesday of each month.	Mandatory Policy for Health facilities as per the NSW Department of Health Bed Reporting Requirements.
Admitted Patient Data relating to Admissions, Separations and Administrative Events	All inpatient units	Reported in Cerner on an ongoing basis so that status reflects the current situation as per NSW Health, Admitted Patient Data Collection	Mandatory Policy for Health facilities as per the NSW Health Admitted Patient Data Collection
Coded Data	All inpatient units	Reported in Cerner in line with timeframes outlined in the NSW Health, Admitted Patient Data Collection	Mandatory Policy for Health facilities as per the NSW Health Admitted Patient Data Collection
Non Admitted Patient Occasions of Service (NAPOOS)	All non inpatient services	Monthly To be entered into WebDOHRS by the 5th working day of every month.	Requirement of the NSW Department of Health monthly.
SNAP Data	All inpatient units that treat sub and non acute admitted patients that are in scope of the Rehabilitation and Extended Care funding model	Reported in SNAPshot Plus on an ongoing basis so that status reflects the current situation. Data from the previous quarter is to be complete and correct by the end of the second week of the month post quarter. E.g. for the quarter January to March all data is to be submitted by the Friday of the 2nd week in April. Note: SNAPshot Plus will be replaced by SNACC during 2009. SNACC is the NSCCAHS accepted SNAP and HACC collection database.	Required to meet timeframes for reporting to the NSW Department of Health and to AROC (Australasian Rehabilitation Outcomes Centre) and PCOC (Palliative Care Outcomes Collaboration).

Financial data including: - Expense data - Revenue data - Overhead cost data - FTE data - Cost centre data including cost centre breakdown by program - NSW health program splits Note: Data requirements are to be further advised by the NSW Department of Health during 2009.	All services	Quarterly To be submitted to the APU, Clinical Costing Unit by the end of the month post quarter e.g. for the quarter January to March all data must be submitted by the last working day in April.	- Mandatory as per NSW Health Episode Funding Policy to enable output funding.

APPENDIX 3 – ANNUAL FUNDING AGREEMENTS

(Annual Funding Agreement for 2010-11 and 2011-12 to be attached here.

Funding Agreement 2010-11

SERVICE UNIT	Start Date	End Date	VOLUME	UNIT PRICE	TOTAL SERVICE PRICE 2010-2011
Inpatient Aged Care Rehabilitation (Dixon unit) 18 beds	1 July 2009	30 June 2011	277 (cost weights)	$12,782	$3,540,701
Inpatient Working Aged Rehabilitation (CARS Unit) 14 beds	1 July 2009	30 June 2011	256	$12,782	$3,272,273
Non Inpatient Working Age Rehabilitation including hydrotherapy	1 July 2009	30 June 2011	To be determined (TBD)	Negotiated Price	$354,734
Community Home Based Rehabilitation	1 July 2009	30 June 2011	TBD	Negotiated Price	$742,573
Total General Rehabilitation					**$7,910,281**
Inpatient Brain Injury Rehabilitation	1 July 2009	30 June 2012	337 (cost weights)	$12,782	$4,307,640
			Adjustment	Negotiated top up funds	$1,022,364
Community Brain Injury Rehab Community Team (BIRCT). **GMCT funded**	1 July 2009	30 June 2012	TBD	GMTT determined	$692,660
Community BIRCT			TBD	Negotiated top up	$604,299
Total Brain Injury Rehabilitation					**$6,626,963**

Part 1 – Head Agreement

SERVICE UNIT	Start Date	End Date	VOLUME	UNIT PRICE	TOTAL SERVICE PRICE 2010-2011
Inpatient Spinal Injury Rehabilitation	1 July 2009	1 July 2012	432 (Cost weights)	$12,782	$5,521,892
				Negotiated top up funds	$887,648
				GMTT determined	$196,498
Inpatient Additional two spinal beds			48 cost weights	$12,782	$613,551
				Top up for additional 2 beds	$98,628
Community Spinal Outreach Service	1 July 2009	30 June 2012	TBD	GMTT determined	$896,528
Community Rural Spinal Cord Injury Service	1 July 2009	30 June 2012	TBD	GMTT determined	$763,418
Total Spinal Cord Injury Rehabilitation					**$8,978,163**
Extended Care Services (Weemala)	1 July 2009	30 June 2012 (dependent on Weemala population)			$2,942,187
Total Extended Care Services					**$2,942,187**
				Sub-total	**$26,457,594**
				Revenue Patient Fees	**$3,223,513**
				Escalation	**$73,692**
				DVA Fees	**$612,719**
				MAA Fees	**$38,000**
				Share of NSW Health Revenue Budget increase	**$307,752**
				Total price	**$22,201,918**

File No: NSCC/09/10218

PART 2 – SERVICE SCHEDULES

This Part 2 contains each of the Service Schedules listed in the Head Agreement (Agreement Summary).

Each of the Service Schedules in Part 2 form part of the Agreement between Northern Sydney Central Coast Area Health Service and THIRD SCHEDULE , as defined in the Head Agreement or in a subsequent Variation of the Head Agreement, as applicable.

Each Service Schedule contains the following:

Section A	Service Specific Terms and Conditions
Section B	Provider Specific Terms and Conditions
B.1	*Service Provider Details*
B.2	*Details of the service units which apply*
Section C	Service Specification

The **Service Specific Terms and Conditions** set out the terms and conditions (if any) that are not outlined in the Head Agreement that may apply to the specific type of service being purchased e.g. state-wide services

The **Provider Specific Terms and Conditions** detail those elements of the Agreement that are unique to THIRD SCHEDULE. These include organisational details, period of agreement and a full list of relevant service units, volumes and price.

Service Specifications describe the service, and set out quality and information reporting requirements additional to those specified in Part 1 (the Head Agreement). Note that standard service descriptions may contain details (particularly service units and reporting requirements) which do not apply to all agreements.

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SECTION A: SERVICE SPECIFIC TERMS AND CONDITIONS

Service Delivery

Royal Rehabilitation Centre Sydney will ensure that rehabilitation services are delivered in accordance with the agreed Area wide model of care and the specified service volumes outlined in Section B.

Changes will not be made to specified volumes (in particular bed numbers) in the absence of approval by Northern Sydney Central Coast Area Health Service (NSCCAHS).

No change will be considered for approval in the absence of a business case which provides details in relation to the proposed change. The business case would include (at a minimum) the following: service goals and objectives, service components, methods of evaluation of the service and anticipated outcomes, evidence base for the proposal, and the impact, e.g. in terms of health, cost, efficiency and access.

Reporting Requirements

Royal Rehabilitation Centre Sydney is required to report to the NSCCAHS in accordance with requirements outlined in the Head Agreement (as they apply to Sub-acute Aged Care and Rehabilitation Services) and requirements outlined in the Sub-acute Aged Care and Rehabilitation Service Specification.

Service Planning

In line with recommendations contained within the 2008 Clinical Services Strategic Plan, some changes may take place to rehabilitation beds located at Royal Rehabilitation Centre Sydney. The November 2008 Supreme Court decision on Graythwaite may also lead to changes in rehabilitation beds located at Royal Rehabilitation Centre Sydney. For this reason the funding period as documented in the Head Agreement, for sub acute and aged care services provided by Royal Rehabilitation Centre Sydney is for a two year period only.

NSCCAHS will provide Royal Rehabilitation Centre Sydney with timely notice of proposed changes to service delivery models and implementation of mandatory performance.

It is expected that Royal Rehabilitation Centre Sydney will actively participate in the Aged Care and Rehabilitation Services Network. Many of the service components outlined in Section 6 below will be subject to review, evaluation, and re-orientation by the Network, in light of activity/throughput, changes to best clinical practice standards and emerging models of care.

Performance Review

The Forum for formal review of reports against indicators outlined in Section 11 of the Service Specification will take place in line with the Performance Management Framework in Part 1 – Head Agreement.

SECTION B: PROVIDERS SPECIFIC TERMS AND CONDITIONS

Provider Details

Provider Name	**Royal Rehabilitation Centre Sydney**
Agreement Commencement Date	**1 July 2010**
Agreement End Date	**30 June 2011**

Details of all service units which apply to this service schedule

SERVICE UNIT	SERVICE MEASURE/S	VOLUME	UNIT PRICE	TOTAL PRICE
Inpatient Aged Care Rehabilitation (Dixson Unit) 18 beds	Cost weights	277	$12,782	$3,540,701
Inpatient Working Age Rehabilitation (CARS Unit) 16 beds	Cost weights	256	$12,782	$3,272,273
Community Home Based Rehabilitation	To be determined (TBD)	TBD	Negotiated price	$742,573
Outpatient clinics	TBD	TBD	Negotiated price	$354,734
Total Price for Sub-acute Aged Care and Rehabilitation				**$7,910,281**

SECTION C – SERVICE SPECIFICATION AGED CARE AND GENERAL REHABILITATION

1 PRINCIPLES

Principles underpinning Aged Care and Rehabilitation (ACR) Services that make up an integrated system:

- Rehabilitation services will be delivered locally within each sector offering the full range of core functions.
- The various components of rehabilitation services will be integrated in a single service structure, with formal linkages to Aged Care and other health services to support continuity of care.
- There are simplified pathways through ACR services and, a reduction in the multiple points of entry to services.
- Uniform referral processes and admission criteria will be applied across NSCCAHS Rehabilitation services.
- Intersectoral collaboration between health services and community networks and residential care providers is visible and effective.
- There will be systematic approaches to determining whether a client is an "aged care client".
- All clients identified as an aged care client are offered a comprehensive multi-disciplinary geriatric assessment appropriate to their care needs.
- There are improved opportunities for all older people to remain as independent as possible and able to participate in community life.
- Where there is more than one ACR service within a sector, ACR functions will be distributed or co-located to ensure equity of access for users in each sub-sector.

2 DEFINITIONS

Rehabilitation aims to assist people to recover function or abilities to achieve the highest possible level of independence following the recent onset of disease or injury. This is achieved through a goal directed, multidisciplinary approach involving medical, nursing and allied health staff. It involves individual assessment, treatment, regular review, discharge planning, and community integration and follow up of people referred to that service.

Sub-acute services (other than rehabilitation) are provided to frail older people who have predominately medical problems requiring restorative inpatient care and more straight forward interventions such as mobility programs and discharge planning.

All clients receiving services in line with this specification are classified under the SNAP casemix classification.

3 SERVICE OBJECTIVES

Provide comprehensive, high quality multi-disciplinary care for the attainment of the highest possible level of independence for clients who have loss of function or ability due to injury or disease.

4 SERVICE USERS

4.1 INCLUSIONS

The following client groups may be included within this service:

- Individuals over the age of 17 years.
- Individuals with disabilities for whom the primary treatment goal is improvement in functioning.
- Frail older people requiring restorative inpatient care and or mobility programs in an inpatient setting for whom the primary goal of intervention is restorative care.
- Individuals admitted for time specific trials of rehabilitation or participating with carers in training.
- Individuals with (but not limited to) the following conditions and impairments:
  - Orthopaedic conditions
  - Amputation
  - Neurological conditions, stroke and non-stroke
  - Medical and post surgical debility
  - Chronic disease
  - Cancer and burns
- Specific to Greenwich Hospital:
  - In addition to the above, clients requiring rehabilitation from cardiac conditions and chronic renal failure requiring dialysis are also included in the service.

4.2 EXCLUSIONS

The following client groups/ conditions are excluded:

- Individuals under the age of 18 years.
- Those with psychological, psychiatric and/or cognitive impairment that has been assessed as precluding the individual from appropriate participation in a rehabilitation program.
- Absence of rehabilitation goals.
- Medically unstable clients.
- Traumatic brain and spinal cord injury.
- People requiring respite care.
- Individuals who have been assessed as requiring, or have been living in, a high care residential aged care facility (unless the goal of rehabilitation is to move clients out of the nursing home into more independent living e.g. hostel or home).
- Those requiring re-conditioning prior to being admitted to a high-level residential aged care facility.
- Non weight bearing orthopaedic without specific short-term rehabilitation goals.

5 ACCESS

5.1 ENTRY CRITERIA

Individuals must meet the following criteria for entry to rehabilitation:

- Current level of function is below premorbid level, and the individual is unable to be discharged to their usual accommodation, due to disability that results from their hospitalisation; and
- Assessment has determined that the clients would demonstrate rehabilitation gains from admission to the program (for some older people rehabilitation gains may be mostly restorative in nature e.g. mobility programs and discharge planning); and
- Specific and achievable rehabilitation goals are identified; and

- The individual has been assessed as having a level of cognitive function that would permit appropriate participation in a program; and
- The individual is medically and psychiatrically stable; and
- Resides within the stated geographical catchment area (see section 5.3); or
- Do not reside in the stated geographical catchment outlined in section 5.3 but are referred from Royal North Shore Hospital or Ryde Hospital or other acute facilities of NSCCAHS in an exceptional case.
- Note: Out of Area clients can only be accepted where a rehabilitation bed is not immediately available in the Area Health Service in which they reside. Where any doubt arises as to the eligibility of a particular patient it is expected that RRCS will seek clarification from the Office of the General Manager, North Shore Ryde Health Service.
- Discharge destination is identified.
- Usually under the care of a rehabilitation physician but older clients may be admitted under the care of a geriatrician.

Other sub-acute criteria:

- Intervention is required to restore/ maximise/maintain function.
- Individuals who are considered to be at risk without this intervention.

5.2 EXIT CRITERIA

Individuals will be discharged when:

- Identified acute rehabilitation goals have been met; or
- Appropriate level of functioning has been achieved within the allocated LOS for impairment code; or
- They are no longer receiving clinical or functional benefit; or
- Individual requests discharge from rehabilitation program; or
- Individual demonstrates non compliance with rehabilitation program; and
- Individual has an appropriate accommodation and social situation to be discharged to

5.3 ACCESS

Facility	Service Setting	Populations in the Catchment Area	Referral Source
Greenwich Aged Care and Rehabilitation	Inpatient	– Lane Cove, Willoughby, and Mosman and North Sydney LGAs – Those residing in the Hornsby-Ku-ring-gai and Northern Beaches LGAs will also be able to access services if referred from RNSH.	– RNSH – Medical and Surgical teams. – Acute geriatric, orthogeriatric teams
Greenwich Aged Care and Rehabilitation	Ambulatory settings Including: Day Therapy, Outpatient Clinics, and Home Based Rehabilitation	– Lane Cove, Willoughby, and Mosman and North Sydney LGAs – Those residing in the Hornsby-Ku-ring-gai and Northern Beaches LGAs will also be able to access services if referred from RNSH	– RNSH – Manly Hospital and Mona Vale Hospital – ACR teams from referring hospitals – Following discharge from sub-acute facility

Service Schedule – Sub-acute Aged Care and Rehabilitation Service Version 4.0

Facility	Service Setting	Populations in the Catchment Area	Referral Source
Royal Rehab Aged Care and Rehabilitation (Dixson)	Inpatient	Ryde / Hunters Hill LGA (over the age of 60)	– RNSH and Ryde Hospital – GPs and medical and surgical teams NOTE: – THIRD SCHEDULE accepts referrals from public and private acute and subacute hospitals within metro Sydney (for clients residing in a LGA in Northern Sydney) where acceptance does not restrict access by public clients
Royal Rehab Working Age Rehabilitation (CARS)	Inpatient and outpatient clinics including hydrotherapy	All LGA in Northern Sydney (usually under 60 years of age)	– Acute public and acute private hospitals within Metropolitan Sydney (for clients residing in a LGA in Northern Sydney) where acceptance does not restrict access by public clients – Medical and Surgical Specialists
Royal Rehab Home Based Rehabilitation Service	Client's residence	All LGAs in Northern Sydney	– Acute public and acute private hospitals within Metropolitan Sydney (for clients residing in a LGA in Northern Sydney) where acceptance does not restrict access by public clients – General Practitioners – Medical and surgical Specialists

6 SERVICE COMPONENTS

6.1 PROCESS

Service Component	Description
Referral and Admission Management	The Service Provider will: • Assess referrals to ensure clients meet entry criteria. • Operate an effective and efficient system to receive and prioritise all referrals into the service. • Develop strategies to facilitate after-hours admissions to inpatient facilities where appropriate admission criteria are met. • Maintain mechanisms to enhance communication between rehabilitation and acute care services to ensure that referrals are timely and appropriate, e.g. regular case conferencing. • Participate in the NSCCAHS Area Aged Care and Rehabilitation Network to collaboratively establish effective mechanisms for referral including: – Provision of a single point of access for referral to inpatient and/or ambulatory care services e.g. Home based rehabilitation or outpatient clinics. – Commitment to development and implementation of a uniform referral system across sectors including referral guidelines; protocols; documentation and use of common IMT Systems. – Develop and implement uniform criteria for admission to rehabilitation units and to ambulatory rehabilitation services across the NSCCAHS in collaboration with the ACR Network. – Implement and evaluate impact of the above processes in collaboration with the ACR Network.
Assessment	The Service provider will: • Conduct assessments in the environment most appropriate to the individual client, i.e. inpatient, home, community, outpatient setting. • Complete comprehensive multi-disciplinary functional and psychosocial assessment. • Conduct and/or facilitate access to the following assessments where appropriate: – Domiciliary assessment, including for young people with disabilities – Dementia Assessment • Refer clients and families to the ACAT for assessment of eligibility for entry to aged care places (residential or community based including access to transition aged care places via TRANSPAC NS when required.

Service Schedule – Sub-acute Aged Care and Rehabilitation Service Version 4.0

Service Component	Description
Provision of Care	The Service provider will: • Provide a multidisciplinary rehabilitation in the most appropriate setting for the client. • 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. • Carry out systematic reassessment of client's progress within the timeframes set out in universal service standards (e.g. Rehabilitation Medicine clinical indicators). • 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 manner in which the rehabilitation plan will be delivered. • Provide an appropriately qualified multi-disciplinary workforce as outlined in Section 6.6. • 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 that formalised protocols and referral processes for assessment and management of clients with delirium, depression, cognitive impairment, confusion and disturbed behaviour are consistent with the ACR Network endorsed model for the management of dementia and delirium in inpatient settings. • Ensure that early and comprehensive discharge planning is undertaken as per below.
Discharge Planning	The Service Provider will: • Commence discharge planning within 48 hrs of admission or during goal planning processes to promote a smooth transition into place of residence and resumption of life roles after discharge. • 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 a FIM score variation. • Provide timely referrals prior to discharge to a locally defined range of subacute post-discharge programs and community services as appropriate including Home Based Rehabilitation (HBR), Home Nursing, Day Therapy Programs. • 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 post-discharge 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.
Access to specialised	The service provider will ensure that access to the following specialised assessments is provided: • Loan equipment to support mobility and activities of daily living (ADLs).

Service Component	Description
assessment services	• Home modifications • ACAT assessments • Continence assessment and management • Sexuality assessment • Wound assessment and management • Prosthetic and orthotic services Affiliate Specific: • Royal Rehab seating clinics
Education	The service will be a source of client and caregiver education and training including: • Training for clients and carers in the use and application of equipment to maximise independence. • Client self care and carer education to optimise functional level, prevent deterioration and maximise self management e.g. training on incorporating exercises and functional skills into all daily living activities, medication administration. • Services available in the community, access to ongoing support for carers. • Outreach education and consultation 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.
Quality Improvement and Risk Management	The service provider will: • Maintain accreditation status in accordance with the ACHS Standards and timetables. • Support adoption of evidence based clinical practices. • Maintain quality of care to clients and maximise client outcomes through continuing education programs and adoption of evidence based best practice guidelines for care. • Comply with mandatory data collection policies and protocols required by the NSW Department of Health, NSCCAHS and other funding bodies in relation to client clinical records, clinical documentation, casemix recording and reporting, privacy and confidentiality of client records • Participate in service review and evaluation activities to facilitate internal and external service planning evaluation, risk management programs, quality improvement and accreditation activities. For example: participation in strategic service planning through the ACR Network; on-going review of client outcomes including measurement of Functional Independence Measure (FIM) scores at client level. • Undertake analysis and review of AN-SNAP data, noting Average LOS per impairment class and other KPIs to support the development of output based funding scenarios. • Undertake client satisfaction survey's and report feedback from client satisfaction survey's to the Area Performance Unit and other Area governance committees as required from time to time. • Participate in the OH&S Numerical Profile assessment periodically.

Service Component	Description
Clinical Teaching and Research	• Maintain education and research activities that meet the requirements for accreditation as an approved placement for the ARFM Training Program for advanced Trainees in Rehabilitation and for Allied Health and Nursing Programs. • Maintain a research profile and report on the Provider's research activity funded by NSW Health funding streams, if applicable.

6.2 SETTINGS

Service Type	Service Definition
Inpatient Care	This component of aged care rehabilitation and general rehabilitation delivered in a sub-acute inpatient setting will have as a minimum: • access to appropriate nursing care 24hrs/day; 7 days/week with an appropriate skill mix across all shifts • Registrar/CMO cover during business hours with on-call access after hours 24/7. • Comprehensive multi-disciplinary assessment, ongoing functional assessment, case management, clinical care co-ordination and where appropriate geriatric assessment. Focus will be on meeting defined short term rehabilitation goals and establishing medium and long term rehabilitation goals in preparation for discharge. • Discharge is planned in advance and will occur when rehabilitation goals have been met to a sufficient level as measured by FIM score and appropriate environmental supports are in place to enable safe return to home or appropriate other residential setting.
Outpatient Clinics	• A component of aged care rehabilitation and general rehabilitation delivered at a hospital clinic following discharge as an inpatient. • Clinic reviews are intended to provide planned assessment, review and evaluation of client's functional status. • Activities may include individual therapist interventions including hydrotherapy. Includes services delivered by medical specialist, allied health and multi-disciplinary clinics. • Activity will be recorded using the NSW Health Non-Admitted Client Activity (NAPOOS) definitions as outlined in the DOHRS Data Collection Guidelines Chapter 5.
Day Therapy Program	Attendance at Day Therapy Program's are recommended for clients who require maintenance services delivered by at least 2 allied health professionals post–discharge from the inpatient setting. • Focus is on facilitating and monitoring progress towards rehabilitation goals, addressing ongoing rehabilitation needs, establishing a programme of education for implementation in the home or other residential setting and to provide referrals where required.

	• Attendance is for a designated period of time, and will generally be less than 3 months. • Activity will be recorded using the NSW Health Non-Admitted Client Activity (NAPOOS) definitions as outlined in the DOHRS Data Collection Guidelines Chapter 5. There is no clear delineation between provision of day hospital and home based rehabilitation services. The following factors should be considered: client preference, availability of the service, access to the service. If the client has been recently hospitalised, home based rehabilitation is preferred to encourage reintegration in a domestic and community setting.
Home Based Rehabilitation (HBR)	Home based rehabilitation services provide intensive, short duration rehabilitation for a range of conditions to clients in their home environment and are usually provided following a hospital admission as an alternative to other post discharge programs e.g. Day Therapy Program. Services include: • multi-disciplinary assessment, direct therapy interventions, specialised assessment and education • Activities are delivered by medical, nursing and allied health professionals within defined program guidelines, e.g. Maximum duration 4-8 weeks; Improvement measured on a validated Instrumental Activities of Daily Living (IADL) scale. • The program is time–limited (4-8 weeks duration) • Activity will be recorded using the NSW Health Non-Admitted Client Activity (NAPOOS) definitions as outlined in the DOHRS Data Collection Guidelines Chapter 5.
Transitional Care	Under this Agreement, NSCCAHS does not recognise Transition care as a service type within the subacute rehabilitation output funding model. Clients that are accepted for a trial of subacute rehabilitation on the basis that they may recover slowly, should have periodic reviews of their rehabilitation goals and FIM scores measured, to ensure that early discharge planning for relocation to alternative to home accommodation is undertaken when function does not improve against benchmark LOS and FIM scores. This will ensure that these admissions do not result in prolonged LOS compared with ALOS data for the same impairment class, which may result in a social hiatus for the client, blocking of beds and potential loss of funding on a cost weight basis.

6.3 ACCESS TO EQUIPMENT

Access to an appropriate range of equipment and appliances is required while clients are utilising the aged care and rehabilitation services. The provider will ensure that the purchase of specialised/major equipment items should be supported by demonstrated evidence of clinical effectiveness and safety of the item.

Access to a short term loan pool for equipment and appliances for up to 3 months should be arranged for clients being discharged as an interim solution, while waiting for access to equipment required for the longer term.

6.4 FACILITIES

The facilities and equipment are adequate in terms of space and usefulness to ensure:

- A high quality, safe clinical and accommodation environment for clients and staff.
- Compliance with the guidelines for accreditation as a medical/allied health training placement location.
- Capacity to meet accreditation standards as outlined in the Australian Faculty of Rehabilitation Medicine (AFRM) Accreditation Guidelines for Rehabilitation Facilities, for training in rehabilitation medicine and other relevant accreditation guidelines for teaching of allied health and nursing personnel.

6.5 SUPPORT SERVICES

Access to the following support services will be provided:

- Radiology services
- Pathology
- Pharmacy
- Supplies and equipment – including prostheses, contact lenses, hearing aids, artificial limbs, wheelchairs and other equipment.

Affiliate specific requirement

- Specialised Seating service (OT and bio-medical engineering)

6.6 WORKFORCE INPUTS

The key input is the multi-disciplinary team. This team will include:

- Rehabilitation Specialist and/or Geriatrician
- Non-Specialist Medical staff (accredited Rehabilitation Registrars or Resident Medical Officers (RMOs). May include Junior Medical Officers (JMOs).
- Allied health professionals (including physiotherapist, Occupational Therapists, Speech Pathologist, Social Workers, clinical psychologist, neuropsychologist).
- Nursing staff including specialist rehabilitation nurses.

- Dieticians and pharmacists will be available to assist the multi-disciplinary team to provide input. Nominated staff from other disciplines should be available when required.
  - Podiatry
  - Orthotics
  - Audiology
  - Optometry
  - Interpreter services
  - Recreational Therapy

- The services of a neuropsychologist are available in services where clients with brain impairment are managed.
- Clinical psychologists are employed in all units where clients with complex behavioural issues are treated and where adjustment to the disability may be an issue.
- Liaison with prosthetists who are able to provide a comprehensive prosthetic service.

7 SERVICE LINKAGES

Services should be well coordinated with other government, non-government and community services as well as being well known to local providers and people.

The Service is required to demonstrate formal and strategic links with:

- Medical and surgical services at acute facilities within the Area
- Local Aged Care and Assessment team (ACAT)
- GPs
- Acute Post Acute Care (APAC)
- Home nursing services
- Community based services including Transitional Aged Care and HACC programs.
- Department of Aging Disability and Home Care (DADHC) relevant regional office
- Vocational rehabilitation services
- Residential aged care providers
- Client /Carer Support Networks, services
- Consumer advocacy services
- Home support care providers
- Equipment management service e.g. PADP
- Amputee Clinics conducted under the NSW Artificial Limb Scheme

8 QUALITY REQUIREMENTS

- Quality requirement as outlined in the Part 1: Head Agreement
- Quality requirements as outlined in Section 6.1 of this service specification.

In addition the service will

- Records rehabilitation outcome data on all clients and contribute to a national database such as the Australasian Rehabilitation Outcomes Centre (AROC)
- Regularly document the Australian Faculty of Rehabilitation Medicine Clinical Indicators.
- Comply with the Australasian Rehabilitation Nurses Association Standards

9 SERVICE UNITS

Service	Service Unit	Service Unit Definition
Inpatient	Cost weighted activity	Cost weights represent the relative value of classes within a classification (in this case it is the SNAP classification). The Rehabilitation and Extended Care Peer Reference Cost is given a value of 1, which represents the average cost of care across all classes. Values within the class are then expressed relative to the base value. E.g. a cost weight of 1.89 means that the particular class of patient is 89% more costly on average than the base cost.
Outpatient clinics Day Therapy Home Based	**2009/10** Negotiated Price **2010/11** NAPOOS or number of clients	In 2009/10 the funding provided for outpatient clinics will be a result of negotiation between NSCCAHS and the service provider. Negotiations will be based any historical amounts provided for the service (where this information is

Rehabilitation		available) and the service providers costs of providing the service. In future years an output measure as negotiated between the service provider and NSCCAHS will be used.

10 GLOSSARY

Debility – is a health and recent illness related functional limitation not specifically assignable to any other condition.

11 REPORTING REQUIREMENTS

Reporting requirements and the mechanism for reporting are outlined below. Where reports are required quarterly, results will be shown by month. The reporting periods for quarterly reports is July to September, October to December, January to March, April to June. The quarterly report will be provided on the 20th of the month following the last month of the reporting quarter.

Area Performance Unit will be the central point for receiving reports prepared by the Third .The role of the APU will be to coordinate the flow of information to the relevant clinical area of responsibility within the Area Health Service. For rehabilitation Services this will be the Aged Care and Rehabilitation Network.

Service Schedule – Sub-acute Aged Care and Rehabilitation Service Version 4.0

Service	Frequency and Reporting Mechanism	Reporting Requirements	Benchmark or Target
Inpatient	Quarterly Reports prepared by APU from DOHRS, SNAPshot Plus and HIE	• Available beds • Occupancy rate • ALOS • SNAP Case Weighted Separations	• Target beds – 34 • Target occupancy = 90% • Case weighted Separations (CWS) negotiated annually as per Funding Agreement.
Inpatient	Quarterly Reports provided by service provider	• Number of clients referred • Number of inappropriate referrals to inpatient rehabilitation program. • Average waiting time from "ready for rehab" to admission. • Number of clients exceeding AN-SNAP classification LOS. • Number of clients waiting for nursing home placement.	• 2009/10 is the first year that these indicators will be collected/reported. • Baseline and targets to be established for 2010-11 and 2011-12 financial year.
Inpatient	ACHS Rehabilitation Clinical indicator set 6 monthly	• Percentage of episodes with assessment completed within 72 hours of admission • Percentage of episodes with assessment completed (within 72 hours) prior to discharge • Percentage of episodes with multi disciplinary rehab plan completed within 7 days of admission • Percentage of episodes with a discharge plan prior to separation • Percentage of episodes where clients achieved functional gain • Percentage of episodes where clients discharge to pre hospital or more independent type of accommodation.	• All indicator results at or above level of ACHS benchmark group
Outpatient Clinics	Reports prepared by NSCCAHS APU quarterly	• NAPOOS	• 2008-09 baseline, thereafter determined by NSW Health Episode Funding policy.
Home Based Rehabilitation	Report prepared by APU quarterly	• NAPOOS	• 2008-09 baseline, thereafter determined by NSW Health Episode Funding Policy.

Service	Frequency and Reporting Mechanism	Reporting Requirements	Benchmark or Target
	Report prepared by Service provider quarterly	• Percentage of clients contacted and commenced with the service and assessment arranged within two working days of receipt of referral.	• Clients will be contacted and commenced within the service and have first assessment arranged within two working days following receipt of referral.

File No: NSCC/09/9666

PART 2 – SERVICE SCHEDULES

This Part 2 contains each of the Service Schedules listed in the Head Agreement (Agreement Summary).

Each of the Service Schedules in Part 2 form part of the Agreement between Northern Sydney Central Coast Area Health Service and Royal Rehabilitation Centre Sydney, as defined in the Head Agreement or in a subsequent variation of the Head Agreement, as applicable.

Each Service Schedule contains the following:

Section A Service Specific Terms and Conditions

Section B Provider Specific Terms and Conditions

B.1 Service Provider Details

B.2 Details of the service units which apply

Section C Service Specification

The **Service Specific Terms and Conditions** set out the terms and conditions (if any) that are not outlined in the Head Agreement that may apply to the specific type of service being purchased e.g. state-wide services.

The **Provider Specific Terms and Conditions** detail those elements of the Agreement that are unique to Royal Rehabilitation Centre Sydney. These include organisational details, period of agreement and a full list of relevant service units, volumes and price.

Service Specifications describe the service, and set out quality and information reporting requirements additional to those specified in Part 1 (the Head Agreement). Note that standard service descriptions may contain details (particularly purchase units and reporting requirements) which do not apply to all agreements.

Table of Contents

SECTION A: SERVICE SPECIFIC TERMS AND CONDITIONS

Service Delivery

Royal Rehabilitation Centre Sydney (RRCS) will ensure that brain injury rehabilitation services are delivered in accordance with the agreed State wide models of care and the specified service volumes outlined in Section B.

Changes will not be made to specified volumes (in particular bed numbers) in the absence of approval by Northern Sydney Central Coast Area Health Service (NSCCAHS).

Reporting Requirements

RRCS is required to report to NSCCAHS in accordance with requirements outlined in the Head Agreement (as they apply to Brain Injury Rehabilitation Services) and requirements outlined in the Brain Injury Rehabilitation Service Specification – Section C.

Service Planning

It is expected that RRCS will actively participate in the Aged Care and Rehabilitation Services Network (includes specialised rehabilitation services). Many of the Service components outlined in Section 6 of the Service Specification below will be subject to review, evaluation, and re-orientation by the Network, in light of activity/throughput, changes to best clinical practice standards and emerging models of care.

Performance Review

The Forum for formal review of reports against indicators outlined in Section 11 of the Service Specification will take place in line with the Performance Management Framework in Part 1 – Head Agreement.

SECTION B: PROVIDERS SPECIFIC TERMS AND CONDITIONS

Provider Details

Provider Name	**Royal Rehabilitation Centre Sydney**
Agreement Commencement Date	**1 July 2010**
Agreement End Date	**30 June 2011**

Details of all Service Units which apply to this Service Schedule

SERVICE UNIT	VOLUME	UNIT PRICE	TOTAL SERVICE PRICE 2009-2010
Inpatient Brain Injury Rehabilitation	337 (cost weights)	$12,782	$4,307,640
		Negotiated top up funds[1]	$1,022,364
Community Brain Injury Rehabilitation Community Team (BIRCT). **GMTT funded**[2]	TBD	GMTT	$692,660
Community Brain Injury Rehabilitation Community Team)	TBD	Negotiated top up	$604,299
Total Brain Injury Rehabilitation			**$6,626,963**

[1] The price for inpatient brain injury services is based on a higher unit price of $15,816 due to the specialist nature of these services. Top up funding represents the difference between the higher unit price of $15,816 and the unit price of $12,782 determined by NSCCAHS for RRCS's sub-acute services.

[2] The Greater Metropolitan Transition Taskforce (GMTT) component of funding in the table above refers to specific State-wide funding for the Brain Injury Service. All other funds in the table above are sourced from NSCCAHS General Funds.

SECTION C: SERVICE SPECIFICATION STATE-WIDE BRAIN INJURY REHABILITATION

1 PRINCIPLES

To provide both inpatient and community based multidisciplinary brain injury rehabilitation services. This may include case management, health education, support services and community skills development. Participants may include clients with traumatic brain injury, and the clinicians and carers who support them in the community.

2 DEFINITIONS AND ACRONYMS

Acquired Brain Injury (ABI)

" injury to the brain, which results in deterioration in cognitive, physical, emotional or independent functioning. ABI can occur as a result of trauma, hypoxia, infection, substance abuse, degenerative neurological diseases or stroke. These impairments to cognitive abilities or physical functioning may be either temporary or permanent and cause partial or total disability or psychosocial maladjustment".

Traumatic Brain Injury (TBI)

"An acquired brain injury occurring as a result of cerebral trauma. Causes of traumatic injury include; external events such as motor vehicle accidents, falls, assaults, sporting accidents or blows to the head".

Non Traumatic Brain Injury – is caused by internal events such as a stroke, lack of oxygen to the brain resulting from ruptured or blocked blood vessels in the brain, brain tumors, poisoning or infections.

NSW Brain Injury Rehabilitation Service (NSW BIRS): a network of services across NSW providing a combination of inpatient, outpatient and community rehabilitation to people who have sustained traumatic brain injury, as well as some other acquired brain injuries.

AROC: Australasian Rehabilitation Outcomes Centre

BIRCT – Brain Injury Community Rehabilitation Team

GMCT – Greater Metropolitan Clinical Taskforce

GMTT – Greater Metropolitan Transition Taskforce

3 SERVICE OBJECTIVES

- To provide high quality, cost effective inpatient rehabilitation to clients residing within NSW, as deemed appropriate by the established entry criteria for clients with a traumatic brain injury.
- To deliver multidisciplinary rehabilitation through an individual, client focused rehabilitation program.
- To promote health and well being for people with TBI living in the community.
- To minimise negative health events and the impact on the individual.

- To provide education and resources for clinicians, clients and carers.
- To provide support to people with TBI in the transition from hospital to home.
- To contribute to strategies to prevent TBI and the effects on individuals and their carers.

4 SERVICE USERS

4.1 INCLUSIONS

- The client groups for inclusion in the service are: individuals over the age of 16 years and under the age of 65 years, of working age, and who have sustained a brain injury as a result of a trauma.
- Clients with non traumatic brain injuries (e.g. hypoxic brain injuries) are considered on a case by case basis, depending on the ability of the service to contribute to the individual's rehabilitation and acknowledging prevailing demand.
- Service users of the Brain Injury Rehabilitation Service include: clinicians (general practitioners, physicians, nursing and allied health staff), care agencies, other support services in the community and hospitals who look after or provide services to people with TBI.

4.2 EXCLUSIONS

- Some clients with non traumatic brain injury. These clients are accepted on a case by case basis depending on factors such as: availability of resources, lack of alternative appropriate services and whether or not rehabilitation need is consistent with staff expertise of the unit.
- Those with psychological, psychiatric and/or cognitive impairment that has been assessed as precluding the individual from appropriate participation in the rehabilitation program.
- Absence of rehabilitation goals.
- Absence of consent to participate in a rehabilitation program.
- Individuals with extreme behaviour disturbance or unstable psychiatric condition.

5 ACCESS

5.1 ENTRY CRITERIA

Inpatient:

- Resides within the stated geographical catchment area; and
- Specific and achievable rehabilitation goals are identified; and
- Assessment has determined that the client would demonstrate rehabilitation gains from admission to the program; and
- Individual is medically and psychiatrically stable; and
- Pre morbidly, cognitively able to actively participate in a rehabilitation program; and
- Discharge destination identified; and
- 16 years to 65 years and of working age

BICRT:

- Clients transitioning from inpatient care requiring ongoing multi disciplinary rehabilitation and where appropriate case management services to assist with community integration support; and
- Resides within the stated geographical catchment area; and
- Pre morbidly, cognitively able to actively participate in a rehabilitation program; and
- Specific and achievable rehabilitation goals are identified; and
- Assessment has determined that the client would demonstrate rehabilitation gains from admission to the program; and
- 16 years to 65 years and of working age

5.2 EXIT CRITERIA

Inpatient:

- Identified acute rehabilitation goals have been met; or
- Appropriate level of functioning has been achieved within the allocated LOS for impairment code; or
- Individual demonstrates non compliance with rehabilitation program; or
- Individual requests discharge from rehabilitation program; and
- Appropriate support services have been arranged and follow-up referrals have been made; and
- Individual has a safe and appropriate discharge destination and social situation to be discharged to

BICRT:

- Identified rehabilitation goals have been met; or
- Appropriate level of functioning has been achieved within a reasonable time frame considering the impairment; and
- Therapy, case management and support, as determined by BICRT is no longer required; or
- Individual demonstrates non compliance with rehabilitation program; or
- Client has relocated out of the demographic area; or
- Client has been referred to another rehabilitation or support service.

5.3 ACCESS/ REFERRAL CATCHMENT

Inpatient Unit:

The Inpatient Unit will serve the population in the catchment area defined below:

- Northern Sydney Area Health Service including former Central Coast Area Health Service
- Central Sydney part of the new amalgamated Sydney West Area Health Service
- Eastern parts of South Eastern Sydney and Illawarra Area Health Services
- Hunter New England Area Health Service
- North Coast Area Health Service

Referrals to this service can be from:

- Clients from acute public and private hospitals who reside in NSW
- Rehabilitation Specialists
- Medical Practitioners

BIRCT:

The Community Team will serve the population in the catchment area defined below:

- Northern Sydney Central Coast Area Health Service (note: the Hunter Brain Injury Rehabilitation Program – BIRP, includes Central Coast residents. Residents on the Central Coast hence access either team depending on their location).
- Parts of Central Sydney and the eastern parts of South Eastern Sydney Illawarra Area Health Service.

Referrals to this service can be from:

- GPs, rehabilitation and medical specialists, nursing and allied health practitioners and carers can refer to this service. All referrals need to be accompanied by a doctors referral. Referral sources include:
- Brain injury units in NSW: ROYAL REHAB, Liverpool Hospital, Westmead Hospital
- Public and private hospitals within NSW
- Community services across NSW such as vocational providers and community health organisations.

6 SERVICE COMPONENTS

6.1 PROCESSES

Service Component	Description
Referral management	***Inpatient*** The Service Provider will: • Assess referrals to ensure clients meet entry criteria. • Operate an effective and efficient system to receive and prioritise all referrals into the service. • Demonstrate effective communication between acute care services and inpatient rehabilitation, and inpatient rehabilitation and outreach services, to ensure that referrals are timely and appropriate for those requiring such services e.g. regular case conferencing
	Brain Injury Community Team (BICRT) • The Clinical Operations Manager for BIRCT accepts or declines referrals at the BIRCT case conference. • Clients accepted to the BIRCT are allocated to an appropriate clinical manager • All associated agencies involved are informed regarding the involvement of the BICRT
Initial Assessment	The Service Provider will: • Complete a comprehensive multidisciplinary functional and psychosocial assessment on admission to the inpatient service. • Perform comprehensive assessment for all clients in their place of residence or community setting. Goals and health interventions are identified and communicated to the team.
Provision of Care	The Service Provider will: ***Across all setting:*** • Provide multi-disciplinary rehabilitation in the most appropriate setting

Service Component	Description
	for the client. • Ensure the focus of care is on optimal achievement of realistic functional and lifestyle goals. • Ensure care is delivered through multidisciplinary interventions, and client and carer education. ***Inpatient:*** • Provide a program that includes: comprehensive assessment, PTA and transitional programs (Newhaven), weekly multidisciplinary case conferencing, behaviour management, family conferencing, client goal setting, progress evaluation, community access and discharge planning. • Develop a goal orientated plan that is linked to timeframes and developed in consultation with the client and family/caregiver. • Carry out systematic reassessment of a clients progress within the timeframes set out in the service standards (e.g. rehabilitation medicine clinical indicators). • Adjust the rehabilitation program to maximise positive outcomes and in accordance with the client's response and achievement of clinical or functional benefit. ***BICRT:*** • Provide allied health and case management to clients of the service as deemed appropriate. • Support community services in problem solving regarding care issues in the community. • Ensure goal planning is completed and co-ordinated to achieve outcomes. • Ensure case conference goals are reviewed. • Ensure discharge documentation attended.
Discharge Planning and follow-up	The Service Provider will: • Ensure that early and comprehensive discharge planning is undertaken. • Plan discharge in consultation with the client, carer/family and agencies as appropriate. A provisional discharge date is allocated relating to AN-SNAP classification. • Ensure referrals are made to appropriate community and other services prior to discharge such as BIRCT. • Provide multi-disciplinary discharge information to general practitioners and other post discharge service providers. • Ensure that transition of responsibility for the client management to other providers has been confirmed and is coordinated. • Follow up 4-6 weeks post discharge from inpatient facility by rehabilitation specialist; regional GP or BICRT as appropriate.
Access to Specialised assessment and management services	Specialised assessments include: • Equipment prescription • Home modifications • Seating services • Behaviour management • Assessment of specialised equipment needs • Assessment of technology needs • Assessment of psychosocial support requirements • Specialised rehabilitation nursing assessments • Continence management • Wound management

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Service Component	Description
	• Sexuality assessments • CNC Brain Injury and Rehabilitation consults for complex issues
Education	The Service will be a source of: • Training for clients and carers in the use and application of equipment to maximise independence. • Client self care and carer education to optimise functional level, prevent deterioration, and maximise self management e.g. training on incorporating exercises and functional skills into all daily living activities; medication administration; services available in the community and access to ongoing support for carers. • Outreach education and consultation to secondary care facilities, GP's, community allied health professionals, residential care facilities, community support teams, family/ carers etc as it relates to individual client needs.
Clinical teaching and Research	The Service will: • Institute and support clinically based research • Maintain awareness of evidence • Implement clinical practice on the basis of evidence • Maintain education and research activities, that meet the requirements for accreditation as an approved placement for the ARFM Training Program, for advanced trainees in rehabilitation and for allied health and nursing programs. • Maintain a research profile and report on the provider's research activity funded by NSW Health funding streams.
Quality	The Service provider will: • Maintain accreditation status in accordance with the ACHS standards and timetables. • Support adoption of evidence based clinical practices. • Maintain quality of care to clients and maximise client outcomes through continuing education programs and adoption of evidence based best practice guidelines for care. • Comply with mandatory data collection policies and protocols required by the NSW Department of Health, NSCCAHS and other funding bodies in relation to patient clinical records, clinical documentation, casemix recording and reporting, privacy and confidentiality of client records. • Participate in service review and evaluation activities to facilitate internal and external service planning evaluation, risk management programs, quality improvement and accreditation activities. For example: participation in strategic service planning through the ACR Network; on-going review of patient outcomes including measurement of functional independence measure (FIM) scores at client level. • Undertake analysis and review of AN-SNAP data, noting Average LOS per impairment class and other KPIs to support the development of output based funding scenarios. • Undertake patient satisfaction survey's and report feedback from patient satisfaction survey's to the Area Performance Unit and other Area governance committees as required from time to time. • Participate in the OH&S Numerical Profile assessment periodically.

6.2 SETTINGS

Service Type	Service Definition
Direct Care Inpatient	Components of Specialist Brain Injury Rehabilitation Service delivered in a sub-acute inpatient setting will have as a minimum: • Access to appropriate nursing care 24hrs/day, 7 days/week with an appropriate skill mix across all shifts • Registrar/CMO cover during business hours with on-call access after hours 24hrs/day, 7 days/week. • Comprehensive multi-disciplinary assessment, ongoing functional assessment, case management, clinical care co-ordination. • Discharge is planned in advance and will occur when rehabilitation goals have been met to a sufficient level as measured by FIM score, and appropriate environmental supports are in place to enable safe return to home or appropriate other residential setting. • Clients are admitted under the care of a rehabilitation specialist. The components of the service are delivered in a purpose-designed 16 bed inpatient facility encompassing secure beds for clients in PTA, ward beds, and transitional living.
Outpatient	• Delivered at a hospital clinic 4-6 weeks following discharge as an inpatient. • Clients are reviewed by the rehabilitation specialist and members of the multidisciplinary team as appropriate. Clinics are provided at RRCS, Royal North Shore Hospital and other centres as dictated by demand and as negotiated with appropriate services (currently, St Vincent's Hospital, Darlinghurst; Community Health Clinic, Erina & Port Macquarie). • Activity will be recorded using the NSW Health Non-Admitted Patient Activity (NAPOOS) definitions as outlined in the DOHRS Data Collection Guidelines Chapter 5. •
Community	• Services are provided to people in their own homes or community settings by allied health, nursing and medical staff who are members of the BIRCT. This component of service commonly comprises of visits by nursing and allied health staff, including the rehabilitation case manager, who works directly with the client to facilitate the rehabilitation goals. • Initial focus of team intervention will include assistance and support for the transition from hospital to home and will include multi-disciplinary assessment and the development of a comprehensive rehabilitation plan. • Following development of this plan the focus of therapy may include: establishing self directed therapy and maintenance programs; training in compensatory strategies to allow optimal function in the community; behaviour management; support for vocational rehabilitation programs; and training and support for community carers and other stakeholders. • Frequency of therapy and duration is related to requirements to address goals and may vary with different phases of rehabilitation. • Rehabilitation may be episodic as a client's rehabilitation needs change or as new goals are identified. Progress is regularly reviewed and goals renegotiated between the client and the treating team. Home visits and therapy sessions are scheduled between the client and therapist depending on the identified goals and intensity of the program. • Activity will be recorded using the NSW Health Non-Admitted Patient Activity (NAPOOS) definitions as outlined in the DOHRS Data Collection Guidelines Chapter 5.

6.3 ACCESS TO EQUIPMENT

Access to an appropriate range of equipment and appliances is required while patients are utilising the brain injury rehabilitation services. The provider will ensure that the purchase of specialised/major equipment items should be supported by demonstrated evidence of clinical effectiveness and safety of the item.

Access to a short term loan pool for equipment and appliances should be arranged for clients being discharged from the inpatient facility for up to three months, as an interim solution while waiting for access to equipment required for the longer term.

Clients under the care of BICRT have access to GMCT funded loan equipment.

6.4 FACILITIES

The facilities and equipment are adequate in terms of space and usefulness to ensure:

- a high quality, safe clinical and accommodation environment for clients and staff.
- compliance with the guidelines for accreditation as a medical/allied health training placement location.
- Capacity to meet accreditation standards as outlined in the Australian Faculty of Rehabilitation Medicine (AFRM) Accreditation Guidelines; for Rehabilitation Facilities, for training in rehabilitation medicine, and other relevant accreditation guidelines for teaching of allied health and nursing personnel.

Inpatient and outpatient facilities must have appropriate physical access for people with disabilities and appropriate areas for rehabilitation activities (e.g. physiotherapy gymnasium, occupational therapy assessment areas, hydrotherapy etc).

Facilities for inpatient and outpatient services include:

- Secure area for clients in PTA (post traumatic amnesia).
- Shared and single room accommodation. Single room accommodation allocated according to clinical need or health fund contribution.
- Flexible accommodation, low dependency area with supervised cooking and meal preparation facilities.
- Private phone and television available for additional charge to client.
- Separate physiotherapy and occupation therapy gyms.
- Hydrotherapy pool
- Recreation room
- Kiosk

6.5 SUPPORT SERVICES

CRS Australia for vocational assessment
Homecare
Private carer agencies
New Horizons
Headway
Head East
Brain Injury Associations

6.6 SUPPORT SERVICES (PROVIDED BY RRCS)

Addition supports for inpatient and outpatients include:

- Pathology – PaLMS
- Radiology including mobile facility
- Clinical pharmacy service and dispensary
- Nursing clinical consultancies: wound, continence, sexuality, behaviour management
- Chaplaincy
- Seating Service
- Wheelchair Maintenance

6.7 SUPPORT SERVICES (PROVIDED BY NSCCAHS)

- Access to Outpatient Departments, dental and acute inpatient services
- Liaison Mental Health with a Memorandum of Understanding, mental health inpatient management for scheduled clients, community mental health.
- Drug and alcohol liaison

7 SERVICE LINKAGES

- Brain Injury units at Liverpool, Westmead, RNS and ROYAL REHAB
- Brain Injury Rehabilitation Program centres especially at Hunter, Tamworth, North Coast Head Injury Service (Port Macquarie, Coffs Harbour, Lismore)
- Acute Neurosurgical Units (especially Royal North Shore Hospital, Royal Prince Alfred Hospital, St Vincent's Hospital, Prince of Wales Hospital)
- Brain Injury Association NSW
- GMCT Brain Injury Directorate

8 QUALITY REQUIREMENTS

8.1 GENERAL

- Quality requirement as outlined in the Part 1: Head Agreement
- Quality requirements as outlined in Section 6.1 of this service specification.

In addition the service will

- Records rehabilitation outcome data on all clients and contribute to a national database such as the Australasian Rehabilitation Outcomes Centre (AROC)
- Regularly document the Australian Faculty of Rehabilitation Medicine Clinical Indicators.
- Comply with the Australasian Rehabilitation Nurses Association Standards

9 SERVICE UNITS

Service	Service Unit	Service Unit Definition
Inpatient	Cost weighted activity	Cost weights represent the relative value of classes within a classification (in this case it is the SNAP classification). The Rehabilitation and Extended Care Peer Reference Cost is given a value of 1, which represents the average cost of care across all classes. Values within the class are then expressed relative to the base value. E.g. a cost weight of 1.89 means that

Service	Service Unit	Service Unit Definition
		the particular class of patient is 89% more costly on average than the base cost
Outpatient clinics; Brain Injury Rehabilitation Community Team	**2009/10** Negotiated Price **2010/11 and 2011/12** NAPOOS or Number of clients	In 2009-10 the funding provided for outpatient clinics and the BIRCT will be a result of negotiation between NSCCAHS and the RRCS. Negotiations will be based any historical amounts provided for the service (where this information is available) and the service providers costs of providing the service. In future years an output measure as negotiated between the service provider and NSCCAHS will be used. Note: Funding from GMCT will not be affected.

10 REPORTING REQUIREMENTS

Reporting requirements and the mechanism for reporting are outlined below. Where reports are required quarterly, results will be shown by month. The reporting periods for quarterly reports is July to September, October to December, January to March, April to June. The quarterly report will be provided on the 20th of the month following the last month of the reporting quarter.

Area Performance Unit (APU) will be the central point for receiving reports prepared by the Affiliate Health Organisation. The role of the APU will be to coordinate the flow of information to the relevant clinical area of responsibility within the Area Health Service.

Service	Frequency and Reporting Mechanism	Reporting Requirements/ Performance Indicators	Benchmark or Target
Inpatient	Quarterly Activity reports prepared by NSCCAHS, APU	• Available beds • Occupancy rate • ALOS • SNAP Case Weighted Separations (CWS)	• Target beds:16 • Target occupancy: 90% • CWS negotiated annually as per Funding Agreement

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Service	Frequency and Reporting Mechanism	Reporting Requirements/ Performance Indicators	Benchmark or Target
Inpatient	6 monthly ACHS indicators Reports provided by RRCS to NSCCAHS	• Percentage of episodes with assessment completed within 72 hours of admission. • Percentage of episodes with assessment completed prior to discharge. • Percentage of episodes with multi disciplinary rehab plan completed within 7 days of admission. • Percentage of episodes with a discharge plan prior to separation. • Percentage of episodes where clients achieved functional gain. • Percentage of episodes where clients discharge to pre hospital accommodation or more independent type of accommodation.	All indicator results at or below level of ACHS benchmark group
Inpatient	Quarterly Reports provided by RRCS	• Days from referral to admission	2010-11 is the first year that this will be collected/ reported. Baseline and targets to be established for 2011-12
Outpatient and Community (BIRCT)	Quarterly Reports provided NSCCAHS APU	• NAPOOS	2008-09 baseline, thereafter determined by NSW Health Episode Funding policy

File No: NSCC/09/9664

PART 2 – SERVICE SCHEDULES

Version 3.0

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The **Service Specific Terms and Conditions** set out the terms and conditions (if any) that are not outlined in the Head Agreement that may apply to the specific type of service being purchased e.g. state-wide services.

The **Provider Specific Terms and Conditions** detail those elements of the Agreement that are unique to Royal Rehabilitation Centre Sydney. These include organisational details, period of agreement and a full list of relevant service units, volumes and price.

Service Specifications describe the service, and set out quality and information reporting requirements additional to those specified in Part 1 (the Head Agreement). Note that standard service descriptions may contain details (particularly purchase units and reporting requirements) which do not apply to all agreements.

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SECTION A: SERVICE SPECIFIC TERMS AND CONDITIONS

Service Delivery

Royal Rehabilitation Centre Sydney will ensure that rehabilitation services are delivered in accordance with the agreed Area wide model of care and the specified service volumes outlined in Section B.

Changes will not be made to specified volumes (in particular bed numbers) in the absence of approval by Northern Sydney Central Coast Area Health Service (NSCCAHS). No change will be considered for approval in the absence of a business case providing detail in relation to the proposed change, evidence base for the proposal and impacts (e.g. health, cost efficiency, access).

Reporting Requirements

Royal Rehabilitation Centre Sydney (RRCS) is required to report to the Area Health Service in accordance with requirements outlined in the Head Agreement (as they apply to Sub-acute Spinal injury Services) and requirements outlined in the State-wide Spinal Cord Injury Service Specification – Section C.

Service Planning

It is expected that RRCS will actively participate in the Aged Care and Rehabilitation Services Network (includes specialised rehabilitation services). Many of the service components outlined in Section 6 of the service specification below will be subject to review, evaluation, and re-orientation by the Network, in light of activity/throughput, changes to best clinical practice standards and emerging models of care

Performance Review

The Forum for formal review of reports against indicators outlined in Section 11 of the Service Specification will take place in line with the Performance Management Framework in Part 1 – Head Agreement.

SECTION B: PROVIDER SPECIFIC TERMS AND CONDITIONS

Provider Details

Provider Name	**Royal Rehabilitation Centre Sydney**
Agreement Commencement Date	**1 July 2010**
Agreement End Date	**30 June 2011**

Details of all Service Units which apply to this Service Schedule

SERVICE UNIT	SERVICE MEASURE	VOLUME	UNIT PRICE	TOTAL PRICE
Inpatient Spinal Injury Rehabilitation (18 beds)	Cost Weights	432	$12,782	$5,521,892
			Negotiated top up funds[1]	$887,648
			GMTT	$196,498[2]
Inpatient Spinal Injury Rehabilitation (2 beds)	Cost Weights	48	$12,782	$613,551
			Negotiated Top up	$98,628
Community Spinal Outreach Service	To Be Determined (TBD)	TBD	GMTT	$896,528
Community Rural Spinal Cord Injury Service	TBD	TBD	GMTT determined	$763,418
Total Spinal Cord Injury Rehabilitation				**$8,978,163**

[1] Price for inpatient spinal services is based on a higher unit price of $14,837 due to the specialist nature of these services. Top up funding represents the difference between the higher unit price of $14,837 and the unit price of $12,782 determined by NSCCAHS for RRCS's sub-acute services.

[2] The Greater Metropolitan Transition Taskforce (GMTT) component of funding in the table above refers to specific State-wide funding for the Spinal Injury Service. All other funds in the table above are sourced from NSCCAHS General Funds.

SECTION C: SERVICE SPECIFICATION SPINAL INJURY REHABILITATION

1 PRINCIPLES

Service will be based on the Principles as outlined in the NSW Health Model of Care for Spinal Cord Injury when finalised.

2 DEFINITIONS

Rehabilitation aims to assist people to recover function or abilities to achieve the highest possible level of independence following the recent onset of disease or injury. This is achieved through a goal directed, multidisciplinary approach involving medical, nursing and allied health staff. It involves: individual assessment, treatment, regular review, discharge planning, and community integration and follow up of people referred to that service.

Specialist Rehabilitation Medicine Service will include all of the following characteristics.

- A Rehabilitation physician directs the program/service and each patient's clinical management is under the supervision of a rehabilitation physician.
- There are clear, written criteria for admission to inpatient and outpatient services.
- Services provided are: multidisciplinary, coordinated, demonstrate integration with external agencies/ services, and are supported by appropriately qualified and experienced professional staff and resources commensurate with the rehabilitation program objectives.
- Treatment modalities for client's are individualised and documented at initial and periodic assessments of functional ability.
- The client's program pursues negotiated rehabilitation goals within appropriate timeframes.
- There is a formal planned discharge procedure and liaison with other agencies to ensure continuity with community services.
- There is continual evaluation of the service and its outcomes.

State Spinal Cord Injury Service (SSCIS)

Background

The SSCIS was established in October 2002 in response to the recommendations of the Greater Metropolitan Services Implementations Group (GMSIG) to the Minister for Health, that the existing adult and paediatric services become part of a state-wide service.

The SSCIS comprises the spinal cord injury units of Royal North Shore Hospital (RNSH), Prince of Wales Hospital (POWH) and the Royal Rehabilitation Centre Sydney (RRCS), the SSCIS Directorate and the SSCIS Spinal Outreach Service
The SSCIS Directorate is comprised of a Director and a Manager and is one of the clinical networks of the Greater Metropolitan Clinical Taskforce.

The principle role of the SSCIS Directorate in partnership with clinicians and other stakeholders is the coordination and provision of services across NSW, for people who have acquired a persistent spinal cord injury (SCI), with evidence of damage to the neural tissues, because of trauma or from a non-progressive disease process (e.g. transverse myelitis; compression by infective process; canal stenosis; haemorrhage; or vascular occlusion). Progressive medical conditions such as: demyelinating, congenital and degenerative conditions of the spinal cord, as well as compression by metastatic lesions are not included in the role of the SSCIS.

This definition acknowledges that individual practitioners within the spinal network also contribute their expertise and clinical services to individuals outside the SSCIS scope of service.

The scope of the SSCIS encompasses both traumatic and non-traumatic injuries, which are acquired conditions. An important defining feature for SSCIS is that the condition is both acquired and non-progressive.

Traumatic Spinal Cord Injury – a defining feature of traumatic SCI is that it is caused by a direct or indirect external event (trauma).

Non traumatic Spinal Cord Injury (NTSCI)
A cluster of aetiology most commonly infective, vascular, ischaemic, a form of myelitis, canal stenosis, spinal column degeneration or associated with a medical intervention e.g. surgery. Post surgical / procedure SCI are defined as a NTSCI even though there may be external intervention.

3 SERVICE OBJECTIVES

The objectives of the spinal inpatient, outreach and ambulatory services are:

- To provide high quality, cost effective inpatient rehabilitation to clients residing within NSW as deemed appropriate by the established entry criteria for clients with a spinal cord injury.
- To provide multidisciplinary care through an individually tailored rehabilitation program.
- To promote health and well being for people with SCI living in the community.
- To provide education and resources for clinicians, clients and carers.
- To provide support to people with SCI in the transition from hospital to home.
- To provide resources and education to assist paediatric clients with SCI to transition into adult services.
- To minimise negative health events and the impact on the individual.

4 SERVICE USERS

4.1 INCLUSIONS

Inpatient:

- Individuals over the age of 16 years, residing in the NSW, North of Sydney Harbour who have sustained a spinal cord injury as defined by the State-wide Spinal Cord Injury Service (see above definitions).

Spinal Outreach Service (SOS):

- People with SCI.
- Paediatric SCI clients who are transitioning to adult services.
- Clinicians (including General Practitioners [GPs], physicians, nursing and allied health staff), care agencies and other support services in the community and hospitals who look after or provide services to people with spinal cord injury.

4.2 EXCLUSIONS

Clients with the following conditions/ characteristics are excluded from the service:

- Congenital conditions
- Metastatic spinal tumours
- Progressive or degenerative spinal conditions e.g. Multiple sclerosis

- Those with psychological, psychiatric and or cognitive impairment that has been assessed as precluding the individual from appropriate participation in the rehab program.
- Absence of rehabilitation goals.
- Absence of consent to participate in a rehabilitation program.
- Ventilator Dependent tetraplegics (exclusion from inpatient service only)

Additional exclusions specific to the SOS include:

- Paediatric Clients
- Clients who do not consent to receive the service.
- Clients who have no discharge destination.

5 ACCESS

5.1 ENTRY CRITERIA

Inpatient:

- Clients immediately post acute SCI (from acute units) are priority number 1 in line with the *'SSCIS Referral Guidelines for Adult Patients with Spinal Cord Injury'* (attached).
- Specific and achievable rehabilitation goals are identified; and
- Assessment has determined that the patient would demonstrate rehabilitation gains from admission to the program; and
- The individual has been assessed as having a level of cognitive function that would permit appropriate participation in a program; and
- The individual is medically and psychiatrically stable.

Ambulatory (Spinal Outreach):

- Clients transitioning after an acute injury are priority number 1 as per the *SSCIS Referral Guidelines.*
- Clients with a spinal cord injury:
  - who have been admitted to a spinal cord injury unit, with a new acute SCI or established SCI injury; or
  - who are seen as part of the Rural Spinal Cord Injury Service (RSCIS);or
  - who are part of the paediatric transition program.

5.2 EXIT CRITERIA

Inpatient:

- Identified acute rehabilitation goals have been met; or
- Appropriate level of functioning has been achieved within the allocated LOS for impairment code; or
- Individual demonstrates non compliance with rehabilitation program; or
- Individual requests discharge from rehabilitation program; and
- At discharge the individual has access to an appropriate accommodation and social situation.

Ambulatory (Spinal Outreach Service)

Clients admitted to SOS will generally exit the service at identified points as follows:

- New acute injury — 18 months.
- Established injury – 6 months.
- Clients part of the RSCIS — 3 to 6 months.
- Paediatric transition program — 18 months.

5.3 ACCESS/ REFERRAL CATCHMENT

Inpatient:

- Spinal Injury Inpatient Rehabilitation will serve the population residing within the geographical catchment area of Metropolitan and rural NSW north of Sydney Harbour
- Referral to this service can be from a range of sources including:
  - Acute SCI units within metropolitan Sydney
  - Acute private hospitals within metropolitan Sydney
  - SCI Rehabilitation Specialists
- Priority of access to specialist inpatient SCI rehabilitation will be line with the *'Service priority guide'* outlined in the *SSCIS Referral Guidelines.*
- Clients referred for readmissions from GPs and Community Services will be prioritised in accordance with the *SSCIS Referral Guidelines*.

Ambulatory (Spinal Outreach Service):

- Client's and clinicians who reside in NSW can access the service by telephone.
- Client's will be accepted for individual management when the following conditions apply:
  - Rural: Client's who live outside the Sydney metropolitan region, within NSW can access clinical support via their local rural spinal cord injury co-ordinator, local clinician and/or can attend clinics conducted in regional areas across NSW.
  - Metropolitan: All referrals are received and accepted from the spinal unit at RNSH, Prince of Wales Hospital and Moorong, at Royal Rehabilitation Centre Sydney.
- Priority of access to the SSCIS outreach service will be in line with the admission priority guidelines documented in the for the *SSCIS Referral Guidelines.*

6 SERVICE COMPONENTS

6.1 PROCESS

Service Component	Description
Referral management	***Inpatient*** The service provider will: • Assess referrals to ensure client's meet entry criteria. • Operate an effective and efficient system to receive and prioritise all referrals into the service and ensure that referrals are managed in line with the *SSCIS Referral Guidelines for Adult Patients with Spinal Cord Injury*. • Referrals are initially prioritised in accordance with SSCIS Referral Guidelines and will also take into consideration, bed availability, time on waiting list, and special conditions such as the requirement for infectious precautions. • Demonstrate effective communication between acute care services and inpatient rehabilitation, and inpatient rehabilitation and outreach services, to ensure that referrals are timely and appropriate for those requiring such services e.g. regular case conferencing.
	Spinal Outreach Service • The SOS representative will accept or decline referrals at the case conference at RNSH, Moorong and POWH • Clients accepted to the SOS are allocated to an appropriate clinical manager at the SOS case conference (weekly). • Referrals are acted upon within 2-4 weeks following discharge from hospital. • All associated agencies involved are informed regarding the involvement of the SOS.
Initial Assessment	The service provider will: • Complete a comprehensive multidisciplinary functional and psychosocial assessment on admission to the inpatient service. • Perform comprehensive assessment for all clients in their place of residence, and goals and health interventions identified and communicated to the team.
Provision of Care	The service provider will: • Provide a multidisciplinary rehabilitation in the most appropriate setting for the client. • Provide a program that includes comprehensive assessment, patient goal setting, case management, clinical care

Service Schedule: Spinal Injury Rehabilitation
Version 3.0

Service Component	Description
	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/care giver and the multi-disciplinary team that is linked to timeframes. • Carry out systematic reassessment of patient's progress within the timeframes set out in service standards (e.g. Rehabilitation Medicine clinical indicators). • Adjust the rehabilitation program 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 care giver or family understand the manner in which the rehabilitation plan will be delivered. • Provide an appropriately qualified multi-disciplinary workforce as outlined in Section 6.7. • Provide an appropriate mechanism to ensure continuity and coordinated care regardless of entry point to the system e.g. case manager, key liaison person. • Ensure formalised protocols and referral processes for assessment of client's with delirium, depression, cognitive impairment, confusion and disturbed behaviours are consistent with the ACR Network endorsed model for the management of dementia and delirium in inpatient settings. • Ensure that early and comprehensive discharge planning is undertaken as per below.
Discharge planning	The Service Provider will: • Commence discharge planning within 48 hours of admission or during goal planning processes. • Plan discharge in consultation with the client, carer/family and agencies as appropriate • Ensure follow up by SOS • Ensure discharge summary / information is provided to GP and ongoing care agencies. Links with appropriate community agencies will be made and discharge documentation forwarded where appropriate.
Access to Specialised Assessment services	Relevant to inpatient and SOS include: • Specialised equipment needs and loan equipment • Home modifications • Specialised seating • Wound management • Assessment of skin and decubitus ulcers • Behaviour management • Continence management • Sexuality assessments • Personal care

Service Schedule: Spinal Injury Rehabilitation
Version 3.0

Service Component	Description
	• Pain management • Assessment of technology needs • Assessment of mobility skills and requirements • Assessment of psychosocial support requirements
Education	The Service will be a source of: • Training for clients and carers in the use and application of equipment to maximise independence. • Client self care and carer education to optimise functional level, prevent deterioration and maximise self management e.g. training on incorporating exercises and functional skills into all daily living activities, medication administration. • Services available in the community, access to ongoing support for carers. • Education and consultation to: secondary care facilities, clinician education (individual and/or group), GPs, community allied health professionals, residential care facilities, community support teams and family/ carers as it relates to individual client needs.

Service Schedule: Spinal Injury Rehabilitation
Version 3.0

Service Component	Description
Quality Improvement and Risk Management	The service provider will: • Maintain accreditation status in accordance with the ACHS Standards and timetables • Support adoption of evidence based clinical practices • Maintain quality of care to clients and maximise client outcomes through continuing education programs and adoption of evidence based best practice guidelines for care. • Comply with mandatory data collection policies and protocols required by the NSW Department of Health, NSCCAHS and other funding bodies in relation to: patient clinical records, clinical documentation, casemix recording and reporting, and privacy and confidentiality of client records • Participate in service review and evaluation activities to facilitate: internal and external service planning evaluation, risk management programs, quality improvement and accreditation activities. For example: participation in strategic service planning through the ACR Network; on-going review of patient outcomes including measurement of Functional Independence Measure (FIM) scores at client level. • Undertake analysis and review of AN-SNAP data, noting Average LOS per impairment class and other KPIs to support the development of output based funding scenarios. • Undertake patient satisfaction survey's and report feedback from patient satisfaction survey's to the APU and other Area governance committees as required from time to time. • Participate in the OH&S Numerical Profile assessment periodically.

6.2 SETTINGS

Service Type	Service Definition
Direct Care Inpatient Rehabilitation	Components of Specialty Spinal Rehabilitation Service delivered in a sub-acute inpatient setting will have as a minimum: • Admission under a Rehabilitation Specialist. • Access to appropriate nursing care 24hrs/day; 7 days/week with an appropriate skill mix across all shifts. • Registrar/CMO cover during business hours with on-call access after hours. • Access to allied health during business hours including: physiotherapy, occupational therapy, speech pathology, dietetics, clinical psychology, social worker and recreational therapy. • A program that includes: holistic assessment, weekly multidisciplinary case conferencing, patient goal setting, progress evaluation, transitional program, community access and discharge planning. • A focus on maximising function, community participation and independent living. • Discharge is planned in advance and will occur when rehabilitation goals have been met to a sufficient level as measured by FIM score, and appropriate environmental supports are in place to enable safe return to home or appropriate other residential setting.

Service Schedule: Spinal Injury Rehabilitation
Version 3.0

Service Type	Service Definition
	• Key issues for discharge planning are: psychological support, personal care, equipment, home modifications, and housing or transition accommodation.
Outpatient Clinic	• A component of specialist rehabilitation delivered at a hospital clinic following discharge as an inpatient. • A staff specialist clinic is held twice weekly and provides medical follow-up for metro, and rural client's as necessary.
Community – Spinal Outreach Service (SOS) and Rural Spinal Cord Injury Service (RSCIS)	• Components of the Specialty Spinal Rehabilitation Service provided to people in their own homes via a multi-disciplinary integrated team comprising: physiotherapists, occupational therapists, nurses, social workers and doctors providing services in metropolitan Sydney (SOS) and rural NSW (RSCIS). • The program has a timeframe dependent on whether or not the patient has a new or established SCI, is part of the paediatric transition program (both 18 months post discharge) or part of the Rural Spinal Cord Injury Service (3-6 months). The model of service delivery varies with the program in the following way. • A home visit to newly injured metropolitan based client's and paediatric transition client's is undertaken to determine the client's needs in relation to health promotion, crisis intervention and community participation. Work is undertaken directly with the client and the generalist clinicians who support the client in the community, to facilitate achievement of health and community participation goals, and competencies in self management. Visits are conducted across metropolitan Sydney in the client's home. The intensity and frequency is determined by the client's needs and will vary over the 18 month period. Direct interventions are provided to the client and consultancy services to clinicians. Clients readmitted to a spinal unit in Sydney are provided with a similar program limited to 6 months post discharge. • Rural client's are offered the opportunity to attend clinics in their area health service on an annual basis. Clinics provided the opportunity for multi-disciplinary expert spinal review conducted by clinicians from the SOS. • The focus is on community reintegration, promotion of health and well-being, education for client's and local primary care team. The objective of the SCI outreach services both rural and metropolitan are to facilitate knowledge and skills transfer so that the patient can independently manage themselves within their own community from a health and community participation perspective.

6.3 ACCESS TO EQUIPMENT AND SUPPLIES

Access to an appropriate range of equipment and appliances is required while client's are utilising the specialist spinal rehabilitation services. The provider will ensure that the purchase of specialised/major equipment items should be supported by demonstrated evidence of clinical effectiveness and safety of the item.

Funding for equipment loan is available through a dedicated pool via the Spinal Outreach Service. Specific criteria insist long term funding options are in place. Funding is available state-wide, providing short-term solutions only to facilitate discharge from hospital and / or minimise the risk for re-hospitalisation.

Small equipment available for loan from equipment pool for short periods following discharge.

6.4 FACILITIES

The facilities and equipment are adequate in terms of space and usefulness to ensure:

- A high quality, safe clinical and accommodation environment for clients and staff.
- Compliance with the guidelines for accreditation as a medical/allied health training placement location.
- Capacity to meet accreditation standards as outlined in the Australian Faculty of Rehabilitation Medicine (AFRM) Accreditation Guidelines for Rehabilitation Facilities, for training in rehabilitation medicine and other relevant accreditation guidelines for teaching of allied health and nursing personnel.

Inpatient and outpatient facilities must have appropriate physical access for people with disabilities and appropriate areas for rehabilitation activities (e.g. physiotherapy gymnasium, occupational therapy assessment areas, hydrotherapy etc).

Facilities for inpatient and outpatient services include:

- Shared and single room accommodation.
- Single room accommodation allocated according to clinical need or health fund contribution.
- Private phone and television available for additional charge to patient
- Physiotherapy and occupational therapy areas
- Hydrotherapy pool
- Recreation room
- Dining room
- Independent living unit
-

SOS

- Provision of services in the patient's home.
- Clinic area available for on site visits with accessible toilet.
- Clinic facilities at local hospitals and community health centres across the state used for rural visits

6.5 SUPPORT SERVICES

Pathology – PaLMS
Radiology including mobile facility
Clinical pharmacy service and dispensary either on or off site
Chaplaincy
Seating Service

Wheelchair Maintenance

The SOS is fully supported by the SSCIS network, which includes access to associated services within the hospital environment.

6.6 SUPPORT SERVICES PROVIDED BY NSCCAHS

Access to outpatient department at RNSH including:
- dental,
- urodynamics,
- SPC clinics.
- Mental Health liaison
- Drug and Alcohol liaison

6.7 KEY INPUTS

The key input is the multi-disciplinary team. This team will include:
- Rehabilitation Specialist
  - Medical staff (accredited Rehabilitation Registrars or Resident Medical Officers (RMOs). May include Junior Medical Officers (JMOs).
  - Allied health professionals (including physiotherapist, Occupational Therapists, Speech Pathologist, Social Workers, clinical psychologist).
  - Nursing staff including specialist rehabilitation nurses.

- Dieticians and pharmacists will be available to assist the multi-disciplinary team to provide input. Nominated staff from other disciplines should be available when required.
  - Podiatry
  - Orthotics
  - Audiology
  - Optometry
  - Interpreter services
  - Recreational Therapy

- The services of a neuropsychologist are available in services where client's with brain impairment are managed.

7 SERVICE LINKAGES

Spinal Cord Injury Association NSW
Spinal Cord Injury Network
Acute Spinal Cord Injury Units
NSW Spinal Social workers network,
NSW Spinal Occupational Therapists focus group
Australian Faculty of Rehabilitation Medicine
Paraquad, PADP, SCIS, SSCIS, Northcott,
Rural networks, GMCT, NSW Health,
Division of GPs
ANZSCOS, TAFE, ANZSCIN
Amputee Clinics conducted under the NSW Artificial Limb Scheme
Department of Aging Disability and Home Care (DADHC)
Vocational rehabilitation services

8 QUALITY REQUIREMENTS

- Quality requirement as outlined in the Part 1: Head Agreement

- Quality requirements as outlined in Section 6.1 of this service specification.

In addition the service will

- Record rehabilitation outcome data on all clients and contribute to a national database such as the Australasian Rehabilitation Outcomes Centre (AROC)
- Regularly document the Australian Faculty of Rehabilitation Medicine Clinical Indicators.
- Comply with the Australasian Rehabilitation Nurses Association Standards

9 SERVICE UNITS

Service	Service Unit	Service Unit Definition
Inpatient	Cost weighted activity	Cost weights represent the relative value of classes within a classification (in this case it is the SNAP classification). The Rehabilitation and Extended Care Peer Reference Cost is given a value of 1, which represents the average cost of care across all classes. Values within the class are then expressed relative to the base value. E.g. a cost weight of 1.89 means that the particular class of patient is 89% more costly on average than the base cost
Outpatient clinics; Spinal Outreach Service; Rural Spinal Outreach Service	**2009/10** Negotiated Price **2010/11 and 2011/12** NAPOOS or Number of clients. Output measure to be negotiated.	In 2009 - 10 the funding provided for outpatient clinics will be a result of negotiation between NSCCAHS and the service provider. Negotiations will be based any historical amounts provided for the service (where this information is available) and the service providers costs of providing the service. In future years an output measure as negotiated between the service provider and NSCCAHS will be used. Note: Funding from GMCT will not be affected.

10 REPORTING REQUIREMENTS

The reporting periods for quarterly reports is July to September, October to December, January to March, April to June. The quarterly report will be provided on the 20th of the month following the last month of the reporting quarter.

Reporting to the SSCIS network quarterly

Service unit measure	Frequency and Reporting mechanism	Reporting requirements	Benchmark or Target
Inpatient (cost weights)	Quarterly Reports prepared by APU from DOHRS, SNAP shot Plus and HIE	• Available beds • Occupancy rate • ALOS • SNAP Case Weighted Separations (CWS)	• Target Beds: 20 • Target Occupancy: 90% • CWS negotiated annually as per funding agreement
Inpatient	Quarterly Reports provided by Service Provider	• Days delay to admission by referral source • Total bed days for client's no longer requiring rehabilitation and awaiting discharge	• 2010/11 is the first year that these indicators will be collected /reported. • Baseline and targets to be established for 2011-12
Inpatient ACHS Clinical indicators.	6 monthly report from AROC	• Percentage of episodes with FIM assessment completed within 72 hours of admission • Percentage of episodes with FIM assessment completed prior to discharge • Percentage of episodes with multi disciplinary rehab plan completed within 7 days of admission • Percentage of episodes with a discharge plan (within 72 hours) prior to separation • Percentage of episodes where clients achieved functional gain • Percentage of episodes where clients discharge to pre hospital or more independent type of accommodation.	• All indicator results at or above level of ACHS benchmark group •
Spinal Outreach Service	Reports prepared by APU	• NAPOOS	2008-09 baseline, thereafter determind by NSW health Episode Funding Policy

11 GLOSSARY

SSCIS- State-wide Spinal Cord Injury Service

RSCIS-Rural Spinal Cord Injury Service

SCIA-Spinal Cord Injuries Australia

File No: NSCC/09/2934

PART 2 SERVICE SCHEDULES

This Part 2 contains each of the Service Schedules listed in the Head Agreement (Agreement Summary).

Each of the Service Schedules in Part 2 form part of the Agreement between Northern Sydney Central Coast Area Health Service and Royal Rehabilitation Centre Sydney, as defined in the Head Agreement or in a subsequent variation of the Head Agreement, as applicable.

Each Service Schedule contains the following:

Section A	Service Specific Terms and Conditions
Section B	Provider Specific Terms and Conditions
B.1	*Service Provider Details*
B.2	*Details of the purchase units which apply*
Section C	Service Specification

The **Service Specific Terms and Conditions** set out the terms and conditions (if any) that are not outlined in the Head Agreement that may apply to the specific type of service being purchased e.g. state-wide services

The **Provider Specific Terms and Conditions** detail those elements of the Agreement that are unique to Royal Rehabilitation Centre Sydney. These include organisational details, period of agreement and a full list of relevant purchase units, volumes and price.

Service Specifications describe the service, and set out quality and information reporting requirements additional to those specified in Part 1 (the Head Agreement). Note that standard service descriptions may contain details (particularly purchase units and reporting requirements) which do not apply to all agreements.

TABLE OF CONTENTS

SECTION A: SERVICE SPECIFIC TERMS AND CONDITIONS

The service provided by Royal Rehabilitation Centre Sydney (RRCS) under this Service Schedule – Extended Care Service, is limited to a specific target group only.

Details of the target group of clients is provided in the Memorandum of Understanding (MOU) between NSW Health, RRCS and Department of Ageing, Disability and Homecare (DADHC) on the 'accommodation, rehabilitation and support arrangements for Weemala clients'. Specifically details are provided in the section 'Phase 1 – Planning for Devolution'. The target group (as at March 2008) consists of:

- 20 long term clients currently residing in Weemala; and
- 5 transition clients

Northern Sydney Central Coast Area Health Service (NSCCAHS) on behalf of the Department of Health under the MOU has committed to provide 'grandparent funding' to support the 20 long term residents of Weemala and the 5 transition clients. The commitment to grandparent fund the transition clients only applies to the transition clients resident at the time the MOU was signed (27 June 2008), and only for those who are unable to transfer to the community.

Since the MOU was signed several transition clients have transferred to the community. As per agreement between NSCCAHS and RRCS, new clients can enter the transition service (to a maximum of 6 places) to reduce the amount of beds vacant and to address access and exit block issues whilst 'Phase 2 – Post Devolution' discussions take place.

NSCCAHS will provide notice to RRCS of one month when it is determined that no further clients are to enter into the transition service. This notice maybe provided at any time regardless of the status of Phase 2 – Post Devolution discussions.

As clients exit the program (decease or transfer to another service provider) funding will be recouped by NSCCAHS on a step cost basis. Agreement on the process for adjustment will be finalised within three months of the commencement of the Performance Agreement and adjustments to funding will be part of the annual review of contracted service levels.

In 2005/2006 the NSCCAHS subsidy (under Health Program 2.9) allocated to Weemala was $2.75 million. This amount supported 42 places in Weemala at that time.

The total amount provided by NSW Health for the grand parented clients will not exceed the current amount allocated for this service, excluding annual CPI adjustments.

SECTION B: PROVIDERS SPECIFIC TERMS AND CONDITIONS

Provider Details

Provider Name	**Royal Rehabilitation Centre Sydney**
Agreement Commencement Date	**1 July 2010**
Agreement End Date	**30 June 2011**

Standard Documentation

It is agreed that Services documented within this schedule will be provided in-line with the standard service specifications included in Section C of this service schedule.

Details of all Service Units which apply to this Service Schedule

Service Unit	Service Measure /s	Volume	Unit Price	Total Price
Inpatient Weemala (transition place)	To be Determined (TBD)	Will be reassessed each year as clients leave the service.	Negotiated Price	$2,942,187
Inpatient Weemala (long term place)	TBD	Will be reassessed each year.	Negotiated Price	

SECTION C: SERVICE SPECIFICATION EXTENDED CARE SERVICE

1 PRINCIPLES

- Extended Care Services are based on the principles underlying the World Health Organisation International Classification of Functioning, Disability and Health (ICF).
- Service provision will include high quality, multi-disciplinary services with emphasis on current best practice standards and long-term duration as required.

Client focussed service delivery

- Service provision will be client focussed and based on the client's assessed needs.
- Models of service delivery will be clearly communicated to clients and their carers and families.
- Carers are recognised as partners in care and consulted where appropriate.
- Services will be provided at the appropriate stages where individual benefits will be maximised.
- Services will be culturally appropriate.
- The interest of the client will be paramount.

Cost effective service delivery

- Service delivery will be based on evidence of best practice.
- Services will be provided whenever possible in settings appropriate to the client, their family and their carer.
- Service delivery models will be responsive to the needs of rural and remote communities.
- Quality services will be provided in line with the recognised standards of professional practice.
- Service providers will build the capacity of families, carers and others (including non-government organisations) to complement their work.

2 DEFINITIONS

Extended Care Service provided by Royal Rehabilitation Centre Sydney (RRCS) is defined as active, extended treatment and rehabilitation that is focused on improvement in activity and participation as well as body structures and function.

3 SERVICE OBJECTIVES

Extended care services aim to support people with life-long disabilities who have high support and chronic complex care needs. This is achieved through the provision of:

- High quality multi-disciplinary support within a rehabilitation framework.
- Client centred and holistic treatment and programmes to maximise social, personal and physical function.
- A long term accommodation setting and planning for long term community care including identification of appropriate community accommodation and community support, where appropriate to promote return to community living where possible.

Specialist Accommodation, Supported Housing and Care Options

- RRCS will consider how best to ensure people with acquired brain injury (ABI), who are continuing to achieve rehabilitation, care and support goals at a slower rate receive the support they require.

4 SERVICE USERS

4.1 INCLUSIONS

The following client groups may be included within this service:

- People with high support and chronic complex care needs that require a long term accommodation setting.
- Clients needing to return to community living where possible and minimise the ill-effects of long term care.
- Clients needing respite and transitional services as they relate to extended care services.

4.2 EXCLUSIONS

The following client groups are excluded from this service:

- Children under 18 years.

5 ACCESS

5.1 ENTRY CRITERIA FOR TRANSITION CLIENTS

- Clients must be transferred from a rehabilitation service provided by Royal Rehabilitation Centre Sydney (spinal injury rehabilitation, brain injury rehabilitation, working age rehabilitation or aged care rehabilitation); and
- An assessment has identified that transition services or respite are required. This may occur at the completion of the client's intensive rehabilitation program:
  - Whilst awaiting discharge to the community. Delay in discharge to the community maybe for a number of reasons, including completion of home modifications, difficulty accessing appropriate support services in the community and lack of appropriate discharge destination.
  - For those clients who on assessment have been identified as likely to demonstrate gains as a result of care under an extended care model (particularly for clients who continue to achieve rehabilitation, care and support goals at a slower rate); or
- The client will benefit from the specialised treatment offered by the extended care service to treat a condition that is preventing/ delaying the completion of a rehabilitation episode.

5.2 EXIT CRITERIA OR DISCHARGE FROM THE SERVICE

- Goals achieved and appropriate discharge options available
- Self-discharge.
- Death

5.3 ACCESS

The service provided as per this specification is only accessible for the client base as outlined in the Memorandum of Understanding between NSW Health, DADHC and RRCS. The client base includes:

- 20 Long term Weemala Residents (note: this refers to 20 specific clients, not places, see Appendix 1 for list of clients).
- 5 transition places

6 SERVICE COMPONENTS

6.1 PROCESS

Service Component	Description
Referral Management	• The service will receive referrals for transition places only. • All clients referred to the transition service will have an assessment completed.
Provision of Care	The Service Provider will ensure that: • Multi-disciplinary clinical review and health care planning are completed at least every 6 months and at more regular intervals where required. • I-CAN – support needs assessment is completed for all clients (including transition clients) and updated annually. • A person-centred plan is developed in association with the client, family and relevant others and programs are provided in accordance with these plans. (Due to the long term nature of the person centred plan these are not completed for transitional residents). • A Health Care Plan is developed for clients with multi-occupational care needs, is reviewed every 6 months and annual medical check up completed. • The client's General Practitioner providers input into Health Care Plan and relevant sections of the plan are completed by the General Practitioner as required. • A case conference for each client is held at a minimum, annually. • All clients will have rehabilitation program goals, clear and measurable baselines and treatment goals. • Care planning and review will take into account the opportunities for less intensive treatment and care. • All clients will have a plan developed for long-term care including the identification of appropriate accommodation and support and, where appropriate, to promote return to community living where possible and minimise the ill-effects of long term care. • Behaviour intervention programs that maximise social and personal functioning are integrated in treatment and rehabilitation including, a comprehensive behaviour support plan and appropriate care management protocols. • Support and education is provided to carers and they are assisted with their ongoing relationship with the client and required community networks. • Respite and transitional services are provided as they relate to extended care services. • Established service network links with referring agencies and other service providers ensure timely discharge and continuity of care. • All clients will receive a nutrition service. The above components of care are applicable to transition clients (with the exception of the person plan). In addition to the above components a formal review of the discharge plan for all transition clients is completed every 6 months.

Service Component	Description
Care Coordination and transfer of care	As the Extended Care Service is a state wide service, compliance with broader policy initiatives is required. Where applicable the service provider will: : • Provide to clients a copy of their multi-disciplinary assessment results and outline of the subsequent plan to assist them in providing information to other relevant professionals, carers and family. • Forward the results of multi-disciplinary assessments to specified professionals involved in the provision of care and support for the individual in line with privacy and consent guidelines. • Subject to the considerations of individual privacy the valuable client information included in a rehabilitation, care and support plan should be made available to the client and those in other settings who may be able to assist in the attainment of the rehabilitation goals. • Share and transfer client information across agencies in a manner that acknowledges the rights of clients, the legislative framework and the current technological capacity of agencies. • Be responsible for the coordination of services for people under the Extended Care Service, at a state-wide level where required. • Maintain agency coordination and communication
Education	The Service Provider will: • Undertake education and research to support practice development, improved quality of care, and client outcomes. Dissemination of information to the health and disability workforce. • Build community capacity through the dissemination of information to the health and disability workforce and to those involved in the care of the client. • Be a source of education and support for carers, other agencies to improve client outcomes.

6.2 SETTINGS

Service Type	Service Definition
Direct Care Inpatient	Long-term support, rehabilitation, and accommodation

6.3 FACILITIES

Clients of the Extended Care Service have access to all facilities on the Royal Rehabilitation Centre Sydney Hospital Campus.

7 SERVICE LINKAGES

The Service assists in the development, and maintenance, of service linkages between:

- NSW Health, NSW Department of Ageing Disability and Home Care, Community Programs e.g. Day Programs, local clubs and facilities and statutory authorities.

8 QUALITY REQUIREMENTS

The service is required to comply with the quality requirement outlined in the Terms and Conditions outlined in Part 1 of the Agreement. In addition, the following quality standards and requirements also apply:

- Disability Services Standards
- DADHC Integrated Monitoring Framework.

9 SERVICE UNITS

Service Unit	Service Measure	Service Measure Definition
Inpatient (transition place)	TBD	TBD
Inpatient (long term place/resident)	TBD	TBD

10 REPORTING REQUIREMENTS

Service Unit	Frequency and Reporting mechanism	Reporting requirements
Inpatient	Quarterly Area Performance Unit (APU) prepare reports from DOHRS and SNAPshot Plus	• Available beds • Bed days • ALOS • Separations
	Quarterly Reports prepared by RRCS and provided to APU	• Separations (transition places, long term places) • Long term resident and transition client list updated and provided to the Area Health Service quarterly. • The Service evaluates the effectiveness of programs and incorporates evidence based practice. • Number of clients with a health care plan • Number of multi-disciplinary clinical reviews • Number of case conferences • Number of patients referred to Weemala • Number of referrals not accepted • Source of referral

11 GLOSSARY

World Health Organisation International Classification of Functioning, Disability and Health (ICF)

The ICF is WHO's framework for measuring health and disability at both individual and population levels. The ICF was officially endorsed by 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21).

The ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of

disability. Disability is not something that only happens to a minority of humanity. The ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric - the ruler of health and disability. Furthermore ICF takes into account the social aspects of disability and does not see disability only as 'medical' or 'biological' dysfunction. By including Contextual Factors, in which environmental factors are listed, ICF allows to record the impact of the environment on the person's functioning.

Health Care Plan – The Health Care Plan is an essential element in client's Person Centred Planning. The tool is tailored to individual needs at a personal and health promotional level. The Health Care Plan includes input from medical, nursing and allied health professionals